



SOUTH DAKOTA  
DEPARTMENT OF HEALTH



OFFICE OF CHILD & FAMILY SERVICES  
**2020 TITLE V NEEDS  
ASSESSMENT REPORT**

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# EXECUTIVE SUMMARY

## MCH POPULATION NEEDS AND TITLE V PRIORITIES NEEDS ASSESSMENT FRAMEWORK

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 abuse 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 abuse	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 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

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 abuse, parenting education and support, equitable 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. South Dakota State University (SDSU) Population Health Evaluation Center will provide support and build state capacity for enhanced performance reporting.

## ROLE OF STATE TITLE V

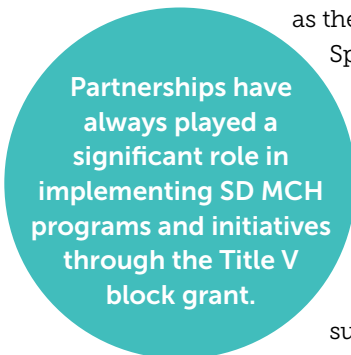
The OCFS administers the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), community health nursing, the Bright Start Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, and the MCH block grant among others. While OCFS has a huge service delivery and outreach 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. Each domain leader prioritizes strategies that are informed by data and address health inequities.

## PARTNERSHIPS

The 2020-2025 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 76 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 develop the MCH workforce. Program planning has been prioritized and cultivated throughout the needs assessment process in collaboration with interagency partnerships, such



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as the Department of Social Services (DSS). Specifically, DSS will expand 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. 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). Moreover, 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.



## MCH SUCCESS STORY

Implementation of a comprehensive needs assessment process that emphasized health equity and engaged multi-sector partners and community members for the first time is a significant success that illustrates federal-state Title V partnerships in action. Specifically, the process engaged new external partners throughout the process, including data collection and action planning, and the Title V program continues to engage these partners. Community members, including adolescents, tribal communities, and underserved populations were engaged to ensure the voice of populations impacted by health issues was included in the process. Moreover, by including a focus on health equity throughout the process, the MCH program has established a foundation to ensure efforts moving forward are focused on addressing health equity across all domains. The needs



assessment provided a foundation to build the capacity of the Title V program and federal-state partnerships in action.

# 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. There are 882,235 living in SD with an average population density of 10.7 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 is 84.4% White, 9% American Indian (AI), 2.4% Black, 1.7% Asian, 2.4% Two or More Races and 4.1% Hispanic or Latino. The population by sex is 49.5% female and 50.5% male. Just under 25% of the state's population are persons under the age of 18, with 7% 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 median household income is \$56,499. 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%. Almost 12% of persons under 65 years of age lack health insurance. In addition, 91.7% of persons aged 25 years and older are high school graduates or higher and 28.5% have a bachelor's degree or higher. Key industries that shape SD's economy include agriculture, mining, finance, 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. Approximately 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 4, 2019, there were 4,442 physicians and 654 physician assistants licensed in SD. In addition, there were 1,140 actively licensed nurse practitioners and 34 actively licensed 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, 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, impacting social media, 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 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 76 local



community health offices. A wide array of public health services is provided including interpreter services, direct services, and outreach services provided by WIC, Title X Family Planning, and the Bright Start Home Visiting program. 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 Chairmen's Health Board on behalf of the Rosebud Sioux Tribe and Sisseton Wahpeton Oyate.

## SOUTH DAKOTA SYSTEMS OF CARE

According to federally available data, the MCH Block Grant in SD aims to serve approximately 11,000 pregnant women, 12,000 infants, 253,000 children and adolescents age 1 through 21, and 45,000 children and youth with special health care needs. SD has 49 general community hospitals, of which 38 are critical access hospitals and 32 provide routine obstetrical services. There are five federally qualified health centers (FQHCs) and 60 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 76 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.

An average of 116,000 South Dakotans relies on Medicaid for their healthcare each month. The vast majority, 68%, are children. Half of the children born in SD each year will be on Medicaid during their first year of life and 35% 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 age 6-19 at 116% FPL, parent/caregiver/relatives of low-income children at 52% FPL; CHIP (Children's Health Insurance Program) at 209% FPL. Twelve percent of women of childbearing age are not insured by public or private insurance and 10 % of children under 200% FPL are uninsured (U.S. Census Bureau, ACS and [Kaiser Family Foundation](#)).



# FIVE-YEAR NEEDS ASSESSMENT SUMMARY

## BACKGROUND AND INTRODUCTION

The DOH's OCFS administers the Title V program and Title V MCH Block Grant for SD. The OCFS has conducted needs assessments every five years to understand the health needs for SD's pregnant women, mothers, infants, children, and CYSHCN. The needs assessment provides an opportunity for the OCFS to evaluate progress towards achieving performance measures, assess population health status for families and individuals (including underserved populations), assess capacity of OCFS staff and programs to serve families and individuals, and to select priorities to address. An external public health consultant, SLM Consulting LLC, was contracted to assist with planning and implementation of this needs assessment. In the fall of 2018, the OCFS initiated the needs assessment process, to help shape the 2020-2025 State Action Plan.

Planning took place between September and December 2018 and included identification of the process design and timelines, staff roles to support planning and implementation, guiding frameworks and principles, partner organization involvement, a communication plan, and data collection methods. Implementation of the needs assessment occurred between January 2019 through December 2019 focused on broad stakeholder engagement and comprehensive data collection and analysis that informed identification of priority needs for SD's maternal and child health population to address between 2020 and 2025. This report provides an overview of the MCH needs assessment process and findings, including strengths and needs of the process and health status of populations by domain.

## PROCESS

### GOAL, FRAMEWORKS, & GUIDING PRINCIPLES

The goal, frameworks, and guiding principles that informed the needs assessment were chosen to ensure the process engaged priority populations across the lifespan and addressed health equity. The needs assessment was shaped by guiding principles that supported a comprehensive and inclusive process.

The goal of the process was to inform priority setting and OCFS planning through integration of needs assessment findings. Two frameworks shaped the needs assessment process, including the Life Course Theory and Health Equity Model. Utilization of the Life Course theory was important to first understand health issues that impact the MCH population at all stages of life, including health patterns and disparities. Utilization of this approach ensured inclusion and understanding of the factors that shaped the health and well-being of families and individuals across a lifespan. Secondly, the Health Equity Model was used in alignment with the Life Course Approach to conceptualize social determinants of health that impact the MCH population across the life course. Specifically, understanding

factors that contributed to health issues, including social, economic, and physical factors, was important to shape the needs assessment and identify root causes impacting health outcomes, priority needs, and action plans. The OCFS adapted the Health Equity Model of the Colorado Department of Public Health & Environment.

Guiding principles that supported the implementation of a comprehensive and inclusive process, as well as the needs assessment frameworks included:

- Evidence-based decision making;
- Using a health equity lens;
- Respond to emerging issues and trends that affect families and individuals in SD;
- Social determinants of health;
- Input from diverse stakeholders and partners;
- Do not reinvent the wheel; and
- Setting realistic priorities and performance measures.

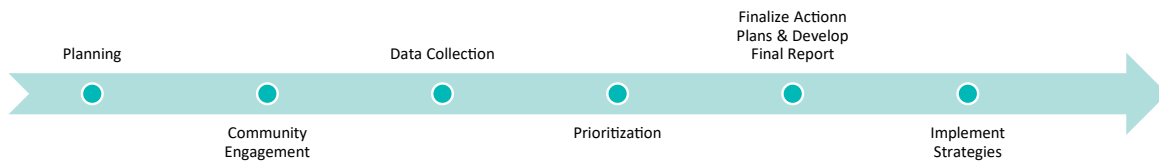
### METHODOLOGY

The needs assessment was shaped by a collaborative

approach that engaged multi-sector partners, families, and individuals from across the state through data collection and information gathering approaches, including surveys, regional partner meetings, and focus groups. Input was sought from partner organizations, families, and individuals who represent broad perspectives, with targeted outreach to ensure representation from diverse SD geographies and underserved populations. New and existing partners were engaged throughout the process, with an emphasis on ensuring transparency regarding the process and fostering sustainable partnerships.

Planning for the needs assessment was conducted

between September – December 2018 in collaboration with OCFS staff, internal partner agencies, and an external consultant, including a Needs Assessment Project Team, OCFS Advisory Committee, and the MCH Impact Team. Planning included identification of the process design and timeline including leadership roles, communication plan, quantitative and qualitative data collection methods, prioritization, finalization of the needs assessment report and implementation of 2020-2025 priorities and evidence-based strategies. Implementation of the needs assessment launched in January 2019, informed by the process design and timeline.



## LEADERSHIP ROLES

The roles that supported planning and implementation of the needs assessment included the following:

- **Needs Assessment Project Team:** This team included a core group of OCFS staff, including the Administrator, MCH Program Director, Bright Start Home Visiting Manager, MCH Epidemiologist, and SLM Consulting. This team served as the core team who helped design and facilitate the process, develop guiding principles, a communication plan, and data collection methods, as well as identified the leadership roles necessary to implement the process. This team met every other week to support planning for the implementation of the needs assessment.
- **OCFS Advisory Committee:** This team included OCFS program leaders who helped inform the process design and timelines, prioritization, and served as a pipeline to partner organizations, families and individuals. Advisory Committee members are in communities across South Dakota. The Advisory Committee was convened monthly starting in November 2018.
- **MCH Impact Team:** This team includes DOH offices and program, including the Office of Chronic Disease Prevention and Health Promotion, Office of Health Statistics, Communications,

Immunization Program, and the OCFS staff who helped to inform decisions on the process, data collection, and identification of priorities for the 2020-2025 Action Plan.

- **Partner Organizations:** Partners included organizations, agencies, and stakeholders who the OCFS Needs Assessment Project Team, Advisory Committee, and MCH Impact Team identified as integral to support a collaborative needs assessment process. This included giving them a voice regarding partnerships and service programs that should be supported to meet the needs of families and individuals. In addition, partner organizations who represented diverse families and individuals were identified to help understand and assess social determinants of health that affect families and individuals in SD.
- **Families and Individuals:** These populations included men, women, children, and youth (including CYSHCN) who are served by the OCFS programs and partner organizations, providing a community perspective on health issues. These populations informed data collection and identification of priority health issues and needs necessary to shape priorities for the 2020-2025 Action Plan.



## COMMUNICATION PLAN

A comprehensive communication plan with media outlets shaped the implementation of the needs assessment. The plan was designed to engage and keep partners, key stakeholders, families, and

individuals and the MCH Impact Team updated on the process. An internal DOH graphic designer formatted communication resources to ensure consistent branding and design. The plan included:

RESOURCE	IMPLEMENTATION
<b>Kick-Off Webinar</b>	Implementation of the needs assessment process was launched in January 2019 through a kick-off webinar facilitated by the OCFS Administrator and Needs Assessment Project Team via the Zoom platform. Members of the Needs Assessment Project Team, OCFS Advisory Committee and MCH Impact Team invited partner organizations via e-mail to participate. The webinar was recorded and disseminated to those unable to attend live.
<b>Monthly Newsletter</b>	Included information regarding OCFS staff, needs assessment activities, and relevant data. The newsletter was disseminated to partners, OCFS Advisory Committee, and MCH Impact Team via MailChimp.
<b>Talking Points for Program Leaders</b>	Resource developed to guide OCFS Advisory Committee on key components of the needs assessment to share with partners as applicable.
<b>E-Mail</b>	Key information important to implement the needs assessment was communicated via e-mail to partners, the OCFS Advisory Committee, and the MCH Impact Team.
<b>Social Media</b>	Posts were shared via Facebook to invite partners, key stakeholders, and families and individuals to participate in community engagement and data collection activities.
<b>South Dakota DOH Website</b>	Information regarding the needs assessment process and opportunities to get involved were posted to the webpage to invite public input and community engagement.

## STAKEHOLDER ENGAGEMENT

A collaborative approach was the foundation of the needs assessment process, focused on engaging diverse partners and stakeholders to inform a comprehensive understanding of health and well-being issues that impact families and individuals across SD. Input was gathered from stakeholders who represented state agencies, community-based organizations, health care providers, tribal agencies, as well as local community members, families, and individuals disproportionately impacted by health and well-being issues. The process engaged stakeholders across the state through

regional partner meetings, focus groups, and surveys that gathered input from individuals, families, and communities. Guiding principles of the needs assessment included:

- 1) Elicit input from diverse stakeholders and partners from a wide geographic distribution
- 2) Build sustainable partnerships with stakeholders and partners to better support families and individuals across SD through programs and services

## PARTNER ORGANIZATIONS

The OCFS Needs Assessment Project Team and Advisory Committee identified existing and new partners to participate in the needs assessment process for data collection, priority setting, and action planning. Engaging partners in this way provided an opportunity to expand the reach of Title V, understand shared priorities and strengthen the foundation of coordinated health and community systems of care.

Partners whose focus included working with women, infants, and children (including children with special health care needs) as well as families and individuals impacted by health disparities were invited to participate. OCFS program leaders leveraged their existing partners to invite their community partners as well. Outreach totaled 110 partner organizations, representing 19 sectors, including but not limited to: state government staff, higher education, community-based organizations,

family-led organizations, private businesses, faith-based organizations, health systems, health professional organizations, community coalitions, Tribal MCH programs including WIC, Tribal colleges, and Tribal government. Many of the partners work within all the MCH domains.

Partner organizations were invited to participate in the January 2019 launch of the needs assessment process via a webinar facilitated by the OCFS Needs Assessment Project Team. Partners were also invited to complete a survey which assessed priority health issues impacting families and individuals they work with in SD. Survey findings informed the design of other data collection methods utilized in the needs assessment including a youth survey, community input survey, and focus groups. Partners were also engaged through regional partner meetings.

Other data collection methods partners participated in included a community input survey to provide feedback on priority health issues impacting the MCH population across the state. Partners were asked to share the survey with their own stakeholders and other relevant organizations. After completion of data collection, partners were invited to participate in a webinar to learn about the key findings to inform priority setting by domain. In-person and virtual meetings were held with partners by domain to discuss key findings and identify

two priorities to focus on in the 2020-2025 State Action Plan. Subsequent action planning was conducted in collaboration with partners to ensure diverse, meaningful input and collaboration moving forward.

Partners were also kept informed of the needs assessment process through a monthly newsletter devoted to providing information about MCH staff and on-going activities. It was important to be transparent with partners and keep them engaged throughout the entire process. The process provided a foundation to build existing and new partnerships that will be important to coordinate MCH programs and support the health and well-being of families and individuals served.

## FAMILIES AND INDIVIDUALS



Engagement of families and individuals was identified as a key component of the needs assessment process early in the planning stage. It was important to inform an understanding of health and well-being issues directly from families and individuals experiencing them. Input was elicited from families and individuals supported by OCFS programs and partner organizations through a community input survey, youth survey, and focus groups. Efforts were made to engage underserved populations disproportionately affected by health and well-being issues, including American Indian, low-income, youth, and rural populations. Partner organizations were integral to support engagement of families and individuals in this process, particularly in communities where OCFS staff and programs did not have a footprint.

The community input survey was disseminated to partner organizations, with the invitation to share it with families and individuals they serve. The survey

was designed to elicit feedback on priority health issues impacting women, infants, children, and adolescents, including those with special healthcare needs. A youth survey was also disseminated to SD youth, grades 5-12, to elicit feedback regarding their health and well-being needs and issues. Targeted efforts to engage these populations included attending local tribal events and youth conferences – 4H and Future Farmers of America - to recruit individuals to complete the surveys. In addition, the community input survey was disseminated to WIC offices statewide, where OCFS staff supported individual and family engagement.

Families and individuals in four SD communities were also engaged through focus group discussions facilitated by SDSU Population Health Evaluation Center. These groups provided the opportunity to gather in-depth feedback on health and well-being needs and issues impacting their communities. Participants were selected based on geographic variation and populations where additional feedback was sought including youth, women, co-parents, and single parents.

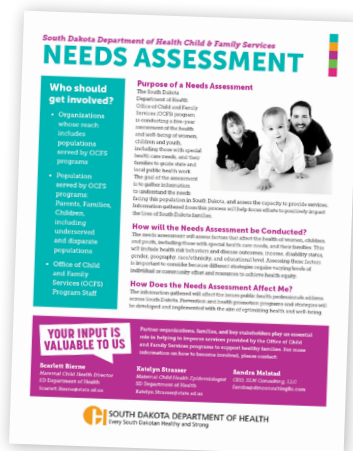
## QUANTITATIVE AND QUALITATIVE METHODS

Comprehensive quantitative and qualitative data collection methods were utilized to assess population health status and issues that impact families and individuals (e.g. women, infants, children, and adolescents, including those with special healthcare needs and underserved populations) across SD, as well as to assess the capacity of OCFS partner organizations and OCFS staff who serve families and individuals across the state. Quantitative and qualitative methods utilized included a partner survey, regional partner meetings, community input survey, youth survey, focus groups, and fall partner meetings.

those issues. Partners were also asked to share contact information for other partners who could help inform the needs assessment. The survey was disseminated electronically and informed the scope of future data collection efforts including the youth and community input surveys, regional partner meetings, and focus groups. The full report is available in Appendix XX.

### OCFS PARTNER SURVEY

The OCFS Partner Survey was a preliminary survey designed to elicit quantitative and qualitative input from partner organizations regarding priority health and wellbeing issues that impact families and individuals they serve. The survey was developed based on existing MCH indicator data and priority health issues. The survey gathered feedback on demographics of survey participants, issues related to women, infant, child, and adolescent health most important for public health professionals to address, as well as recommended data sources relevant to



### REGIONAL PARTNER MEETINGS

Partner meetings were held in five regions across the state with a total of approximately 100 partners to discuss unique health and well-being needs of women, infants, children, and adolescents, including those with special health care needs. SD is a geographically diverse state, shaped by rural and urban communities, nine federally recognized American Indian tribes, and unique issues that impact each of these areas. To foster stakeholder engagement, it was integral that OCFS took the opportunity to engage partners in their communities and gather qualitative data. [See the full 2019 OCFS Needs Assessment Partner Report](#)

### REGIONS

Members of the OCFS Needs Assessment Team, OCFS Advisory Committee, MCH Impact Team, and Partner organizations convened for meetings in three geographically diverse SD communities; Rapid City, Pierre, and Sioux Falls to discuss the health and well-being needs of the MCH population unique to regional areas. The CYSHCN domain was incorporated into the child and adolescent domain discussions with the understanding that the CYSHCN priorities would be identified separately in future priority-setting processes.

Meetings were also held in two tribal communities, Pine Ridge and Sisseton. The meeting in Pine Ridge was held with Raising Healthy Families Together, an informal network of social service organizations providing services to the residents of the Oglala Lakota Nation on the Pine Ridge Reservation. This group meets quarterly on the first Thursday of the month.

The meeting in Sisseton was held with the Sisseton Wahpeton Oyate, First 1000 Days Initiative Interagency Forum, whose mission is creating collective impact in the first 1,000 days for healthy, resilient families on the Lake Traverse Reservation. The forum is comprised of service providers from tribal programs, non-tribal programs, and IHS. They meet on the third Thursday of each month.

## AGENDAS

Meetings included an overview of the needs assessment process (including frameworks), guiding principles, and goals. An overview of findings from the Partner Survey, as well as data relevant to MCH programs, indicators, and performance measures was provided. Data briefs were also developed to provide an overview of data relevant to the health of SD women, infants, children, and adolescents. This overview was important to help inform participation and discussion.

Partners in Rapid City, Pierre, and Sioux Falls participated in small group discussions by domain (women, infants, children, and adolescents) throughout the meeting. They participated in a storytelling activity and shared successes their organizations have had to address/improve the health and well-being of domain populations. Participants completed a 5 R's assessment to inventory the local system as it relates to the domain populations, including the roles (actors involved in the local system shaping the issues under study), relationships (what are the important relationships between actors), rules (rules, policies, laws governing what happens in local system), resources (inputs such as budget, personnel, time, data, trust available to local system), and results (what are the actual and desired bigger picture results that help understand how the system is functioning).

Participants used the inventory to complete an Asset/Gap activity, where they identified local assets available to support the health and well-being of domain

populations, as well as gaps that hinder the health and well-being of the population. Based on the assets and gaps identified each domain group identified the top five priorities that participants felt should be addressed in their region. Information from these meetings was used to inform development of the Community Input Survey.

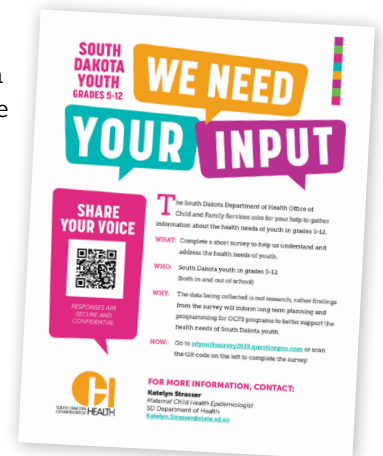


## YOUTH SURVEY

The OCFS supports an adolescent health program whose purpose is to reduce negative health outcomes for youth 10 to 19 years old through provision of programs, services, and community collaboration. The youth survey was a key data collection method used to elicit feedback from SD youth for the first time in an

MCH needs assessment. The OCFS Adolescent Health Program collaborated with the Sexual Risk Avoidance Education and Personal Responsibility Education Program, the OCFS Needs Assessment Team, and SDSU EA Martin (EAM) Program to develop the survey. This collaboration helped shaped quantitative and qualitative data collected in the survey to guide adolescent programming.

The survey elicited input from 659 SD youth, grades 5-12, regarding priority health issues affecting them, including health problems, access/use of healthcare, substance use behaviors, bullying, sexual education and health, and prevention behaviors. The survey was





disseminated electronically to partner organizations who serve youth, as well as via hard copy at local and state conferences targeted at SD youth. Specifically, OCFS Needs Assessment Project Team and Advisory Committee members attended local events as a DOH vendor to share resources and invite participants to complete the survey. SDSU EA Martin Program staff managed and analyzed the survey data and developed the final report. OCFS staff and contractors worked with MPH student interns to analyze and code the open-ended questions. [See the full 2019 OCFS Youth Survey Report](#)

## COMMUNITY INPUT SURVEY

A Community Input Survey was a key data collection method used in the needs assessment process to seek input from community members and partners important to the process. The survey was developed by the OCFS Needs Assessment Team and SDSU EAM Program, to elicit feedback about unmet needs affecting the health of infants, children, adolescents, and women, as well as community services utilized. The survey elicited input from 1,020 SD families and individuals served by OCFS programs, OCFS partner organizations, as well as concerned parents, parent/guardians of children with special health care needs, community service providers, educators, health care providers, policy makers, tribal government, and government employees who support these populations.

The survey was disseminated electronically to the OCFS Advisory Committee, MCH Impact Team, and OCFS partner organizations, who were asked to disseminate to other partners as well as families and individuals they serve. The survey was also available on the DOH website for public access.

The survey was also disseminated via paper-copy to all DOH community health clients (including WIC clients) and at local events sponsored by partner organizations, including health fairs hosted by tribal partners.



Specifically, OCFS Needs Assessment Project Team and Advisory Committee members attended local events as a DOH vendor to share resources and invite participants to complete the survey. Dissemination was targeted at underserved populations served by OCFS programs and partner organizations to understand opportunities to address health equity in future program planning.

SDSU EAM Program managed and analyzed the survey data and developed the final report. OCFS staff and contractors worked with Master of Public Health student interns to analyze and code the qualitative data. [See the full 2019 OCFS Community Survey Report](#)

## FOCUS GROUPS

Focus groups were held in four SD communities with unique populations, including women living on an American Indian reservation, co-parenting adults in a rural community in northwestern SD, single parents in eastern SD, and youth in southeastern SD. The focus groups were held to capture in-depth feedback on the health and wellbeing issues that impact families and individuals in rural and underserved communities. The focus groups were facilitated by SDSU's Population Health Evaluation Center and informed by a focus group discussion guide. Questions that guided focus group discussion were developed with collaboration from the OCFS Needs Assessment Project Team. [See the full Needs Assessment Focus Group Findings document](#)

## DATA SOURCES

Data sources utilized to inform the needs assessment included regional partner meetings, secondary data, MCH indicator data, as well as state and federal performance measures are summarized below:

TYPE	DESCRIPTION
<b>Data Briefs</b>	Data briefs were developed specific to women, infants, child, and adolescent domains, which include data specific to each population and the health issues impacting them. The briefs were disseminated to the OCFS Advisory Committee, the MCH Impact Team, and partners via e-mail and at in-person meetings. <a href="#">See 2019 Child Health Data Brief</a>
<b>MCH Indicators</b>	Common measurements for the health of these populations were drawn from federally available data sources such as the National Survey of Children’s Health, PRAMS, National Vital Statistics System, Youth Risk Behavior Survey, Behavioral Risk Factor Surveillance System, and American Community Survey. These indicators were used in the data briefs and presentations to needs assessment partners.
<b>MCH National Performance and Outcome Measures</b>	MCH/Title V specific national performance and outcome measures were informed by the indicator data and shared with partners through data briefs and data presentations at regional meetings.
<b>Regional Partner Meetings</b>	Five Regional Partner Meetings were held across the state to understand regional differences and needs within MCH populations. <a href="#">See 2019 Needs Assessment Partner Summary Report</a>
<b>Surveys</b>	The Community Input Survey and Youth Survey were both conducted as a part of this needs assessment to gather input South Dakotans on their unmet health needs. Refer to Appendix for Needs Assessment Community Survey and Youth Survey Reports Executive Summaries.
<b>Focus Groups</b>	Four focus groups were held to understand the needs of youth, single parents, co-parenting individuals, and Native American women. Refer to Appendix for the Focus Group Executive Summary.

### INTERFACE OF DATA, PRIORITY NEEDS, AND ACTION PLAN

Needs assessment data informed shared decision-making by partners and OCFS staff to identify preliminary priority needs of women, infant, children, CYSCHN, and adolescents served by the MCH program and partners. The Needs Assessment Project Team and key OCFS Advisory Committee members met in December 2019 to finalize priorities for each domain based on the needs assessment data. Each domain leader outlined chosen priorities, possible partners, suggested evidence-based strategies and how the priorities might align with National Performance Measures (NPM) or State Performance Measures (SPM). After discussing the priorities identified through the needs assessment process, the group chose NPMs and SPMs that align. Facilitators were then chosen to lead each NPM/SPM workgroup which would

include external and internal partners. Each NPM/SPM facilitator met with new and existing partners to begin looking at strategy development to form the State Action Plan.

In February 2020, members of the Needs Assessment Project Team and OCFS Advisory Committee participated in Evidenced-Based Decision-Making training using Results Based Accountability framework provided by John Richards, Strengthen the Evidence for MCH Programs and Oscar Fleming, National MCH Workforce Development Center. The technical assistance provided an opportunity to create an evidence-based action plan using Evidence-Based Strategy Measures (ESM) that advance NPMs. During the training attendees analyzed the story behind the data, identified partners and what role they play, and discussed what works and what resources and activities we need to address the problems.



## FINDINGS

### MCH POPULATION HEALTH STATUS

#### WOMEN/MATERNAL HEALTH

##### Strengths and Needs

Findings from the needs assessment revealed many notable strengths and needs in women/maternal health. Feedback elicited from partners at the regional partner meetings recognized strengths including: workforce development programs, available data (e.g. Pregnancy Risk Assessment Monitoring System (PRAMS), access to healthcare services (e.g. Federally Qualified Health Centers and Indian Health Services), the 211 Helpline, community programs (e.g. Family Planning, counseling services, the South Dakota QuitLine), and existing partnerships and collaboration between agencies that promote health. Needs identified specific to women/maternal health largely centered on social needs, mental health, and substance abuse, as well as access to healthcare services.

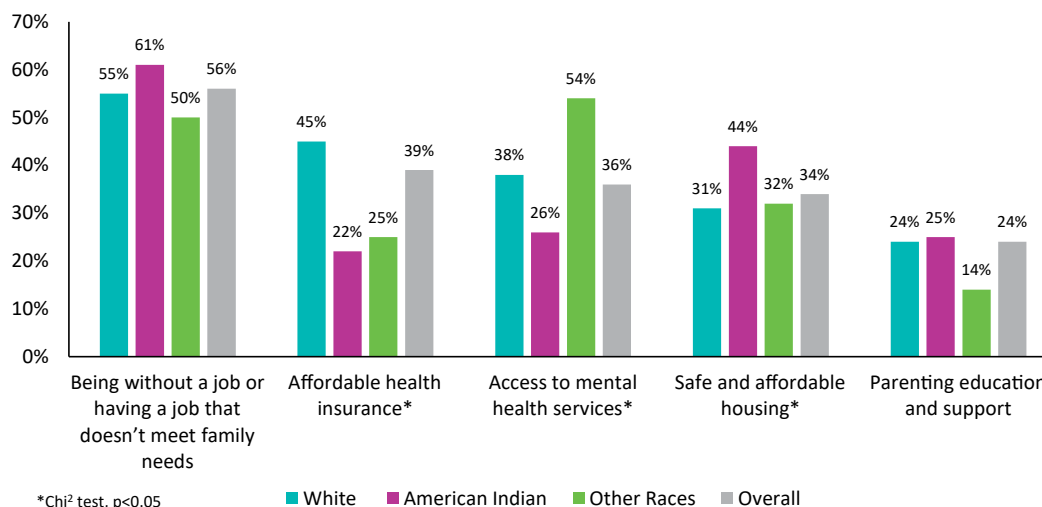
##### Successes, Challenges, & Gaps

Input from the regional partner meetings, along with qualitative data from the community input survey and focus groups revealed some challenges and gaps for all women. Social needs, including lack of transportation, joblessness or having a job that does not meet the family's needs, lack of education, and poor housing conditions were noted gaps in women/maternal health outcomes. Data also revealed gaps in access to

healthcare services and providers, lack of sexual health education, lack of cultural awareness and the need for improved advocacy around women's health issues (DOH, 2019).

Women's mental health and substance abuse were common themes across the state. Focus group participants were concerned about gaps in counseling services and underutilization of available services due to a lack of awareness and confidentiality. Participants also identified concerns around substance abuse, especially methamphetamine. Findings from the community input survey indicated that access to mental health services and substance abuse prevention and treatment were ranked among the top six priorities. Specifically, women who were married, who had a higher income, and were white or a race other than American Indian stated that access to mental health services was more likely to be an unmet need than women who were not married, who had a lower income, and were American Indian. While the MCH program has had limited success in increasing the number of women ages 18-44 who received a well-woman, preventative medical visit each year, SD did report a higher rate of visits in 2018 compared to the national average (77% vs. 74%, respectively). Needs assessment findings indicate the importance of such a visit as a care coordination and referral starting point for women.

Figure 1. Percentage of participants that ranked being without a job or having a job that doesn't meet family needs, affordable health insurance, access to mental health services, safe and affordable housing, and parenting education and support, in the top three unmet needs for women, by race (n=897).



Maternal attitudes and behaviors of SD mothers also reflects challenges and gaps in morbidity and health risks as outlined in 2018 PRAMS data, including:

- 67% of mothers statewide reported drinking alcohol 3 months before pregnancy, and 8% reported drinking alcohol the last 3 months of pregnancy.
- 25% of mothers statewide reported smoking the 3 months before pregnancy and 10% smoked the last 3 months of pregnancy.
- 16% of women reported depression 3 months before pregnancy, 17% reported it during pregnancy, and of those that had a postpartum visit, 13% reported symptoms indicative of postpartum depression.
- Women that were enrolled in the SD WIC program were more likely than those not enrolled in WIC to have depression during pregnancy (26% vs. 13%) and score high on indicators for postpartum depression (21% vs. 10%) (SD PRAMS, 2018).



### **Current MCH Block Grant Efforts**

Current efforts to support women/maternal health include: 1) partnering with Title X and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to promote the well-woman visit, 2) partnering with the WIC program to increase the number of well-woman visit referrals made, and 3) working with one of the major insurance companies in the state to send out a reminder letter regarding well-woman visits to women of childbearing age, an evidence-based strategy.

The OCFS has not formally addressed the mental health status of its clients in community health offices across the state. However, opportunities to implement new strategies, as well as enhance the current strategies can better support this effort, ensuring an emphasis

on health equity. New strategies to address this priority using MCH funds will include: 1) implementing an evidence-based behavioral health screening tool to be utilized in all OCFS sites; 2) creating a toolkit of evidence-based resources on maternal mental health/substance abuse to support referral; 3) training OCFS field staff on recognizing the symptoms of perinatal depression; and 4) the use of the selected screening tool and when/how to refer. Developing new partnerships with multi-sector, diverse partners to help address this priority need will also be key to equitability supporting women across the state, including underserved and vulnerable populations.

## **ADOLESCENT HEALTH**

### **Strengths and Needs**

Notable strengths in the adolescent health domain include the following: the availability of community resources, activities, and recreational opportunities; training resources; collaboration across youth programs and non-profit organizations; youth led groups; and telehealth.

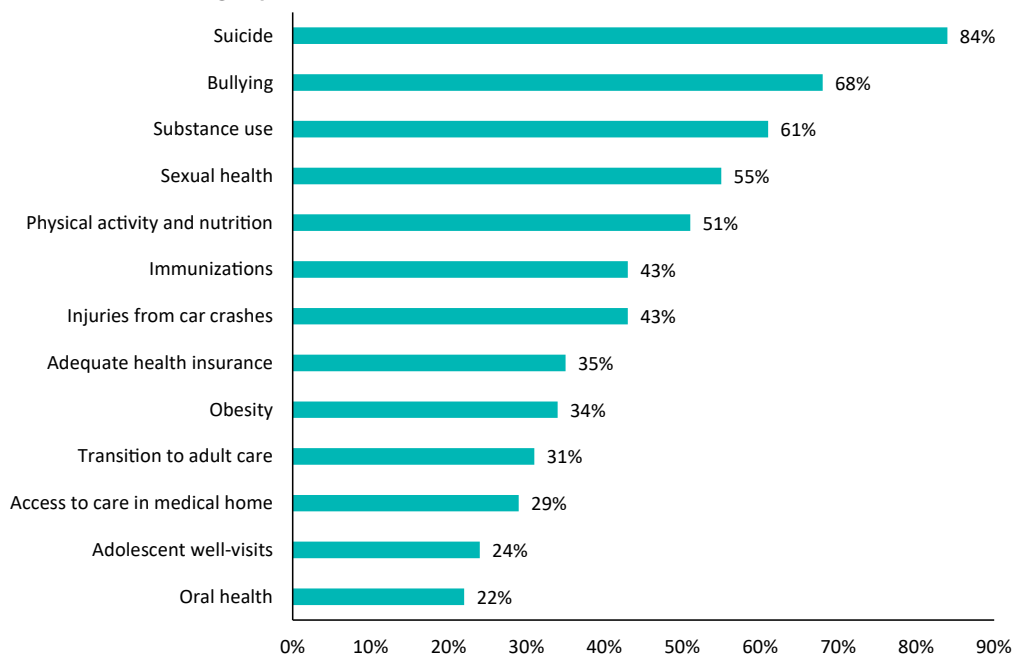
Despite these identified strengths there are additional needs specific to adolescent health including a focus on mental health, substance abuse, sexual health, and health behaviors.



### **Successes, Challenges, & Gaps**

Much of the data identified in the needs assessment highlights poor outcomes for adolescents in SD. Specifically, both adolescent mortality and adolescent suicide rates for 10 through 19-year-olds in 2017 were some of the highest in the country at 51.7 per 100,000 and 30.0 per 100,000, respectively (DOH Vital Statistics, 2017 and MCHBG Annual Report, 2019). In addition, the youth survey identified the top five health concerns among youth age 11-18 as: 1) suicide, 2) bullying, 3) substance abuse, 4) sexual health, and 5) physical activity and nutrition. Survey data also indicated that youth felt that resources were lacking in the areas of mental health, reproductive or sexual health, and substance abuse treatment and prevention. Sexual health and suicide prevention were the two top priorities consistently noted throughout the needs assessment process (DOH, 2019).

**Figure 2. Percentage of participants that either ranked health problems in their top five or selected them as being important**

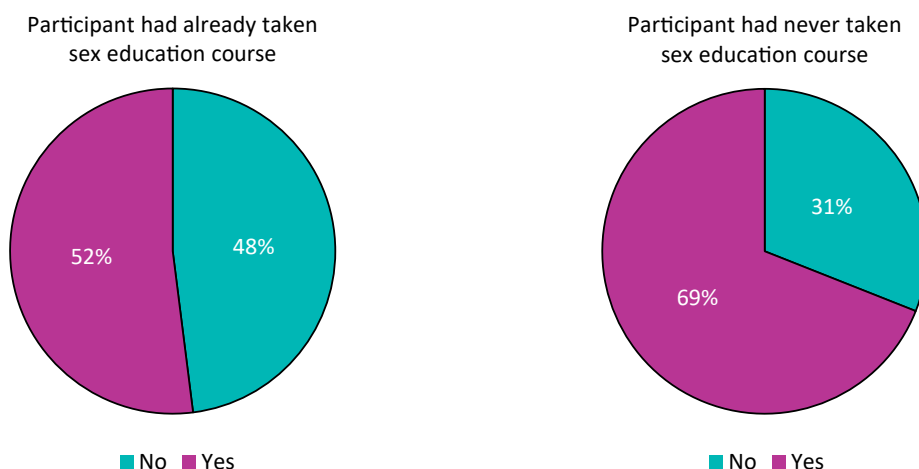


The community input survey found similar unmet needs among the adolescent age group. Thirty-nine percent of respondents felt that access to mental health services was an unmet need. Life skills training, substance use prevention and treatment, youth voice in decisions affecting them, and safe and affordable housing were the other unmet needs with the greatest number of responses. Individuals with lower income and American Indian respondents were more likely to report that the lack of a youth voice was an unmet need among adolescents, while higher income and white respondents were more likely to state that access to

mental health services was a greater need adolescents (DOH, 2019).

The youth survey asked whether participants would take a sex education course if one were offered in their community, including whether they had taken a course before. Of the participants that had already taken a sex education course, 52% of them said that they would take another class. Of those that had never taken a sex education course, 69% said that they would take a class. This reinforces a gap in education, as well as a challenge to identify how sexual health education can be offered (DOH, 2019).

**Figure 3. Whether or not participants would take a sex education courses if one were offered in their community by whether they had previously taken a sex education course.**



Eighty-four percent of youth that responded to the Youth Survey identified suicide as one of their top five health concerns. Seventeen percent of respondents said that they had seriously considered attempting suicide. Depression and suicide also surfaced as two main mental health concerns in the adolescent focus group. Focus group participants thought that bullying and lack of healthy coping mechanisms for stress contributed to the suicide epidemic.

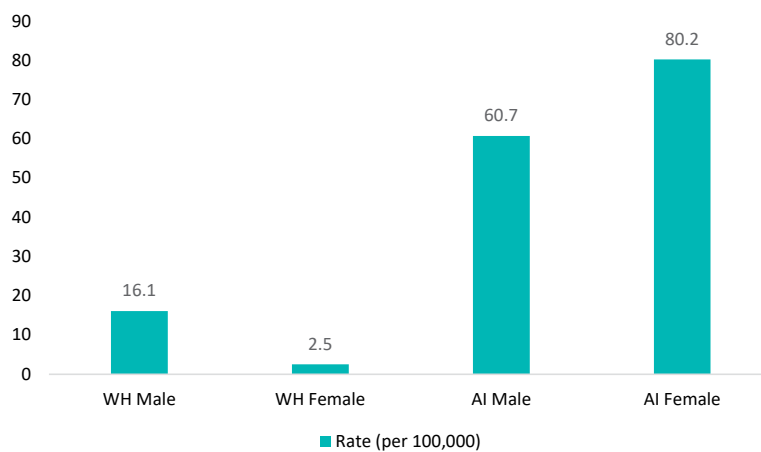
The following data describes the health status of adolescents in SD as it relates to suicide:

- American Indian children have disproportionately higher hospitalization rates due to attempted suicide-related injuries and the rate differences

between American Indian and white children are increasing over time. Injury hospitalization rates among females has increased more rapidly and now surpasses that of males (Bai W, Specker B. Racial differences in hospitalizations due to injuries in South Dakota children and adolescents. *J Racial Ethnic Disparities* 6:1087, 2019).

- Adolescent suicide rate for age 15 through 19 was 29.2 per 100,000 from 2016-2018.
- Adolescent suicide rate by race and sex for ages 10-19 is shown below. White females have the lowest rate of suicide at 2.5 deaths per 100,000 while American Indian females have the highest rate at 80.2 deaths per 100,000 (South Dakota DOH, 2018).

Figure 4. Suicide Rate by Race and Sex, Ages 10-19, South Dakota (2009-2018)



While there are notable challenges for the adolescent domain there has been some success in addressing the needs of adolescents across the state. Specifically, data gleaned from the Youth Survey provides current baseline data specific to youth. Until now, the most recent source of youth data used to inform the adolescent health domain is from the Youth Risk Behavior Survey in 2015. New partnerships have also been established with organizations serving youth, which helps expand the reach and impact of adolescent health services and program. In addition, improvements have been made in youth immunization rates and teen birth rates. Teen birth rate for ages 15 to 19 has decreased each year from 2013 to 2018 while youth immunization rates have increased for meningococcal conjugate, Tdap, HPV, and seasonal influenza from 2017

to 2018 (DOH Vital Statistics, 2018). Moreover, we have seen an increase in the number of teachers, physicians and nurses trained in a youth suicide prevention course.

**Current MCH Block Grant Efforts**

Suicide and sexual health have been on-going issues for all ages in South Dakota, but the data highlights enhanced strategies and activities are needed specific to adolescent health, including an emphasis on health equity. The MCH program will enhance services for this population and align resources related to health, wellness, and education on topics such as suicide, mental health, and sexual health. A core protective factor for both sexual health and suicide prevention are healthy relationships in adolescence. Adolescence is a time for young people to explore and develop



relationships by connecting with peers, parents, teachers or a romantic partner. Relationships might be unhealthy or healthy and can be emotional, physical or sexual. A need to educate parents and adolescents on what services are available in their local communities and when to utilize services was identified during the needs assessment.

Outreach to existing statewide programs and new multi-sector partners will be important to learn from and build on their successes. By fostering these partnerships, the MCH team will begin to provide a platform to address healthy relationships in adolescent and suicide prevention. In addition to learning about current programming, the MCH program needs to identify culturally appropriate strategies and services for American Indian adolescents who are disproportionately affected by these issues.

In an era where social media plays a large role in adolescent lives, enhanced strategies to address health through social media will be key. The youth survey showed that social media was one of the top three sources of health information for 48% of youth. As a result, DOH has been developing the Cor Health SD platform. Cor Health SD is a social media platform using [Instagram](#) and [Facebook](#) to provide educational messaging to young people and their parents. New social media messaging will be developed to enhance content shared through this platform.

The MCH program foresees an opportunity to provide programs that will include a diverse youth voice to not only assure that we are meeting the needs of SD youth but working alongside them to improve health outcomes. Beyond creating Cor Health SD, the MCH program has identified a need to develop a youth council to ensure the youth voice is included in future programming efforts.



## CHILD HEALTH

### **Strengths and Needs**

Strengths identified within the child domain include statewide programs and partnerships; data sharing between programs and partnerships; healthcare and dental services; cultural diversity and tribal sovereignty; resources such as food pantries and homeless shelters; mental health services; and telehealth. The community input survey noted needs included: safe and affordable housing; parenting education and support; affordable health insurance; substance use prevention and treatment; and access to healthy foods. Unmarried individuals and individuals who earned a low income stated that affordable housing was a need for improving child's health, while white respondents and respondents who reported a higher income stated that parenting education and support was the greatest unmet need. However, parenting education and support was a recurring theme with all demographics throughout the needs assessment. Qualitative feedback identified that parents want more education on topics ranging from growth and development of children to nutrition and cooking healthy meals. Lack of knowledge of available resources was commonly stressed as a barrier to achieving wellness. One respondent stated that "resources for single fathers" would be an asset (DOH, 2019).

### **Successes, Challenges, & Gaps**

Specific gaps identified regarding child health include: limited healthcare and dental workforce capacity; access to services (especially in rural areas); lack of policy and regulation for seat belt use; lack of daycares and preschool standards; lack of resources for parents or lack of knowledge how to access these; transportation; parenting skills/education; cultural competency; and mental health and substance abuse resources and services.

### **Current MCH Block Grant Efforts**

The MCH program identified opportunities to expand and enhance current efforts to support child health with an emphasis on health equity. Specifically, the program will review possible enhancements on developmental screening in the areas of promotion and staff education. The OCFS field staff has been instrumental in administering Ages and Stages Questionnaires (ASQ) as well as ASQ Social Emotional (ASQ SE) questionnaires across the state. The MCH program will continue to support Community Health Offices to administer these screenings by providing continuing education opportunities for staff, as well as strengthening the tracking and referral pathways for children with an identified need based on screening results. The SD MCH program has successfully partnered with the Learn the Signs, Act Early campaign to provide training and technical assistance to local Community Health Offices, as well as with the Part C (Birth to Three) program at both state- and local-levels for guidance on referring children with a developmental need.

The MCH program will focus efforts expanding partnerships to identify and address gaps in parenting education and support. Specifically, the program will explore ways to partner with Medicaid to look at ASQ reimbursement rates and well-child data to help identify gaps and collaborate on new activities to address these gaps.



## **INFANT/PERINATAL HEALTH**

### **Strengths and Needs**

Strengths identified within the infant domain included: programs such as Birth to 3, Cribs for Kids, and WIC; and the partnerships between statewide agencies that serve this population. South Dakota's percent of low birth weight infants and percent of preterm deliveries continues to remain lower than the national average. In 2017, the percent of low birth weight deliveries was 6.9% compared to 8.3% nationally, and the percent of preterm births was 9.3% in South Dakota compared to

9.9% nationally (DOH Vital Statistics). However, priorities that still need to be addressed regarding infant/perinatal health include social needs, access to health care services, mental health and substance abuse, and childcare.

### **Successes, Challenges, & Gaps**

South Dakota's successes in Infant/Perinatal Health have been shown with the percentage of infants placed to sleep on their backs (87%, ranked 4th out of 31 states) and on a separate approved sleep surface (41.6%, ranked 1st of 31 states) (SD PRAMS, 2018). Some of the gaps that were identified through the needs assessment process included: social needs, such as transportation and affordable housing; policies that hinder data sharing; lack of Medicaid Expansion; a need for more parent education and life skills training; mental health and substance abuse treatment for mothers; access to health care services and care (specifically specialty care); affordable and accessible childcare; and cultural stigma. Another notable gap identified for the infant domain is continuing education and programming around infant sleep. Although SD's infant mortality rate has been steadily declining, the post neonatal and Sudden Unexpected Infant Death (SUID) mortality rates remain high. Data on infant mortality and sleep addresses a gap in care and the need for continued interventions:

- In 2017, the post neonatal mortality rate for infants was 2.2 deaths per 1,000 live births, compared to the national rate of 1.9.
- In 2017, the sleep-related sudden infant death (SUID) rate was 115.4 deaths per 100,000 live births, compared to the national rate of 93.0.
- In 2017, the infant mortality rate was 7.7 per 1,000 births, compared to the national rate of 5.8 (DOH Vital Statistics, 2017).
- Based on data from SD's Infant Death Review (2014-2018), 70% of infant deaths (post hospitalization) occurred in an unsafe sleep environment (DOH, 2018).

### **Current MCH Block Grant Efforts**

The MCH program has collaborated with partners to support implementation of programs specific to infant/perinatal, including the Association of American Retired Persons (AARP) to educate grandparents on safe sleep guidelines; tribal MCH programs to provide





safe sleep environments to native families in need; and East and West River Death Review teams to provide prevention recommendations to keep infants safe. However, information elicited in the Needs Assessment process identified opportunities to build and foster new partnerships to collaborate on programs and strategies that address infant/perinatal health. Specifically, new partnerships established in the process with the SDSU Extension Services, Sanford Health, Department of Social Services' Policy Strategy Department, and the Center for the Prevention of Child Maltreatment will be fostered to support implementation of key strategies. New strategies to address the post neonatal and SUID mortality rates include: safe sleep radio advertising in tribal communities; collaborating with the Safe Passage research team on culturally appropriate safe sleep education tools for Indigenous populations; and forming a statewide prevention focused committee to turn death review data into action. All these strategies will be addressed with an emphasis on health equity.

## CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)

### Strengths and Needs

Strengths in the CYSHCN domain were identified in a 2018 survey that was conducted by the DOH and SDSU to identify needs and gaps in services for families of CYSHCN in SD.

Among survey respondents that have access to family-centered care, 64.8% of families of CYSHCN reported feeling like a partner in their child's care, 69.3% reported receiving care that was sensitive to their family's values and customs, 66.9% felt their provider listens carefully to them, 63.7% felt their provider spends enough time



with their child, and 65.9% reported receiving specific information they need from their provider for their child. Despite the noted strengths, the survey also revealed the unmet needs faced by CYSHCN and their families. These include difficulty in paying medical bills; distance to medical care; difficulty with scheduling or long waits for appointments; lack of insurance coverage or denial of service; and missing school and work for appointments.

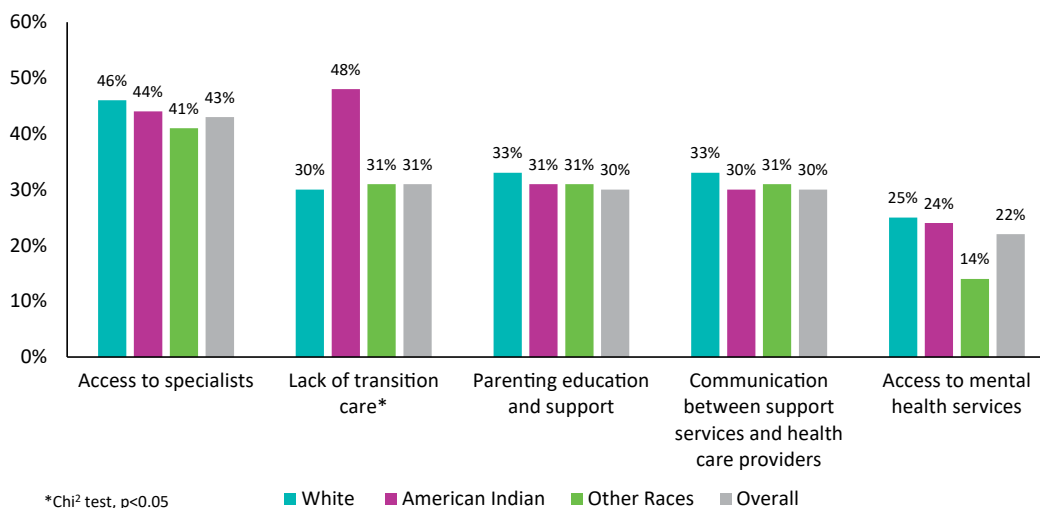
### Successes, Challenges, & Gaps

South Dakota's successes in CYSHCN are seen in the 2017-18 NSCH data, which revealed SD is ranked 3rd in the nation for percent of children with special health care needs having a medical home, with a percentage of 53%, compared to the U.S. rate of 43% and significantly greater than SD's 2016-17 rate of 50%. SD is also seeing an increasing trend in the percentage of CYSHCN who report receiving care in a well-functioning system, with a slight but significant increase from 15.6% in 2016-17 to 16.3% in 2017-18 (NSCH).

Some challenges and gaps in the care of CYSHCN were also identified. Data from the 2018 DOH-SDSU survey indicated that among families of CYSHCN, only 52% received effective care coordination services compared to 62% nationally, 28% reported difficulty getting a needed referral for health care services compared to 26% nationally, and only 43% reported receiving care in a medical home, similar to the national rate. Other challenges identified in the survey included costs of care, distance to medical care, difficulty with scheduling or long wait times for appointments, lack of insurance coverage (or denial for service) and missing school or work for appointments.

The top five unmet needs identified in the community input survey among CYSHCN include: access to specialists (46%), lack of transition care (33%), parenting education and support (33%), communication between support services and health care providers (32%), and access to mental health services (24%). Parenting education and support was a greater unmet need according to higher income versus lower income individuals. A higher percent of American Indian respondents noted that lack of transition care was a greater unmet compared to white respondents (48% vs. 30%, respectively). These data highlight gaps in resources, services, and programs to address priority needs of the CYSHCN population (DOH, 2019).

**Figure 5. Percentage of participants that ranked access to specialists, lack of transition care, parenting education and support, communication between support services and health care providers, and access to mental health services in the top 3 unmet needs of children and youth with special health care needs, by race (n=897).**



**Current MCH Block Grant Efforts**

Improving access to care and services for the CYSHCN population has been an ongoing priority of the SD CYSHCN program. Current efforts to address this need have been primarily focused on direct service reimbursement through the Health KiCC Program, which covers the cost of medical care, medications, and medical equipment for eligible families enrolled in the program. However, this approach only addresses a financial need and does not address the other unmet needs relating to accessing care and services, including distance to medical care, difficulty scheduling appointments, and missing school and work for appointments.

To more effectively address all the identified needs of this population, the CYSHCN program has been phasing out the Health KiCC Program over the past five years in order to focus time and funding on the development of new programs that will serve SD CYSHCN population statewide. The 2018 DOH-SDSU survey as well as the community input survey highlighted needs that can be addressed through expansion of diverse care coordination programs. Programs that can serve CYSHCN with very complex medical conditions that need better access to specialists that address mental and behavioral health will be the focus. A strategy to explore additional options of care coordination that can address the varied needs identified has been put in place for the next block grant cycle.

Key partnerships have been successful to address the needs of CYSHCN. Special needs car seats are being provided to families in need through a partnership with DSS Child Safety Seat Distribution Program. Through a contract with the Department of Human Services Respite Care Program, respite care is provided to families of CYSHCN across the state. The CYSHCN program also has a contract with Sanford Children's Specialty Clinic which provides operating costs to support clinics that provide a geneticist and genetics counselor to Rapid City eight clinic days per year. Strategies to enhance these partnerships include adding representatives from each partnership to the CYSHCN workgroup to collaborate on new ideas and ways we can enhance these existing partnerships and programs.

The CYSHCN program will also enhance current strategies to support coordination of the newborn screening program. SD's Newborn Screening panel is mandated by state statute and provides direct services that decrease infant morbidity and mortality in the state. MCH funding supports a newborn screening coordinator and contracted partnerships with the State Hygienic Laboratory at the University of Iowa and with Sanford Health. The State Hygienic Laboratory conducts testing on all newborn screening specimens for the state. Sanford Health provides the services of a follow-up nurse for out of normal range results, genetic counseling, and medical consultations.

## TITLE V PROGRAM CAPACITY

The South Dakota Department of Health (DOH) is an executive agency within state government. The Division of Family and Community Health (FCH) is the public health service delivery arm of the DOH and administers MCH services. FCH consists of three offices; Disease Prevention Services, Chronic Disease Prevention and Health Promotion, and the Office of Child and Family Services (OCFS). The MCH program is part of the OCFS.

The Office of Child and Family Services 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 oversight to state-employed nurses, nutrition educators and dietitians for the provision of public health services in the state. This includes 193 field staff, in 7 geographic regions, and 10 Central Office staff. Linda Ahrendt, M.Ed is the OCFS and Title V Administrator and has been with the DOH for 20 years. Jennifer Folliard, MPH RDN is the OCFS Assistant Administrator and MCH Director and has been with the DOH for 5 months. Whitney Brunner, BS serves as the CYSHCN Director and has been with the DOH for 1 year. Other MCH team members and internal partners include:

- Rhonda Buntrock, OCFS Assistant Administrator, WIC program Administrator
- Peggy Seurer, OCFS Assistant Administrator, Public Health/Clinical Services Manager
- Carrie Churchill, Home Visiting Program Manager
- Lauren Pierce, Newborn Screening Coordinator
- Sara Gloe, South Dakota Family Planning (SDFP) Program Nurse Manager
- Emily Johnson, SDFP Nurse Consultant
- Jill Munger, MCH Women/Infant Coordinator/Child Death Review
- Sarah Barclay, MCH Child/Adolescent Coordinator
- Taylor Pfeifle, Women's Health Consultant, Maternal Mortality Review
- Tim Heath, Immunization Program Director
- Mark Gildemaster, Data Statistics Manager

- Katelyn Strasser, MCH Epidemiologist
- EA Martin, SDSU contractor, MCH and home visiting epidemiology
- Derrick Haskins, DOH Communication Director

The DOH contracts with an epidemiology team and has a designated MCH epidemiologist to continually analyze available data and develop fact sheets/articles based on their findings. This information is shared with our MCH Impact Team and MCH workgroup partners to increase awareness and improve programming. The MCH programs also continue to improve its website content and works with a media contractor to grow and shape MCH communications and marketing efforts across the state.

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. The MCH team works closely with field staff on data collection for federal and state reports and program evaluation.



**Women/Maternal Domain:** One facilitator coordinates the state action plan activities for NPM #1 along with multi-sector workgroup members. Services for women provided with MCH funds include:

- Modified case management of high-risk pregnant women (not covered by Medicaid)
- For Baby's Sake website and Facebook page – information promoting healthy moms and healthy babies
- Developing and implementing maternal mortality prevention plans in Community Health Offices across the state
- Postpartum home or office visits (mothers not covered by Medicaid)
- Prenatal education/counseling for pregnant moms

**Perinatal/Infant Domain:** One facilitator coordinates the state action plan activities for NPM #5 along with multi-sector workgroup members. Services for infants provided with MCH funds include:

- Developing and implementing infant mortality prevention plans in Community Health Offices
- Newborn home or office visits (mothers/infants not covered by Medicaid)
- Cribs for Kids safe sleep kit distribution/safe sleep education for parents/caregivers
- Statewide Infant Death Review



**Child Domain:** One facilitator coordinates the state action plan activities related to NPM #6 along with multi-sector workgroup members. Services for children provided with MCH funds include:

- 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.

**Adolescent Domain:** One facilitator coordinates the state action plan activities for NPM #10 and SPM #2 along with multi-sector workgroup members. Services for adolescents provided by MCH funds include:

- Program collaboration on a variety of activities as part of interagency workgroups and community-based programming designed to promote health, prevent disease and reduce morbidity and mortality among children and adolescents including abstinence, school health guidance, drug/alcohol prevention, rape prevention, and intentional/unintentional injury prevention.

**CYSHCN Domain:** One facilitator, the CYSHCN Director, coordinates the NPM #11 state action plan. As the direct reimbursement program, Health KiCC, is being phased out, the CYSHCN program has concentrated on a new care coordination model with Sanford Children's Hospital in Sioux Falls through a registered nurse care coordinator. This program is in its pilot year and addresses the need to improve access to specialists, decrease travel costs, and provide a medical home for CYSHCN. Additionally, the CYSHCN program partners with DSS to provide special needs car seats, DHS to provide respite care to families, and Sanford Health to provide genetic outreach clinics for the western half of the state. When a family applies for social security disability benefits for a child under age 21, the CYSHCN program provides the family with a list of programs and services they may be eligible for. The CYSHCN Director also sits on the SD Council on Developmental Disabilities whose mission is to assist people with intellectual and developmental disabilities and their families in achieving the quality of life they desire through advocacy and systems change.

The Newborn Screening program identifies babies who may have a metabolic disorder and alerts the baby's physician to the need for further testing and special care. SD currently screens for 29 disorders either pursuant to statute or administrative rule. This program also works with hospitals to encourage screening of newborns for hearing loss prior to hospital discharge or by one month of age.

**Other programs within OCFS** serving the MCH population include the South Dakota Family Planning Program (SDFP), the WIC program, and the Bright Start program.

The **Family Planning program** provides voluntary family planning services to help both men and women in postponing, preventing, achieving, or facilitating the birth spacing of their children.

The **WIC program** promotes and maintains the health and well-being of nutritionally at-risk women, infants and children up to age five. WIC provides nutrition education/counseling, breastfeeding support (i.e., information, breast pumps, breastfeeding peer counselors, etc.), healthy foods, referrals to health care providers and health/social services agencies, and immunizations (if needed). In 2019, the SD



WIC program served 3,946 pregnant women, 648 postpartum women, 6,993 infants, and 17,127 children.

The **Bright Start Nurse Home Visiting program** provides services to high risk families during pregnancy continuing until the child's third birthday. The program focuses on high-risk pregnant mothers and new parents with limited economic and/or social and health resources. Bright Start implements the Nurse Family Partnership model with eligible clients, and a non-evidence-based curriculum with clients who don't meet model criteria. The DOH operates Bright Start in the following counties: Pennington, Brown, Butte, Lawrence, Oglala Lakota, Bennett, Beadle, Marshall, Day and Roberts while the Children's Home Society operates the program in Sioux Falls and surrounding communities. In FY 2020, Bright Start served 596 families.

**Other programs within the Division of FCH** serving the MCH population include the Office of Disease Prevention (ODP) and the Office of Chronic Disease Prevention and Health Promotion (OCDPHP).

The **Office of Disease Prevention** coordinates infectious disease prevention and control programs. Within ODP, the Immunization Program provides vaccines for VFC-eligible children. The program also provides recommendations and education on adult immunizations such as influenza, pneumonia



and tetanus. The Immunization Program provides vaccine materials, training, and support to both public and private providers and works in partnership with local and statewide coalitions. ODP staff investigate sources of STI infections, provide treatment, and apply preventive measures to those exposed. Field offices provide confidential counseling and testing for HIV/AIDS as well as educational materials, training for the public, schools and health care providers, and assistance with health care costs for those with HIV disease. The office provides TB clinics and contracts with the private medical sector for evaluation, treatment

and follow-up of TB cases. ODP also conducts disease outbreak investigations in the state.

**Office of Chronic Disease Prevention and Health Promotion** coordinates a variety of programs designed to promote health and prevent disease. The All Women Count! (AWC) Breast and Cervical Cancer Control program coordinates statewide activities to promote early detection of breast and cervical cancer. Mammograms, Pap Smears and related exams are available at no cost to eligible women at many physician offices, mammography units, family planning clinics, and other clinics throughout the state. The Tobacco Control Program (TCP) coordinates state efforts to prevent young people from starting to use tobacco products, help current tobacco users quit, and reduce non-smokers' exposure to secondhand smoke. The TCP assesses tobacco use patterns and identifies cessation needs and appropriate evidence-based strategies in order to develop more effective interventions for identified disparate populations.

Other programs within the DOH serving MCH families include the **Office of Public Health Preparedness and Response** which directs the state's public health emergency response efforts. Past DOH preparedness funding has been used to strengthen the public health infrastructure in SD including improvements in communication and computer systems for DOH field staff.

# TITLE V PROGRAM PARTNERSHIPS, COLLABORATION, AND COORDINATION

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 76 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. For example, the Huron office provides billable services through Medicaid, WIC program services, the Vaccines for Children’s program and immunization services, Bright Start Home Visiting, TB services, community education, client need coordination, emergency preparedness, and other public health programs. Title V funds help support developmental screenings, preventive school health screenings and education, Cribs for Kids infant safe sleep program, prenatal and postpartum education for high-risk pregnant women, client need coordination for children and pregnant/postpartum women, and interpreter services to facilitate program services.

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.

## SIGNIFICANT LONG-STANDING OR EMERGING PARTNERS

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:** The OCFS is both grantee and implementing agency for the MIECHV program. Bright Start uses the Nurse Family Partnership (NFP) model in eight sites covering over 14 counties in SD. In 2018, Bright Start nurses provided services to 566 families. Of these families, 409 were first time mothers enrolled in the evidence based NFP program. The other 157 were multiparous pregnant women, admitted postpartum, or exceeded the 28-week gestation mark that is required by NFP. The Bright Start Home Visitation Project Director will be actively engaged with the workgroup implementing strategies under NPM 1 and NPM 5.

**State Systems Development Initiative (SSDI):** SD was awarded a [SSDI grant in 2020](#) 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):

WIC serves participants through 76 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 2018 to September 2019, WIC served an average of 14,896 participants per month. In addition,





WIC is serving 56% of WIC income eligible participants in SD, which includes: 42% of eligible children; 99% of eligible infants; and 90% of eligible women.

**Rape Prevention Education Grant (RPE):** RPE aims to decrease sexual violence by funding community-based organizations like The South Dakota Network Against Family Violence and Sexual Assault and Sisseton Wahpeton Veterans Memorial Youth Center who use the public health approach to decrease sexual violence risk factors and increase sexual violence protective factors through implementation and evaluation of prevention strategies. 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) Grant:** SANE is being utilized statewide to carry out three goals: Increase the opportunity for victims of sexual assault across rural SD to receive services in their communities and increase awareness of law enforcement services; develop and sustain a learning collaborative that supports the continuing education needs of SANE certified and trained practitioners; and to create, develop, and build an infrastructure of forensic nursing education into University of South Dakota's (USD) nursing studies. 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):** 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. The program targets young people between the ages of 14 and 19 who are homeless, in foster care, live in rural areas or in geographic areas with high teen birth rates, or come from racial or ethnic minority groups. In addition to education on abstinence and contraceptive use, PREP also offer services to prepare young people for adulthood by implementing activities that provide young people the knowledge and skills to reduce risky behaviors and make healthy choices. Topics include healthy relationships, positive youth development, financial literacy, and parent-child communication. 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):** 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. Through partnerships with LSS and Boys & Girls Club the MCH team is able to reach youth where they are: serving youth that are living in under-resourced regions and areas with high rates of teen births and STIs; culturally underrepresented populations, especially Hispanic, African American, or Native American; youth in or aging out of foster care or adjudication systems; youth who are victims of trafficking, runaway and homeless youth; and other vulnerable populations. Young people participate in activities focused on self-awareness and healthy habits. The goals of this program are to lower both Chlamydia rates and teen birth rates among young people in SD. The Lutheran Social Services Project Director and Boys and Girls Club Program Coordinator for SRAE will engage as an active partner on the SPM 1 workgroup.

**Family Planning:** SD Family Planning Program (SDFPP) delivers statewide services through a network of 23 sites and provides services to low income individuals to increase healthy maternal/infant outcomes. In calendar year 2019, the SDFPP provided services to 4842 clients and procured an Electronic Health Record (went live 1/1/20) to increase continuity of care for clients. 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:** These health systems 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



76 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. Materials such as brochures, referral cards, posters and keychain wrist straps are supplied to youth, schools and other key agencies. They will engage as a new active partner on NPM 7.2 workgroup.

#### South Dakota's Office of Emergency Management:

This office 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 (vaccines, antibiotics, antidotes) in the event of a public health emergency. PHPR helps local POD sites develop their plans and maintain the infrastructure and expertise needed to respond to emergencies in their communities. County Emergency Managers work closely with OCFS field staff to maintain and exercise these POD plans to assure readiness.

## OTHER PROGRAMS WITHIN THE DOH

**Infant Death Review (IDR):** Through a (MOU) between DOH and member agencies, volunteer professionals across the state conduct IDR. Two regional teams, East and West River, are made up of members from law enforcement, DSS Child Protection Services and Behavioral Health, DOH, hospital staff, fire departments, Emergency Medical Services (EMS), Forensic Pathology, Division of Criminal Investigation (DCI), Bureau of Indian Affairs (BIA), IHS, Great Plains Tribal Chairman's Health Board, and the States Attorney's offices. The teams meet 2-3 times a year to review infant deaths (post hospitalization) within their regions. The teams began utilizing a common data collection tool (Child

Death Review Case Reporting System) from the National Center for Fatality Review and Prevention in 2012. DOH's Office of Data, Statistics and Vital Records provides data for the review process. IDR 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 Chairman's Health Board.

**Tribal MCH Programs:** Informal, but long-standing, partnership 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 Chairman's Health Board (GPTCHB):

GPTCHB offers public health support to s that share borders with North and South Dakota, Nebraska and Iowa. GPTCHB provides MCH services which include direct service, research, epidemiology, and technical assistance. This organization will be part of the workgroup addressing SPM 2.



## PUBLIC HEALTH AND HEALTH PROFESSIONAL EDUCATION PROGRAMS/UNIVERSITIES

**SDSU Population Health Center:** The 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 2.

**USD Sanford School of Medicine (SSOM):** The MCH program has fostered a partnership with SSOM 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 ORGANIZATION

**HelpLine Center:** This 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; Teen crisis texting support – Text4Hope; Youth Mental Health First Aid training; Suicide Prevention Training for Primary Care providers; and training for high school faculty on teen suicide prevention/intervention. The

Helpline Center is a long-standing partner, who was actively engaged in the Needs Assessment process. They will engage as an active partner on the NPM 7.2 workgroup.

**Center for the Prevention of Child Maltreatment:** The Center provides centralized child abuse and maltreatment prevention, workforce development and direct service statewide. This Center has a formal partnership with DOH to administer the state’s SANE grant and was actively engaged in the Needs Assessment process.

## IDENTIFYING PRIORITY NEEDS AND LINKING TO PERFORMANCE MEASURES

A structured and inclusive priority-setting process was shaped by collaboration with the MCH Impact Team and OCFS partner organizations. The Needs Assessment Project Team analyzed findings from quantitative and qualitative data and developed a priority setting tool to help select preliminary priority needs by domain (women, infant, children, adolescent, and CYSHCN).

Based on the data findings, the number of priority needs varied from 10 to 13 for each population domain. Each priority need was scored on a five-point scale (Definitely Not (1), Probably Not (2), Probably (3), Very Probable (4), and Definitely (5). Criteria included the following:

SIGNIFICANCE TO PUBLIC HEALTH		
<b>Seriousness of the issue:</b> Does the priority impact a large number or high percentage of people in our state?	<b>Health equities:</b> Do health disparities and inequities exist? (Are sub-populations more affected than the general public?)	<b>Available data:</b> Does data (e.g. mortality, morbidity, socioeconomic factors) show the need to address the priority?
ABILITY TO IMPACT THE ISSUE		
<b>Evidence-based strategies:</b> Are there evidence-based strategies for improving this issue?	<b>Momentum for change:</b> Does internal support for implementation exist to impact the issue?	<b>Momentum for change:</b> Does external (ex. Partner orgs., statewide efforts) support for implementation exist?
CAPACITY TO ADDRESS THE ISSUE		
<b>Leadership:</b> Should the state health department take the lead on the priority?	<b>Current resources:</b> Are sufficient resources (funding, people, expertise, etc.) available or obtainable?	

Each tool was first disseminated to the MCH Impact Team to assist with narrowing down the priority needs prior to engaging partner organizations. Additional priority setting methods were utilized with partner organizations to help further narrow down priorities

and ensure a collaborative and inclusive priority-setting process. Partner organizations, the MCH Impact Team, and the OCFS Advisory Committee were engaged in fall partner meetings to support the priority setting process.

## FALL PARTNER MEETINGS

The OCFS Needs Assessment Project Team organized partner meetings to support engagement and identification of priorities based on the needs assessment data findings. A webinar was held with partner organizations, the OCFS Advisory Committee, and the MCH Impact Team to provide an overview of the needs assessment process and data findings.

Additional in-person/virtual meetings were held by domain (women, infants, children/CYSHCN, and adolescents) with partner organizations, OCFS Advisory Committee members, and members of the MCH Impact Team to identify two key priorities to focus on in the five-year action plans. Domain leaders (MCH staff) led the meetings and provided an overview of current strategies being implemented by the OCFS to address specific priority areas. Meeting participants were also invited to share the activities they were currently working on within each population domain. This discussion helped participants to understand what is currently happening across the state and identify opportunities for future programming.

Priority needs identified previously were shared with meeting participants to review. The Dot Method was

utilized to support priority setting during each domain meeting. Criteria utilized was modeled after the priority tool used with the MCH Impact Team outlined before, including significance to public health (seriousness of the issues, health equities, available data), ability to impact the issue (evidence-based strategies and momentum for change), and capacity to address the issues (leadership and current resources). Participants voted in two rounds and narrowed priorities down to two for each domain. Priority areas not selected were moved to a parking lot, understanding some of them could still be addressed and/or integrated into strategies within the identified priority areas.

Following the fall partner meetings, the MCH team and other key OCFS program staff met in-person to discuss the priorities identified and narrow down the focus to one priority per domain. This was important to ensure the priorities identified aligned with corresponding NPMs and SPMs. The seven priority needs and their corresponding NPMs and SPMs are listed in the table below.

PRIORITY	MCH POPULATION DOMAIN	NPM OR SPM
<b>Mental health/Substance abuse</b>	<b>Women/Maternal Health</b>	<b>NPM 1 Well-Woman Visit</b>
<b>Infant safe sleep</b>	<b>Perinatal/Infant Health</b>	<b>NPM 5 Safe Sleep</b>
Parenting education and support	Child Health	NPM 6 Developmental Screening
Mental health/Suicide prevention	Adolescent Health	NPM 7 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



Other common needs noted across domains included social determinants of health such as employment, housing, and transportation. These did not rank as high as other priorities in the process because the MCH program has limited resources to address these issues. Specifically, OCFS felt that the MCH program should not be the lead on addressing these needs. The OCFS does recognize their importance in the overall health of individuals and will continue to engage partners who can better address these issues. It was also discussed that at some point in the future strategies could be developed around these needs. Childcare, parenting education, and mental health/substance abuse were other common themes across domains.

Lack of affordable and accessible childcare was noted in the infant and child domains. In South Dakota, childcare falls under the authority of the Department of Social Services. A representative from this group routinely participated in needs assessment activities and the priority setting process. OCFS collaborated with this representative to share data for their own needs assessment that was being conducted. Parenting education, mental health, and substance abuse were also frequently cited across population domains. The MCH team chose to link each of these priority needs to the NPM/SPM with the best potential to move the needle.