Maternal and Child Health Services Title V Block Grant

South Dakota

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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SOUTH DAKOTA DEPARTMENT OF HEALTH

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

July 16, 2021

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

Dear Director:

I am pleased to submit the FY 2022 South Dakota Maternal and Child Health Block Grant application and annual report. Should you have any questions concerning this application, please contact Jennifer Folliard at 605.367.5374.

Sincerely,

Linda Ahrendt

Linda Ahrendt
Administrator
Office of Child and Family Services
South Dakota Department of Health

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

South Dakota maternal and child health needs mirror many of the same challenges faced by rural and frontier states. Access to healthcare services, including the ability to travel to these services, and social needs like housing and food were identified throughout the Needs Assessment. Other challenges include access to mental health and substance 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 misuse	Women/Maternal Health	NPM 1 Well-Woman Visit
Safe sleep	Perinatal/Infant Health	NPM 5 Safe Sleep
Parenting education and support	Child Health	NPM 6 Developmental Screening
Mental health/Suicide prevention	Adolescent Health	NPM 7 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 misuse, parenting education and support, access to care and services, and a cross-cutting priority for data sharing and collaboration. The action plans will inform strategies and activities outlined to address priority health issues implemented in collaboration with MCH partners. MCH domain leaders will build on the training provided by John Richards and additional data support and capacity to engage in evidenced-based practice, and monitoring of performance measures.

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 development of the MCH workforce. Program planning has been prioritized and cultivated throughout the needs assessment process in collaboration with interagency partnerships, such as the Department of Social Services (DSS). Specifically, DSS 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.

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

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

III.A.3. MCH Success Story

The SD CYSHCN Program, in partnership with Sanford Health and South Dakota State University, began work in 2019 to pilot a patient navigation program at the Sanford Children's Hospital in Sioux Falls, SD. In this program, Title V funds support a Registered Nurse Patient Navigator who is housed in the Sanford Children's Hospital and provides extensive care coordination services to children with very complex medical needs. The program includes an ongoing, comprehensive third-party evaluation provided by South Dakota State University.

In April 2020, the pilot year of the program began with the first cohort of 30 participants. All participating families were invited, but not required, to participate in the evaluation of the program. Families were asked to provide a list of affiliated medical and non-medical professionals that work with the enrolled patient. The professionals were then surveyed on their perceptions of coordination of care, quality of communication between providers, and types of support needed for children with complex medical conditions and their families. The enrolled families were also surveyed to assess their satisfaction with coordination of care and care planning, barriers to receiving adequate care services, and unmet medical and other family needs. In addition to participant and affiliated professional surveys, the RN Patient Navigator also uses a Care Coordination Measurement Tool (CCMT) to document interactions and interventions with the families.

After nine months of program implementation, data from the CCMT showed that the Patient Navigator prevented 43 missed clinic visits, 7 cases of non-adherence to treatment plan, 2 medication errors, 1 unnecessary ED visit, and 9 unnecessary visits to the Sanford Children's Specialty Clinic. In addition, of 244 patient encounters at the clinic, 60.9% required clinical care coordination services.

Participants and affiliated professionals were given post-surveys after nine months, and the results of those surveys are not yet available. However, the program had enough documented success through the CCMT to expand the program to a second cohort of 20 participants in 2021, with a third cohort of 30 participants expected in late 2021 or 2022. A Pediatric Certified Nurse Practitioner will be joining the program in 2021 to provide additional care coordination services to children with complex medical needs and their families.

III.B. Overview of the State

Demographics, Geography, Economy

South Dakota traverses over 75,000 square miles in the upper Midwest and is one of the United States' most rural and frontier geographic areas. SD is home to diverse landscape that is divided into east and west by the Missouri River. There are 886,667 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 84.6% White, 9% American Indian (AI), 2.3% Black, 1.5% Asian, 2.5% Two or More Races and 4.2% 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 6.9% 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 $58,275. 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%. 12.2% 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 28.8% have a bachelor's degree or higher. Key industries that shape SD's economy include agriculture, mining, finance, healthcare, manufacturing, and tourism.

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

Strengths and Challenges

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

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

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

Despite the growth in the healthcare industry and strategies to address the healthcare workforce, SD residents are challenged by the limited access to healthcare. Over two-thirds of the state is designated by the federal government as a Health Professional Shortage Area (HPSA). Health care provider shortages exist in primary care, dental health, and mental health. There are also 71 Medically Underserved Areas/Populations (MUA/P), including a shortage of primary care health services across the state. As of May 25,2021, there were 4,788 licensed physicians and 705 physician assistants licensed in SD. In addition, there were 1,145 actively licensed nurse practitioners and 48 actively licensed certified nurse midwives.

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

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

Roles, Responsibilities and Targeted Interests of State Health Agency

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

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

The strategic plan 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 Leaders' 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 437,000 women of child-bearing age including 11,000 pregnant women, 12,000 infants, 253,000 children and adolescents age 1 through 21, and 36,404 children and youth with special health care needs. SD has 49 general community hospitals, of which 38 are critical access hospitals and 9 offer labor and deliver and obstetrics services. There are fifty-one federally qualified health centers (FQHCs) and fifty-eight rural health clinics. There are also five IHS hospitals in SD, of which only two provide routine obstetrical services. SD has one children's hospital located on the East side of the state and 125 general pediatricians and approximately 75 subspecialists to serve the MCH population.

The Departments of Health and Social Services continue to prioritize and focus on social needs and behavioral health services integration. The OCFS is the outreach arm and community presence of the DOH and works closely with DSS programs that support health, social needs and behavioral health including Medicaid, Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). These programs work directly with the 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.

In state fiscal year 2020141,620 South Dakotans participated in Medicaid for their healthcare. 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 38% 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. Findings from a secondary analysis done by the IPUMS-USA, University of Minnesota of the American Community Survey note that 14.6% of women of childbearing age and 6.5 % of children are not insured by public or private insurance.

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

Needs Assessment Update

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

The MCH Epidemiologist, who leads the state performance measure to improve data sharing and collaboration, distributed a survey to a wide network of partners in April 2021 to assess the data use and needs of partners, with the goal of making data more accessible, useful, and equitable based on this feedback.

South Dakota PRAMS continues to survey mothers to understand maternal attitudes and behaviors related to pregnancy. In 2020, SD PRAMS implemented a COVID-19 supplement to learn how the pandemic was affecting MCH populations.

The Sanford Patient Navigation Program surveys families of children with special healthcare needs as well as their affiliated professionals to gain ongoing perspective of the needs faced by this population and the professionals that provide services to them. This information is used by the CYSHCN Program to continue shaping the Patient Navigation Program to fill gaps in services and improve outcomes for these children and their families.

A recent change noted by the SD Department of Health in the health status of the state's MCH population is a significant increase of 469% in syphilis cases from 2020 to 2021. Specific risk factors with the recent case increases include having intimate relations with anonymous partners and/or relations under the influence of drugs or alcohol. The MCH Program has an SPM dedicated to healthy relationships, with a goal of increasing education and support, STI prevention, and pregnancy prevention.

A noted change in SD's MCH service delivery began in November of 2019, when the Office of Child and Family Services (OCFS) embarked on a process to assess its structure and staffing to identify opportunities to better meet client needs and deliver services more efficiently across the state. This includes gaining a better understanding of the public health services and supports most needed in communities across South Dakota and identifying and evaluating the viability of current service delivery models.

To guide this project, OCFS has been working with several consultants from Health Management Associates (HMA), and a project team comprised of OCFS and division leadership, central office staff members, and regional manager representatives. The assessment team efforts included the following areas of focus:

- **Data Collection** – reviewed OCFS services, incorporating information about other service providers, and researching best practices in other states for public health programs and for WIC
- **Fiscal and Business Review** – looked at current revenue and cost streams, examining financial tools and tracking, and studying service delivery contracts
- **Structure Assessment** – reviewed organizational charts, FTE, and job descriptions, evaluating current service delivery models, studying WIC operations, making a site visit to the Rapid City/Pine Ridge/Kyle offices, and talking with regional managers and central office teams
- **OCFS Vision and Theory of Change** – developed a vision statement for OCFS, and a theory of change (TOC) model. The OCFS assessment team will use these tools to serve as "guardrails" for all future work, to ensure the programs and services focus on the outcomes identified as most important.

The vision of the OCFS moving forward is: *Build **equitable systems** and **leverage partnerships** to serve South Dakotans where they are and **provide resources for them to make healthy decisions** for themselves and their families.*

In late 2020, the assessment team focused on synthesizing all of the information captured, and generated ideas about what would the "future OCFS" look like across several categories of work that embody the general domains of

programs, services, and functions in OCFS:

- **Organizational Structure** – which incorporates Program Alignment, Staffing, and Internal Partnerships
- **External Partnerships** – including Contracts (formal agreements) and Other Types of Collaboration (informal efforts or those without structured agreements)
- **Data for Administration and Cross-Office Functions** – comprised of Financial Data (revenue and cost), Program Management Data (staff time, contracts, grants, etc.), Reporting and Data Transparency, and Consolidating/Aligning Data Systems
- **Continuous Quality Improvement and Evaluation** – which includes Staff, Programs, and Disparities Among Populations
- **Digital Services Delivery** – comprised of Capability and Capacity to deliver services virtually
- **Communications** – including Key Partners, Clients, and Crisis Communications

Each of the key implementation categories includes prioritized strategies that will lay the groundwork for a plan detailing the ideas that rose to the top as priorities for change.

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

The goal of this reorganization is to:

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

Regional leadership teams will:

- Position regions for growth and ability to be dynamic vs. static
- Focus on outcomes to measure achievement, progress, and success
- Center on equity for both clients and staff
- Allow for flexibility to match staffing and services to different needs of each region
- Continue with a standardized statewide framework for regions to function with a centralized support system

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.

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

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

These partners tended to represent the infants, children, and adolescent domains.

Maternal Child Health Bureau Investments: Bright Start Home Visitation Program includes OCFS as both grantee and implementing agency for the MIECHV program. Bright Start uses the Nurse Family Partnership (NFP) model in eight sites covering over 14 counties in SD. The Bright Start Home Visitation Project Director will be actively engaged with the workgroup implementing strategies under NPM 1 and NPM 5.

The State Systems Development Initiative (SSDI) grant was awarded to SD 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) 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.

Rape Prevention Education Grant (RPE) aims to decrease sexual violence by funding community-based organizations who use the public health approach to decrease sexual violence risk factors and increase sexual violence protective factors. The Sexual Violence Project Specialist for the South Dakota Network Against Family Violence and Sexual Assault will engage as an active partner on SPM 1 workgroup.

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

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

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

SD Family Planning Program (SDFPP) delivers statewide services through a network of 23 sites and provides services to low income individuals to increase healthy maternal/infant outcomes. The Title X Project Director will be actively engaged with the workgroup implementing strategies under NPM 1.

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

Other State Government Agencies: South Dakota Department of Social Services DOH has an MOU with SD Medicaid to provide direct healthcare services and modified case management within the 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. They will engage as a new active partner on NPM 7.2 workgroup. South Dakota's Office of Emergency Management partners with DOH's Office of Public Health Preparedness and Response (PHPR) and OCFS in providing emergency response efforts across the state. OCFS field staff in community health offices are assigned to a Point of Dispensing (POD) site to dispense emergency pharmaceuticals in the event of a public health emergency.

Other Programs Within the DOH: Child Death Review (CDR), through a (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. DOH's Office of Data, Statistics and Vital Records provides data for the review process. CDR is funded exclusively by MCH dollars.

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

Great Plains Tribal Leaders Health Board (GPTLHB) advocates for its constituents to have access to health resources available in the areas of research, education, assistance, prevention, and outreach. This organization will be part of the workgroup addressing SPM 2.

Public Health and Health Professional Education Programs/Universities: SDSU Population Health Center is a formal, long-standing partner that provides technical assistance to the MCH team to develop, monitor and evaluate the program's overall objectives. They assisted with the development, execution, and evaluation of the Needs Assessment and will continue to provide technical expertise but will also serve on the workgroup that will direct State Performance Measure 2.

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

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

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

Priority	MCH Population Domain	NPM or SPM
Mental health/Substance misuse	Women/Maternal Health	NPM 1 Well-Woman Visit
Infant safe sleep	Perinatal/Infant Health	NPM 5 Safe Sleep
Parenting education and support	Child Health	NPM 6 Developmental Screening
Mental health/Suicide prevention	Adolescent Health	NPM 7 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 MCH domain leaders have formed diverse workgroups that meet quarterly to inform and help carry out the activities in the domain action plans. Domain leaders also track their collaboration efforts utilizing the Wilder Collaboration Index and carry out ongoing evaluations of their programs. They continue to evaluate the needs of the populations they serve through surveys and data analysis.

The OCFS provides leadership and technical assistance to assure systems are promoting the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. OCFS provides oversite to state-employed nurses, nutrition educators and dietitians for the provision of public health services in the state. The OCFS moved from a 7 region structure to a 4 region structure in June 2021. With this change, the leadership of each region is expanding to include a regional manager, dietitian lead, nurse lead, and billing/operations lead.

Linda Ahrendt, M.Ed is the OCFS and Title V Administrator and has been with the DOH for 21 years. Jennifer Folliard, MPH RDN is the OCFS Assistant Administrator and MCH Director and has been with the DOH for 1 year. Whitney Brunner serves as the CYSHCN Director and has been with the DOH for 1 year. Other MCH team members include the following:

- Rhonda Buntrock, OCFS Assistant Administrator- WIC Program Administrator
- Peggy Seurer, OCFS Assistant Administrator- Public Health/Clinical Services
- 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 Nurse Consultant/Infant Death Review Coordinator
- Sarah Barclay, MCH Child/Adolescent Coordinator

- Christine Catts, Maternal Mortality Case Abstractor
- Kendra Rooney, Sexual Violence Prevention Coordinator
- Amy Mattke, Case Management
- Tim Heath, Immunization Program
- Mark Gildemaster, Manager, Data and Statistics
- Katelyn Strasser, MCH Epidemiologist
- EA Martin, SDSU contractor, MCH and home visiting epidemiology
- Daniel Bucheli, Communication Director

The DOH contracts with an epidemiology team and has a designated MCH epidemiologist to continually analyze our available data and develop fact sheets/articles based on their findings. The MCH program also continues to improve its website content and works with a media contractor to grow and shape maternal and child health communications and marketing efforts across the state.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

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 toward 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, Goals, Frameworks and 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.

Two frameworks shaped the needs assessment process, including the Life Course Theory (LCT) and Health Equity Model (HEM). Utilization of the LCT was important to first understand health issues that impact the MCH population at all stages of life, including health patterns and disparities. Secondly, the HEM 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 HEM 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.

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.

Families & 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.

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.

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.

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. 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.

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.

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. 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 application supporting documents.

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.

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. This 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. The full report is available in application supporting documents.

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 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 full report is available in application supporting documents.

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. A summary report can be found in the application supporting documents.

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. 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. The full Needs Assessment Report can be found here 2020 Title V Needs Assessment Report.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Women/Maternal Health: 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, access to healthcare services, the 211 Helpline, community programs, 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.

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.

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 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: 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.

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).

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).

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).

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.

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 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).

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.

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 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.

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).

The MCH program has collaborated with partners to support implementation of programs specific to infant/perinatal, including the Association of American Retired Persons 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 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.

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).

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.

In order 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 statue 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

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

The 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.

III.C.2.b.ii.b. Agency Capacity

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.

III.C.2.b.ii.c. MCH Workforce Capacity

The OCFS provides leadership and technical assistance to assure systems are promoting the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. OCFS provides oversite to state-employed nurses, nutrition educators and dietitians for the provision of public health services in the state. 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
- 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. The MCH programs also continues to improve its website content and works with a media contractor to grow and shape MCH communications and marketing efforts cross 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.

III.C.2.b.iii. 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.

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

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

Maternal Child Health Bureau Investments: Bright Start Home Visitation Program includes OCFS as both grantee and implementing agency for the MIECHV program. Bright Start uses the Nurse Family Partnership (NFP) model in eight sites covering over 14 counties in SD. The Bright Start Home Visitation Project Director will be actively engaged with the workgroup implementing strategies under NPM 1 and NPM 5. The State Systems Development Initiative (SSDI) grant was awarded to SD 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) 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.
Rape Prevention Education Grant (RPE) aims to decrease sexual violence by funding community-based organizations who use the public health approach to decrease sexual violence risk factors and increase sexual violence protective factors. The Sexual Violence Project Specialist for the South Dakota Network Against Family Violence and Sexual Assault will engage as an active partner on SPM 1 workgroup.

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

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

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

SD Family Planning Program (SDFPP) delivers statewide services through a network of 23 sites and provides services to low income individuals to increase healthy maternal/infant outcomes. The Title X Project Director will be actively engaged with the workgroup implementing strategies under NPM 1.

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

Other State Government Agencies: South Dakota Department of Social Services DOH has an MOU with SD Medicaid to provide direct healthcare services and modified case management within the 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. They will engage as a new active partner on NPM 7.2 workgroup. South Dakota's Office of Emergency Management partners with DOH's Office of Public Health Preparedness and Response (PHPR) and OCFS in providing emergency response efforts across the state. OCFS field staff in community health offices are assigned to a Point of Dispensing (POD) site to dispense emergency pharmaceuticals in the event of a public health emergency.

Other Programs Within the DOH: 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. 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 are 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) 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 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) and the MCH program have fostered a partnership as a formal and emerging partner who now leads the state's Early Hearing Detection and Intervention collaborative. Previously the DOH led this grant. USD also houses the state's medical school and along with SDSU jointly houses the state's only public health program.

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

III.C.2.c. 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. Criteria included significance to public health, ability to impact the issue, and capacity to address the issue.

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.

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.

Priority needs identified previously were shared with meeting participants to review. The Dot Method was utilized to support priority setting during each domain meeting. 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
Mental health/Substance abuse	Women/Maternal Health	NPM 1 Well-Woman Visit
Infant safe sleep	Perinatal/Infant Health	NPM 5 Safe Sleep
Parenting education and support	Child Health	NPM 6 Developmental Screening
Mental health/Suicide prevention	Adolescent Health	NPM 7 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.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,149,068	$2,343,567	$2,149,068	$2,074,993
State Funds	$1,700,080	$1,611,368	$1,695,079	$1,609,382
Local Funds	$87,000	$149,570	$117,472	$39,373
Other Funds	$0	$0	$0	$0
Program Funds	$810,000	$1,224,994	$1,378,312	$1,153,643
SubTotal	$4,746,148	$5,329,499	$5,339,931	$4,877,391
Other Federal Funds	$20,193,754	$22,729,620	$20,487,960	$21,996,626
Total	$24,939,902	$28,059,119	$25,827,891	$26,874,017

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

	2022	
	Budgeted	Expended
Federal Allocation	$2,319,160	
State Funds	$1,035,794	
Local Funds	$13,485	
Other Funds	$0	
Program Funds	$700,263	
SubTotal	$4,068,702	
Other Federal Funds	$20,895,980	
Total	$24,964,682	

III.D.1. Expenditures

The mission of the South Dakota (SD) Maternal and Child Health (MCH) Program is to improve the health and well-being of SD families and to assure access to preventive and primary health care services for mothers, infants, children, adolescents and young adults which also includes children and youth with special health care needs. SD continues to focus on the priority needs that were identified within the five-year needs assessment that was completed for the FY 2016-2020 MCH Block Grant cycle. The Office of Child and Family Services (OCFS) utilizes funds to enhance work in communities and tribal areas across the state. The expenditures complement the mission of the SD MCH program.

The OCFS is divided into three sections: Community Health Services, WIC, and MCH. These sections work collaboratively to utilize funding appropriately to support outreach to vulnerable populations through nurses and dietitians located in 76 community health offices across the state. SD has a small MCH staff comprised of three full time program coordinators, one half-time Women's Health Consultant (who is also an abstractor for Maternal Mortality Review) and the MCH Director that work with internal and external partners to implement the state action plan.

For FFY 2020 expenditures, SD met federal Title V requirements that at least 30 percent of federal funds support CYSHCN activities. In addition, at least 30 percent of federal funding was used for preventive and primary care for child and adolescent activities. SD did not exceed the 10% administrative requirement. South Dakota's maintenance of effort was fully met.

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

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

CYSHCN	$845,217
Pregnant Women/Infants	$1,937,461
Child/Adolescents	$1,432,407
All others	$190,642

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

Direct Services	$31,296
Enabling Services	$2,658,356
Public Health Services and Systems	$1,805,933

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

Expenditures that are related to program management, including contract management, are implemented by MCH

program staff within the OCFS. All MCH program activities include data analysis, evaluation, and continuous quality improvement activities to drive data driven decisions and program improvement.

Office of Child and Family Services

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

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

Women and Infants:

- Modified case management of high-risk pregnant women not covered by Medicaid
- For Baby's Sake website and Facebook page – promoting healthy moms and healthy babies
- Developing, implementing and evaluating local office maternal mortality prevention plans
- Postpartum home or office visits including assessment, education/counseling, anticipatory guidance, client need coordination, referral and follow-up
- Prenatal education/counseling for pregnant moms who are not high risk
- Ages and Stages Developmental Screening and related education, counseling, and anticipatory guidance for infant caregivers. Referrals as needed
- Ages and Stages Social and Emotional Screening and related education, counseling, anticipatory guidance for infant caregivers. Referrals as needed.
- Developing, implementing, and evaluating local office infant mortality prevention plans
- Quality Assurance activities
- Newborn home or office visits including assessments, education/counseling, anticipatory guidance, client need coordination, referral, and follow-up (mothers/infants not covered by Medicaid)
- Cribs for Kids safe sleep kit distribution/safe sleep education for parents/caregivers
- Infant death review

Child and Adolescent:

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

Children and Youth with Special Health Care Needs

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

- Care coordination and development with an emphasis on evaluation.

Budgeted versus expended:

During FY20 and FY21, the OCFS has responded in a variety of ways to the COVID-19 pandemic. Many of the form field notes on budget and expenditure differentials are due to the pandemic response of the OCFS and our contractual partners.

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

Due to staff responding to the COVID-19 pandemic work time was allocated to COVID-19 efforts, clinics were closed, and some programs were not able to complete planned activities.

Significance of federal MCH Block Grant funding support:

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

Accountability:

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

The DOH Division of Finance provides hard-copy grant reports monthly to the MCH Director. More detailed reports are available on a shared drive where end users can utilize a pivot table to bring into focus the expenses by detail to track expenses on a regular basis. Contracts are monitored and invoices approved by MCH staff to assure program activities are accounted for. If a contract is determined to be a subrecipient contract the Division of Finance assists with monitoring and compliance. A monitoring guide is available to DOH staff to ensure a monitoring plan and methods for proper oversight of subrecipient entities is in place. The guide also includes tools and suggestions that could be included in the monitoring process.

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

Opportunities:

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

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

Challenges:

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

III.D.2. Budget

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

The budget outlines areas for which Title V funds will be allocated. Development of the budget complies with the "30-30" requirement for primary and preventive care and special health care needs for children and adolescents and is consistent with the requirements to limit administrative costs to no more than ten percent. The DOH maintains the overall level of funds for MCH at the level established in FFY 1989 and monitors funding allocations quarterly to ensure compliance. Each year the DOH spends more than the federal allocation but it is difficult to reflect this due to the overlapping periods of obligation under the previous fiscal year and the spending of funds in the current fiscal year. The DOH continues to align funding resources to support the MCH priority areas and selected measures.

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

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

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

Proposed budget for FY2022 reflects:

- A shift to a more sustainable revenue-based model through review of the operations and implementation of services in local communities. This is reflected by an increase in program income being utilized to support efforts for the MCH populations.
- Ongoing efforts for federal spending to be maintained within one federal year’s allocation. Historically, SD was behind in federal spending, but with additional programming and increased costs due to inflation, the federal funds are now spent in less than a year. As a part of the Office of Child and Family Services needs assessment process, a review of the service delivery structure will assist in meeting the federal funding allocation. As more program income is being generated, less federal dollars are being accessed to support our ongoing efforts.

A large portion of our funding supports workforce infrastructure and capacity to deliver services. Without the Title V

Block Grant dollars, services to our MCH population would need to be provided at a reduced capacity, either reaching fewer people or conducting fewer program activities. In addition, our capacity to communicate and work with our existing MCH partners would be greatly affected. Although our state is able to leverage funding from other sources, the loss of MCH funding would result in a change of priorities to meet program requirements.

For the FY22 budgeted amounts, our agency used FY19 expended amounts when creating the budgeted amounts. The expenses for FY20 were not typical due to COVID. We felt budgeting based on those FY20 expenses would not provide the most accurate budgeted amount. We based our budgets more on the percentage of the federal allocation.

III.E. Five-Year State Action Plan

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

State: South Dakota

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

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

The Division of Family and Community Health is the service delivery arm of the DOH. It administers programs and provides direct health care services such as community health nursing, MCH programs, nutrition programs, infectious disease control, and chronic disease prevention/health promotion activities. Within this division, the Office of Child and Family Services (OCFS) coordinates programs and services that serve infants, young children, adolescents and pregnant and postpartum women. These programs and services are delivered by DOH staff working in a network of 76 sites across the state. Programs and services that directly relate to MCH populations are listed below. The programs with an asterisk are partially or fully funded by MCH. The other programs are programs Title V coordinates within the OCFS to enhance program delivery.

Programs for Infants & Young Children

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

Programs for Children & Adolescents

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

Programs for Pregnant & Postpartum Women

- WIC
- Breastfeeding Peer Counseling
- Family Planning
- Baby Care – modified case management for high risk pregnant women*
- Bright Start/Nurse Family Partnership Home Visiting Program

While the OCFS has a huge service delivery and outreach presence, it is just one piece of the efforts to serve the maternal and child populations. It is partnerships with other Divisions within DOH, other state agencies, and local entities that supplement capacity to meet the needs of our MCH population. This is accomplished through both formal (MOUs and contracts) and informal (committee/council memberships) collaboration efforts and partnerships.

MCH domain leaders, funded through Title V, serve as the backbone for collaboration with interagency partners and with external community-based or research organizations. Each domain leader prioritizes strategies that are informed by data and addresses health inequities through collective impact. Each of the domain workgroups will be evaluated using the Wilber Collaboration Index at the end of this year.

To ensure fidelity to the health equity model and life course theory, MCH domain leaders will build multi-sector partnerships and workgroups to address the priority needs of the MCH population. Through this collaboration the State Action Plans have been developed and external partners will continue to be instrumental in implementation.

The Life Course Theory and Health Equity Model shaped the needs assessment process and planning. During that process it became clear that to diagnose health disparities and begin to address health inequities, there is a need for focused data systems building and reporting. Systems building requires sustained efforts, and intentional culturally appropriate outreach. The MCH domain leaders will engage with the MCH epidemiologist, who is leading SPM 2, to ensure data needs are communicated. Challenges may arise with interagency data sharing, data privacy concerns and data coordination with Indigenous nations.

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

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

The DOH released its 2020-2025 Strategic Plan in January of 2020. The plan provides a road map for the future and guides staff working together to achieve meaningful outcomes. Goal 5 of the Strategic Plan, *strengthen and support a qualified workforce*, was developed to address the workforce needs of the Department. The first objective under this goal is to establish a DOH Workforce Development plan by 2021. This was not achieved, due to the need for COVID-19 response, but will be a priority for 2022. This presents an opportunity to provide insights from the Title V Needs Assessment regarding long-term pathways for MCH professional development and short-term training for domain leaders and field staff. While the first 6 months of the state's strategic plan has been disrupted by COVID-19, the Department of Health's quick and responsive innovations to the crisis will also advance workforce development and will inform future planning.

In October 2019, the DOH began to explore accreditation through the Public Health Accreditation Board (PHAB) and has recently been reinvigorated. Domain teams were established to review accreditation requirements and identify gaps and weaknesses. The original timeline had established an early fall 2020 completion date for the required plans (e.g. state health assessment, state health improvement plan, workforce development plan, quality improvement plan and performance management plan). Due to COVID-19, this effort was suspended and is now set to be completed in the next few years.

The Division of Family and Community Health is the service delivery arm of the DOH and administers MCH services and programs within the Title V Block Grant. The Office of Child and Family Services (OCFS) provides leadership and technical assistance to assure health, public health, and social systems are promoting the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. MCH domain leads provide training and ongoing technical assistance to DOH field staff as well as private healthcare providers who deliver MCH services and programs. In the coming year, the OCFS will under-go a reorganization of regional community health structure and teams towards public health model through a theory of change. This will offer more opportunities for advancement in the MCH dietitian and nurse professional fields and develop a core of paraprofessionals. MCH domain leaders will utilize the TRAIN platform to systematize training and offer guidance around quality improvement and assurance for new community health staff.

Over the last year, MCH domain leads have built off the training provided through the National Center for Education in MCH on evidenced-based practice when developing strategies relevant to the delivery of MCH services. The MCH and other OCFS administrative staff have participated in health equity, family engagement skills building sessions through the MCH Workforce Development Center to support the upcoming community health offices transition. The MCH Director and the CYSHCN Director will complete the Building Expertise in Administration and Management, BEAM, training in summer of 2021. The MCH team works closely with field staff on data collection for federal and state reports and program evaluation. These efforts will be enhanced through the development of SPM #2, *Improve data sharing with partners and the public and collaborate with new partners to enhance MCH data* which exposes a need for data interpretation training and peer learning with MCH domain leads and field staff.

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

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

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

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

Additional strategies to assist in staff retention and recruitment include:

- Department-wide engagement survey – all employees of the DOH were asked to take part in a confidential survey to assist in strengthening the infrastructure of the Department. The survey looked at engagement level, satisfaction with workplace, and opportunities for improvement. Results were shared to assist in enhancing the work experience.
- The Bureau of Human Resources surveys new employees and those leaving their positions – to identify ways to improve our processes and employee retention.
- Allowing alternate work schedules and alternate work locations (other than the state office in Pierre) for central office positions
- Differential pay for hard to staff tribal or frontier positions

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

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

The OCFS and the MCH program are committed to implementing meaningful family engagement at an office-wide level. In 2018 the OCFS enlisted the assistance of a consultant to hold a Family Engagement Strategic Planning meeting with staff in order to identify strengths, weaknesses and opportunities and threats (SWOT) across OCFS programs. In addition to the SWOT activities and planning, a definition for OCFS Family Engagement was also developed - *Accomplishing Change Together (ACT) through partnerships, relationship building, family voices, with integrity and respect.*

The needs assessment brought to light the need for more engagement with external partners (outside state government), including those impacted by the programs and strategies that each workgroup will develop and implement. To build and continue to develop community-based partners and family leaders, the OCFS has developed a broad strategy for engagement leveraging our 76 community health offices. The OCFS recent completion of the office-wide services assessment and resulting change in regional and leadership structure will facilitate this approach to outreach and engagement.

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

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

Communication and Outreach

- Assess communication preferences of OCFS clients within the 76 community health offices and with community and state partners.
- Support OCFS regional managers' time to build community and family engagement collaboratives.
- Continue to develop online communities through the Cor Health (adolescents), For Baby's Sake (women and infants) web and social media channels and the development of the new MCH website.
- Identify and better understand the needs of English as a second language or non-English speakers in South Dakota.

Develop Community and Family Leaders

- MCH training offered to regional managers and MCH domain leads on Collective Impact as a model for community collaboration.
- Develop a statewide network, relying on family centered, patient or provider organizations to develop family leaders.

- Utilize the TRAIN platform, which allows training to be video recorded and disseminated, to OCFS regional managers, community partners and family leaders.
- Support and learn from the development of the Youth Council, which is a main strategy within the Child/Adolescent domain.
- Learn from the breastfeeding peer counselors' model – WIC breastfeeding peer counselors provide a valuable service to their communities, addressing the barriers to breastfeeding by offering breastfeeding education, support, and role modeling. The WIC program identifies mothers who were previous breastfeeding WIC participants to fill these paid positions.

Program Development, Improvement and Evaluation

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

- Development of the CYSHCN and infant safe sleep survey
- PRAMS guides much of our work and is an opportunity to hear from SD mothers.
- Expand the WIC annual survey to include not just WIC services but MCH services as well. These surveys are completed for statewide, regional and clinic information and are incorporated in the clinic nutrition and marketing plans as goals and objectives for overall improvement to the program.
- Public comment and direct solicitation of external reviewers of the MCH Block Grant

Training and Professional Development

- Each year there will be opportunities for gathering ideas and strategies for statewide family engagement implementation within the OCFS. Every other year the OCFS will hold an All Staff Conference to train field staff on various topics including family engagement.
- Renewed focus on orientation and onboarding new employees, cultural competency and health equity.
- MCH staff serve on multiple state and national advisory panels, councils, and workgroups that bring together family/consumer partners. This includes but is not limited to the advisory group for the HRSA Hearing Screening grant, early intervention State Interagency Coordinating Council, Developmental Disabilities Council, South Dakota Youth Suicide Prevention Advisory Committee, Oral Health Coalition, Bright Start Home Visiting Community Advisory Boards, Community Based Child Abuse Prevention Board, and the USD Center for the Prevention of Child Maltreatment Advisory Committee. These groups while each having their own focus all include consumers that provide insight and direction to inform decision making at all levels. This assists in ensuring our services are targeted to best meet consumer needs.

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

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

Name/credentials	Title/organization	Funding	Roles/responsibilities
Katelyn Strasser, MPH, RN	MCH Epidemiologist SDDOH	SSDI, PRAMS, WIC	Analyst for MCH data including infant birth, infant and maternal mortality, FAD data, and WIC data.
Tianna Beare, BS	Program Manager SDSU	PRAMS, Title V	Analyst for infant death review data
Lacey McCormack, PhD, MPH, RD	Associate Professor SDSU	PRAMS, Title V	Project director and data analyst for the SD PRAMS
Tracey McMahon, MS	Evaluation Specialist, SDSU Population Health Evaluation Center	Title V	Evaluation specialist for MCH programs
Anju Kurup, MPH	OCFS Data Analyst Black Hills Special Services Cooperative	WIC, COVID-19 Enhancing Detection ELC grant	Analyst for child death review data, creates reports and dashboards for infant mortality, assists with FAD data visualization

South Dakota Department of Health supports one FTE for epidemiology, Katelyn Strasser, Maternal Child Health Epidemiologist. Katelyn has a Master of Public Health degree and completed the CityMatch beginner/intermediate MCH Epidemiology course in 2019. She works on data across the Office of Child and Family Services on infant and maternal mortality data, MCH FAD data, WIC data, and other MCH program related data needs. She also works with SD PRAMS to translate data into action and coordinates the PRAMS steering committee. She is involved with establishing South Dakota's MMRC and serves as the workgroup leader for SPM 2 that focuses on equitable data sharing and collaboration.

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

Over the past two years, the Office of Child and Family Services, which includes MCH/Title V, conducted a services assessment. This included a discussion of how to better align services and programs across the office and how to serve South Dakotans more equitably. Many recommendations around data emerged from this process, and they were collected and organized into recommendations for future use. Some of the tasks associated with these recommendations include the following: creating standard data measures and language across the office, identifying data at the office and program level that should be translated into dashboards or other reports, using a new Electronic Health Record for data collection, providing timely data to staff, and giving staff the tools and training they need to access and understand the data. Over the next few years, the MCH Epidemiologist will work with other staff from across programs to complete these tasks, making maternal child health data more visible and practical for

programmatic changes. Staff will also be given training on evidence-based strategies and how to understand data to drive services.

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

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

The SSDI Grant Program supports a full time MCH Epidemiologist who establishes and maintains routine communication with the SSDI project team, Office of Child and Family Services (OCFS) managers and program managers, and contractors. This is accomplished by: 1) data sharing at monthly MCH Team meetings and monthly OCFS manager meetings and; 2) sharing data and epidemiology updates at monthly Division of Family and Community Health Administrator's meetings by the Office of Health Statistics and the epidemiology staff within the division and; 3) data sharing through agreements with the DOH Office of Vital Records to review maternal and child deaths in the state.

The MCH team participated in a training to learn how to implement evidence-based strategies and measures to continuously evaluate the progress being made in the workgroup activities. The MCH epidemiologist checks in regularly with MCH domain leaders to assess progress toward objectives and evidence-based strategy measures. The epidemiologist also oversees the MCH cross-cutting domain focused on data sharing and collaboration. Other methods of evaluation include MCH staff utilizing infant mortality data from vital statistics, PRAMS, and infant death review to evaluate programs focused on safe sleep.

The SSDI Grant Program has supported several projects, products, and resource materials that support State Title V program efforts in addressing its MCH priority needs. In 2020, the MCH Epidemiologist contributed to a South Dakota Medicine Journal publication regarding safe sleep behaviors among South Dakota mothers and the role of the health care provider. She has also provided training to community health nurses on gestational diabetes in South Dakota. A presentation was given to the South Dakota Public Health Association on SD Maternal Morbidity and Mortality.

PRAMS data has been presented to the Great Plains Tribal Leaders Health Board MCH and Epidemiology departments, the Great Plains Tribal Leaders Health Board Birth to 1000 Days Interagency Forum, and to Urban Indian Health. The 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties has been created for the 9 recognized tribes in South Dakota as well as for Urban Indian Health and the Great Plains Tribal Leaders Health Board. The SD PRAMS WIC Final Report was published in 2019. In 2020, the 2018 PRAMS Final Report, PRAMS Survey Data Report, PRAMS Disability Report, and PRAMS Opiate Report were published.

The SSDI Grant Program has also supported the creation of several fact sheets on topics affecting SD mothers including alcohol intake in women of childbearing age, maternal oral health, importance of early and often prenatal care for mothers, preconception and postpartum care, health insurance, pre-pregnancy body mass index, smoking during pregnancy, breastfeeding, adverse childhood experiences, abuse before and during pregnancy, safe sleep, teen pregnancy rates, and electronic vapor product use.

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

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

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

The MCH Epidemiologist works closely with DOH data staff including the vital records manager, injury epidemiologist, and chronic disease epidemiologist. This allows the MCH program timely access to data and opportunities to collaborate on data projects. Child and maternal death review are also housed within the Maternal and Child Health program section of the OCFS. Data and recommendations coming from these review committees can be shared with MCH partners and implemented into MCH programs and other programs across OCFS.

One of the current MCH/Title V state performance measures is equity in data sharing and collaboration. The MCH epidemiologist leads this workgroup and has other epidemiologists from DOH and other organizations across the state including Great Plains Tribal Leaders Health Board, Missouri Breaks Research, South Dakota State University, the University of South Dakota, and Medicaid. This has resulted in more diverse voices in the creation of MCH data projects and dissemination of this data.

The CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) was implemented in South Dakota in 2017 and has played a significant role in expanding MCH data capacity. PRAMS has become the main source for maternal and infant health indicators. It has been shared widely through various reports, data briefs, presentations, newsletters, and publications. The data from PRAMS helped inform the 2020 MCH Needs Assessment and priority setting process. This grant also has a multi-disciplinary steering committee that guides data dissemination and ideas for data-to-action activities.

The MCH Epidemiologist also collaborates closely with the WIC program staff, including the WIC Data Specialist. The WIC team and MCH Epidemiologist are currently working on an office wide action plan that includes implementation of both WIC and MCH goals through the community health offices. This will help the two programs work together on shared outcomes such as breastfeeding, obesity, and safe sleep. For example, the plan will contain staff goals and evaluation around safe sleep (infant domain priority) and sexual health education (state performance measure for adolescents). The WIC Data Specialist and MCH Epidemiologist also look at Pediatric Nutrition Surveillance System (PedNSS) and Pregnancy Nutrition Surveillance System (PNSS) data for child and maternal health indicators that could support program efforts.

The MCH Epidemiologist frequently builds MCH data capacity with MPH students. An MPH student recently analyzed and presented anemia data of mothers who were on the WIC program. The MCH Director, MCH Epidemiologist and WIC data analyst supported a University of South Dakota honors public health student research, which resulted in a thematic analysis of the 76 community health clinics' community health needs assessments. The MCH Epidemiologist also applied to host an MCH epi intern for the summer of 2021 and was matched with a Masters of Epidemiology student from Emory. This project will focus on creating a plan for officewide data reporting and visualization that includes overarching MCH outcomes and program specific data. The intern will research the outcomes (e.g. reduce obesity, reduce youth suicide, and increase breastfeeding rates) to find the best data sources and indicators for each outcome. The intern will also decide how to report that data (e.g. at state or county level, by race/ethnicity, by other demographic characteristics, etc.) and give recommendations for data visualizations for both an internal facing (DOH) and public facing dashboard. If time allows, the MCH epi would also like the intern to research South Dakota's data on social determinants of health and how that might factor into a data dashboard to give context to the disparities.

South Dakota also hired a contracted data analyst position to assist the MCH Epidemiologist with projects across OCFS. The data analyst created logic models for each MCH domain, made an infant mortality dashboard with Tableau, assisted the MCH Epidemiologist with creating a data report from the FAD data, and will be analyzing child

death review data now that South Dakota has expanded child death review to include children through age 12.

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

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

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

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

This plan will function as a framework amongst plans managed and maintained within and outside of SDDOH. These plans are maintained separately from this framework, and OPHPR is involved in the process for updating these plans as well as this framework.

The OCFS Administrator is involved in emergency operations planning within the Department of Health and was Community Mitigation Lead within the incident command team tasked with community outreach, business support, engagement and school monitoring during the COVID-19 pandemic. The Department of Health emergency operations planning team is currently working to create and update the DOH EOP that fits within the larger Emergency Operations Framework.

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

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

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

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

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

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

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

In the last year, the MCH program has partnered more intentionally with the University of South Dakota's Center for the Prevention of Child Maltreatment (CPCM). CPCM with substantial support from the Title V Director and the MIECHV Director to secure funding through the HRSA Early Childhood Compressive Systems. This effort included support from Departments of Education, Social Services and Health, and will begin implementation in the next few months. This funding award will support South Dakota's first attempt to align, coordinate and ultimately improve early childhood services and systems.

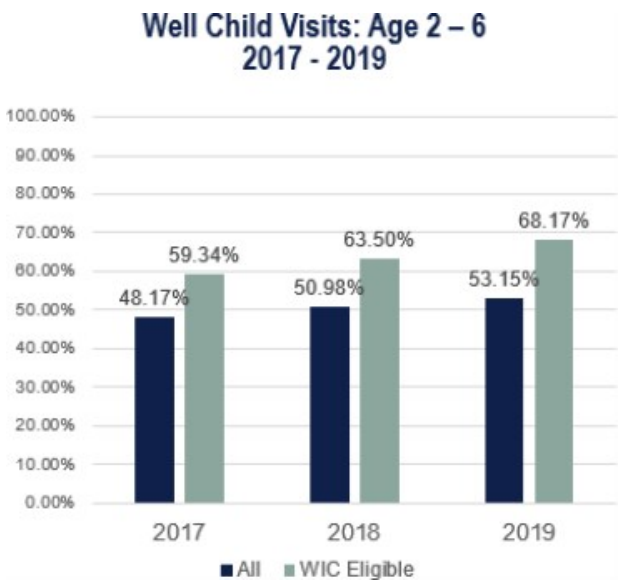
In the upcoming year, the MCH adolescent domain leader is embarking on a broad project to align goals, resources and services for youth. The Healthy Relationship Evaluation project will coordinate evaluation efforts regarding youth Healthy Relationships of 5 programs: Rape Prevention Education, Title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

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

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

The relationship focuses on patient and provider outreach, increased utilization of healthcare services, and coordination of innovative initiatives and programs for MCH populations. Long-standing examples of this relationship include allowable coverage and billing of modified case management for pregnant women, ASQ and ASQ-SE administered and follow up in all state-run community health offices and financial support of the Nurse Home Visiting Program.

The OCFS and Medicaid have also established an interagency collaborative which meets quarterly. One successful initiative resulting from this collaborative is between Medicaid, Title V and WIC to coordinated on provider, and patient education and awareness around immunizations and well-child visits. Through this collaboration both Departments have worked to ensure that providers and recipients understand Medicaid coverage of breast pumps, and other maternity services. In addition, this collaboration has had a significant positive impact on the rate of well child visits for children age 2-6. WIC nurses provide eligible recipients with valuable resources and follow up including assisting recipients to make well child visits.



In 2021, South Dakota was selected to participate in the National Academy for State Health Policy Maternal and Child Health Policy Innovations Program. A group of 8 states will work over the next two years to build state capacity to address maternal mortality for Medicaid-eligible pregnant and parenting women. The states participating in the Policy Academy are Georgia, Idaho, Illinois, Iowa, Louisiana, Pennsylvania, South Dakota, and Virginia.

The three goals of this initiative are as follows:

- Goal 1: Research and review data to develop a policy recommendation for pregnancy as a qualifying condition for the health home program by January 2022.
- Goal 2: Develop a framework for implementing value-based payment arrangements in rural Medicaid fee for service facilities by Dec 2022.
- Goal 3: Evaluate current home visiting maternal health programs to identify policy improvements by June 2022.

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

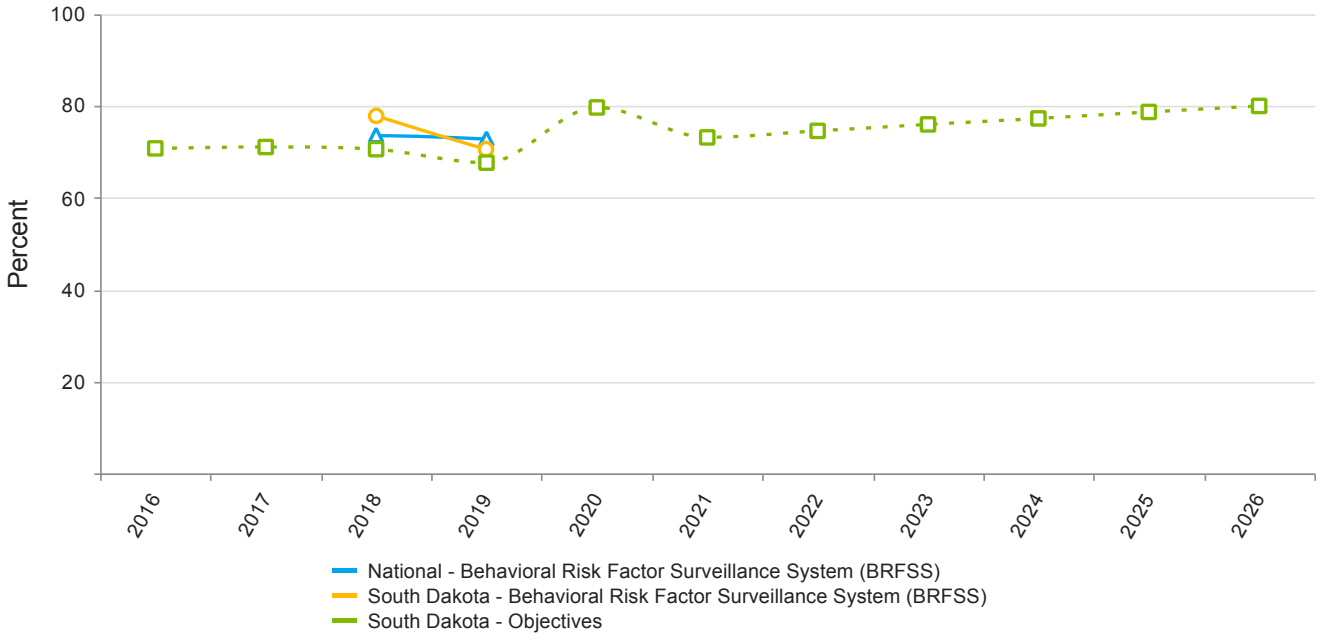
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	57.1	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	16.6	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	7.0 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	9.6 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	27.8 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	4.6	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.9	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	2.9	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.9	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	92.5	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2019	10.8 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	1.4	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	19.2	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	12.6 %	NPM 1

National Performance Measures

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



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					79.6
Annual Indicator				77.6	70.4
Numerator				110,174	101,908
Denominator				141,888	144,765
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.1	74.5	75.9	77.2	78.6	79.9

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	100	
Numerator	4,596	
Denominator	4,596	
Data Source	SD WIC IT	
Data Source Year	2019	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	10	
Numerator	495	
Denominator	4,954	
Data Source	SD WIC IT	
Data Source Year	2020	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (South Dakota) - Women/Maternal Health - Entry 1	
Priority Need	
Mental Health/Substance Misuse	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
Decrease percent of women on the SD WIC program who experience postpartum depressive symptoms following a recent live birth from 17.1% (2019) to 16.2% by 2025 (PRAMS)	
Strategies	
1.1: Implement an evidence-based and equitable behavioral health screening tool and referral protocol within the Office of Child and Family Services (OCFS) to assess for perinatal depression.	
1.2: Create toolkit of resources on Maternal Mental Health/Substance Misuse and Health Equity for OCFS field offices.	
1.3: Develop partnerships with diverse, multisector statekholders to address maternal mental health and substance use through a health equity lens.	
ESMs	**Status**
ESM 1.1 - % of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening	Active
ESM 1.2 - % of WIC clients whose PHQ 9 score met criteria for a referral and were referred	Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Women/Maternal Health - Annual Report

Fiscal year 2020 was a challenging year for the MCH workgroup within the Women's Domain. At the start of this grant cycle, workgroup members actively participated in meetings and activities related to the MCH Needs Assessment process. March - September found workgroup members actively involved with the Department of Health's COVID response. Members fulfilled various roles within the COVID Surge including: leading community mitigation efforts, completing COVID investigations for active cases, responding to web Emergency Operations Center calls, contact tracing, 10-day call backs (to release clients from isolation), and staffing the COVID -19 information hotline. Every member of the workgroup was assisting in one way or another either part or full-time. Despite these challenges, the workgroup continued addressing strategies on the current state action plan. The results of these efforts are described below.

Priorities for the 2015-2020 Women/Maternal Domain:

- Promote preconception/inter-conception health; and
- Promote oral health for all populations

Under the National Performance Measure/Domain framework, one National Performance Measure (NPM) was chosen and the objectives, strategies, and activities are identified within the State Action Plan. In addition to the activities listed on the State Action Plan there are other women/maternal health efforts that MCH team members support to assist in addressing the priority needs. Efforts included:

- Office of Child and Family Services' (OCFS) Community Health offices promoted Health Coverage Open Enrollment (November 1 – December 15, 2020) by dispersing *Get Covered South Dakota's* pamphlets to client's who did not have health coverage. The pamphlet provides instructions on how to sign up for health insurance on the Marketplace, how to get help in signing up (location of Navigators) and the location of all Community Health Centers in South Dakota (SD) that have a sliding fee scale for services and are a part of the Community Healthcare Association of the Dakotas (CHAD).
- Department of Health (DOH) partnered with Delta Dental in SD to promote oral health for new moms: Delta Dental distributed a SMILE kit to all new moms at birthing hospitals across the state. Resources included in the kits: an adult size toothbrush and a handout *Tips on Caring for Your Teeth*. Delta Dental distributed 8,500 Smile Kits in calendar year 2019.
- DOH's Tobacco Program promoted smoking cessation services for pregnant and postpartum women by:
    - Placing ads in SD Medical Journal (2,000 subscribers)
    - Posting Facebook ads targeting women of childbearing age
    - Collaborating with Delta Dental to provide QuitLine information to families who have a smoker in the home. Delta Dental's Regional and Mobile clinics placed a QuitLine sticker on a child's take-home paperwork when the child reported that someone in their home smokes. In 2019, Delta Dental staff gave out 1,248 stickers with QuitLine information.

At the end of this reporting period the MCH Impact Team workgroup members assigned to each National or State Performance Measure were asked to complete a data collection form. The data collection form was a checklist of the strategies that the program was to address during the grant year. The workgroup members rated the degree to which the strategies were implemented, and the percentage of completion is included as the ESM for each measure. In addition to this assessment for each measure, data was reported to provide a quantitative context for each strategy. This ESM process allowed us to better report progress to date on all strategies. Data collection forms can be found at the link below:

https://doh.sd.gov/documents/MCH/2020/DetailSheet_NPM1_FY20.pdf

DOH Strategic Plan Goal 1: Enhance the accessibility, quality, and effective use of health resources.

National Performance Measure 1: *Percent of women ages 18-44 with a past year preventive medical visit (data source: BRFSS)*

Data Statement:

The routine checkup item changed in 2018 and is not comparable to previous survey years. Due to this change, it is not possible to determine whether the original target was reached. In 2019, South Dakota ranked 36th in the nation, with 70.4% of women having a preventive visit in the past year compared to a U.S. rate of 72.8%. This was down from a South Dakota rate of 77.6% in 2018 but the absolute changes from last year to current year and from state to U.S. rate are not significant.

The full-length South Dakota MCH Annual Data Summary can be found here:

https://doh.sd.gov/documents/MCH/2022_SDMCH_DataSummary.pdf

State Objective:

By June 30, 2020, increase the percent of women, ages 18 through 24 years, who had a preventive medical visit in the past year from 59.3% (2016) to 66.2%. (data source: BRFSS)

State Objective Data Statement:

The routine checkup item changed in 2018 and is not comparable to previous survey years. Due to this change, it is not possible to determine whether the original target was reached. In 2019, South Dakota ranked 36th in the nation, with 70.1% of women ages 18 through 24 years having a preventive visit in the past year compared to a U.S. rate of 71.3%.

Strategies:

1.1. Partner with other agencies (state and other) to promote yearly preventive visits.

- MCH team continued to partner with the SD Women, Infants, and Children's (WIC) Program to promote Well Women visits: Well Women visit referrals increased from 317 in FY '19 to 347 in FY '20 in spite of changes to WIC certifications during the pandemic. (Most certifications were extended or completed over the phone during the pandemic.)
- MCH team continued partnering with the Bureau of Human Resources (BHR) to promote Well Women visits: BHR sent out reminder letters to all 18-39-year-olds reminding them to see their provider yearly for a preventive visit (evidence-based strategy). The letters include a list of preventive services covered at 100%. In FY '20 (07/01/2019-06/30/2020) 31% of women between the ages of 18-24 submitted a claim for a preventive visit (CPT codes 99385 & 99395). Up 1% from last year.
- Partnered with the SD Family Planning program to promote Well Women visits: SD Family Planning has 23 locations across the state each offering annual exams to clients on a sliding scale fee.
- The NPM #1 interagency team did not meet during this grant year due to members responding to the pandemic.

Challenges:

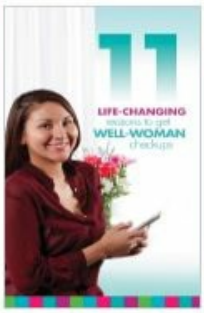
- The MCH program has limited outside partners in this arena. We need to reach out to other community partners and stakeholders to be part of the initiative.

1.2. Educate women on the importance of yearly preventive visits.

- BHR promoted a yearly preventive visit at all SD state employee health screening sites across the state. This years' promotion included a one-sided handout dispersed from the sign-in table (11,308 health screenings were completed in FY 2020: July 2019-June 2020).
- Data briefs on preconception care, prenatal care, and postpartum care were disseminated to 160 partner/stakeholders as part of the MCH Needs Assessment to encourage promotion of a Well Women visit.

Data presented was from the 2018 SD PRAMS.

- A Facebook post titled *11 Life Changing Reasons to Get Well Women Check-ups* ran on For Baby's Sake Facebook page for Women's Health Month in May. The post had a link to For Baby's Sakes Website *Scheduling Annual Well Women Check-ups* and ACOG's Well Women Exam infographic. An ad also ran on Snap Chat to reach a younger audience. A second Facebook post, *An Ounce of Prevention* also ran during this grant year. Refer to social media metrics table for all post and ad reach.

POST IMAGE	TITLE	TYPE (Paid/Organic)	CUMULATIVE REACH	AVERAGE FREQUENCY
	An Ounce of Prevention	PAID	24,145	3.98
	11 Reasons to Get Well-Woman Checkups	PAID	56,144	4.08
	11 Reasons to Get Well-Woman Checkups Snapchat	PAID	35,682	7.69
	Bright Start	PAID	21,252	4.78
	Bright Start	PAID	21,240	4.80
CUMULATIVE TOTALS ALL POSTS (unduplicated reach)			**111,986**	**5.07**

- An ad was placed in Black Hills Parent magazine to promote yearly preventive visits for all family members. Black Hills Parent magazine reports a readership of 80,000 and distributes copies to 475+ locations throughout the Black Hills of SD.

Challenges:

- Finding an effective way to disseminate information that young women will read and act on.

1.3 Implement training for Office of Child and Family Services staff related to preconception/inter-conception health.

- The SD Family Planning PowerPoint training (developed in FY 2019) was revised to include new clinic locations across the state.
- A training module was developed for the OCFS field staff on the All Women Count program delineating services it provides to low income women.
- A training module was developed to include the SD Tobacco Program's offerings for women in their childbearing years.

Challenges:

- Field staff were unable to complete any of the above trainings this FY as they were surged to assist with

COVID investigations in March 2020 and continued to work on COVID response through the end of this grant period.

- Determining the most effective way to provide training with limited budget.

ESM: The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure that all women are aware of the importance of annual well women visits

69% completion of identified strategies.

Women/Maternal Health - Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Women's/Maternal Health Domain for the period October 1, 2021 through September 30, 2022. Priority needs identified through the Needs Assessment process in this domain were: mental health, substance misuse, access to healthcare services, and various social needs such as lack of transportation, lack of desirable employment, poor housing, and lack of education. Mental health and substance misuse were common themes across the state especially for women with low socio-economic status. Selected priorities are still relevant, and strategies have been revised to screen more women for Perinatal Depression (added a pregnancy screening to hopefully catch issues before baby is born and decrease the incidence of postpartum depressive symptoms). Priority needs and the corresponding National Performance Measure are as follows:

Priority Needs: Mental Health/Substance Misuse

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

ESM 1.1: Percentage of WIC clients with a positive response to the Whooley questions that received a PHQ 9 screening.

ESM 1.2: Percentage of WIC clients whose PHQ 9 score met criteria for a referral and were referred.

2021-2022 Objective and Strategies

Decrease the percent of women on the SD WIC program who experience postpartum depressive symptoms following a recent live birth from 17.1% (2019) to 16.2% by 2025 (PRAMS)

Proposed Strategies:

1.1: Implement an evidence-based and equitable behavioral health screening tool and referral protocol within the OCFS to assess for perinatal depression.

- Initiate depression screening using the Whooley questions and PHQ 9 tools once during pregnancy and postpartum in all OCFS offices. (revised activity)
- Work with DSS Behavioral Health and Sage Consultants to develop an equitable policy for screening clients in all OCFS offices. (new activity)
- Develop an equitable and accessible referral pathway for clients who have a positive score on the PHQ 9.

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

- Collaborate with diverse, multisector partners to identify equitable and accessible treatment options for women across the state.
- Update OCFS field office resource guides to include information on accessible mental health treatment options. (new activity)

1.3: Develop partnerships with diverse, multisector stakeholders to address maternal mental health through a health equity lens.

- Expand NPM #1 workgroup to include partners and community members with lived experience who are committed to this work. (new activity)

New Efforts

- Suicide Prevention: the NPM 1 workgroup will partner with the NPM 7.2 workgroup to develop a suicide

prevention pamphlet to display in the OCFS field offices. (clients are more likely to talk to staff or feel more comfortable talking with staff about suicidal ideation if there is information in the waiting room about depression/suicide.)

- Equity Training: the MCH team will explore new ways to train field staff within the OCFS to view the services they provide through a health equity lens utilizing the TRAIN platform.

- Maternal Morbidity and Mortality: Support the work of the multidisciplinary Maternal Mortality Review Committee to identify risk factors contributing to maternal morbidity and mortality and work to improve health outcomes for women and their families.

- Stakeholder Collaboration: the MCH team will continue to partner with other state and local agencies and community members who are also addressing these priorities for women of childbearing age.

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

- Continue to educate all women on the importance of yearly preventive visits which address mental health as well as physical health.

- Continue to support the OCFS Baby Care program to provide prenatal and postpartum education, assist low income pregnant women to obtain early and on-going prenatal care, provide smoking cessation counseling and referrals and link women to resources that can help support healthy pregnancies and healthy newborns.

- Continue to partner with Title X, Bright Start Home Visiting, the SD WIC program, and other community partners to promote yearly check-ups for women of childbearing years and their families.

- Continue to support the CDC's PRAMS and utilize the findings for planning, assessing, and evaluating our programs with the goal of improving health outcomes for women and infants.

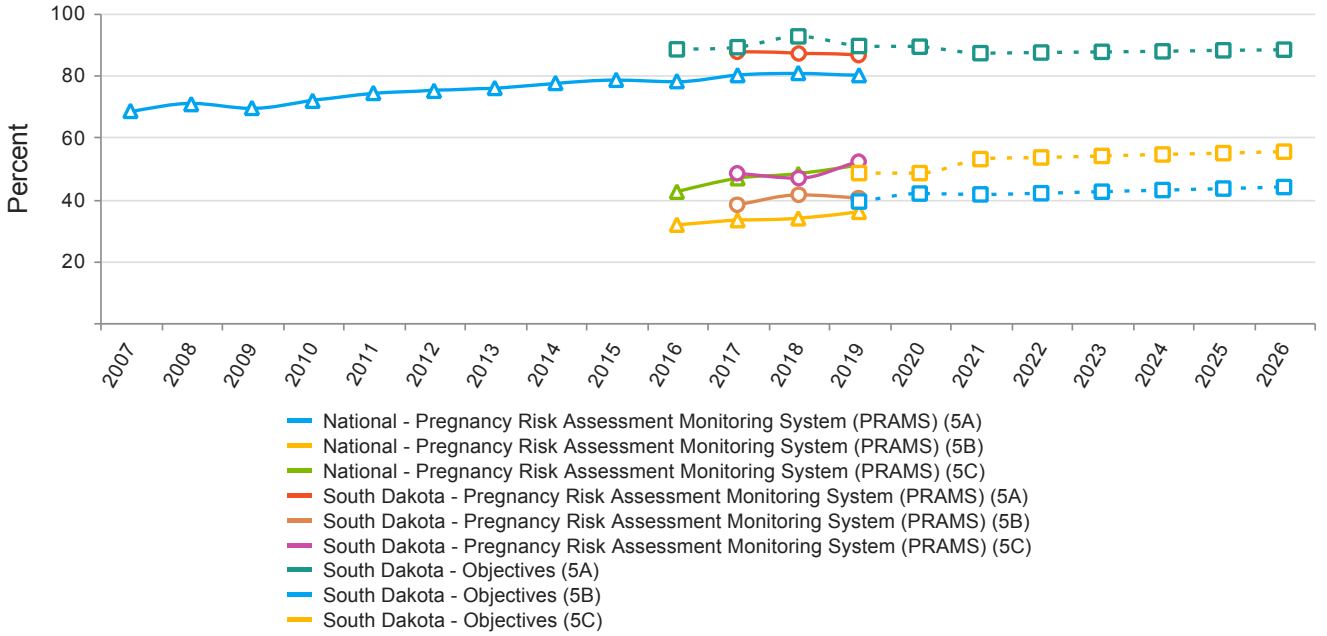
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.9	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.9	NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	168.2	NPM 5

National Performance Measures

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



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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective	92.4	89.3	89.1
Annual Indicator	87.6	87.0	86.6
Numerator	9,793	9,485	9,150
Denominator	11,174	10,900	10,566
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	88.2	88.9	92.4	89.3	89.1
Annual Indicator	86.7	91.7			
Numerator	9,607	10,013			
Denominator	11,078	10,922			
Data Source	SD PRAMS LIke Survey	SD PRAMS Like Survey			
Data Source Year	2014	2016			
Provisional or Final ?	Final	Final			

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	87.0	87.2	87.4	87.6	87.9	88.1

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		39.2	41.8
Annual Indicator	38.4	41.6	40.5
Numerator	4,014	4,380	4,136
Denominator	10,466	10,533	10,223
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			39.2	41.8
Annual Indicator	26			
Numerator	2,821			
Denominator	10,844			
Data Source	SD PRAMS Like Survey			
Data Source Year	2016			
Provisional or Final ?	Final			

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	41.5	41.9	42.4	42.9	43.4	43.9

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		48.4	48.4
Annual Indicator	48.2	46.9	52.0
Numerator	5,069	4,923	5,339
Denominator	10,516	10,495	10,267
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			48.4	48.4
Annual Indicator	44.7			
Numerator	4,681			
Denominator	10,472			
Data Source	SD PRAMS Like Survey			
Data Source Year	2016			
Provisional or Final ?	Final			

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	52.9	53.4	53.9	54.4	54.8	55.3

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

ESM 5.2 - % of daycares who respond to survey and indicate that they follow safe sleep guidelines

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
2022	2023	2024	2025	2026	
Annual Objective	100.0	100.0	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (South Dakota) - Perinatal/Infant Health - Entry 1	
Priority Need	
Safe Sleep	
NPM	
NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	
Objectives	
Reduce the number of SUID deaths related to unsafe sleep environment from 115/100,000 in 2017 to 104/100,000 by 2025 (NVSS)	
Increase the percent of infants placed to sleep without soft objects or loose bedding from 52% in 2019 to 54.8% in 2025 (PRAMS)	
Strategies	
5.1: Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media, print, and radio.	
5.2: Collaborate with diverse community partners to provide Child Death Review and disseminate findings to all South Dakotans.	
5.3: Collaborate with diverse, multi-sector organizations/agencies to promote safe sleep.	
ESMs	**Status**
ESM 5.1 - % of Child Death Review (CDR) team members who scored above 80% on a post-test	Active
ESM 5.2 - % of daycares who respond to survey and indicate that they follow safe sleep guidelines	Active
ESM 5.3 - % of birthing hospitals that receive information on certification process that become safe sleep certified	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

Perinatal/Infant Health - Annual Report

Fiscal year 2020 was a challenging year for the MCH workgroup within the Perinatal/Infant Domain. At the start of this grant cycle, workgroup members actively participated in meetings and activities related to the MCH Needs Assessment process. March - September found workgroup members actively involved with the Department of Health's COVID response. Members fulfilled various roles within the COVID surge including completing COVID investigations for active cases; facilitating COVID vaccinations across the state including planning and contracting with outside entities; and re-assigning and scheduling public health staff to COVID activities. Every member of the workgroup was assisting in one way or another either part or full-time. Despite these challenges, the workgroup continued addressing strategies on the current state action plan. The results of these efforts are described below.

During our 2015 MCH Needs Assessment one (1) state priority need was identified that was inclusive of the perinatal/infant population:

- Reduce infant mortality

Under the National Performance/Domain framework, 1 National Performance measure was chosen and the objectives, strategies, activities are identified within the State Action Plan framework. In addition to the National Performance measure activities there are **other perinatal/infant efforts** that MCH team members/DOH field staff support to assist in addressing perinatal/infant health priority needs. Efforts included:

- A NPM #5 workgroup member shared safe sleep resources/information with nurses from Ballard OB/GYN clinic in Rapid City. Nurses at the clinic will be starting a monthly safe sleep class for their clients.
- South Dakota State University's E. A. Martin Program released the 2018 PRAMS data related to NPM #5 Safe Sleep in the fall of 2019. The NPM #5 workgroup reviewed the data and discussed ways to continue to promote the safe sleep message to caregivers. A Safe Sleep data brief was also added to the DOH website for public viewing in January of 2020 (based on the 2018 PRAMS data).
- Health professionals (nurses and dietitians) from each DOH Community Health Office across the state (76 offices total) completed training from the Michigan Public Health Institute (MPHI) titled *Helping Families Practice Infant Safe Sleep.* The training was a strategy for their local Infant Mortality Plan. Health professionals make contacts with local providers, attend community events, and network with local agencies to get infant mortality prevention messages into their communities.
- Bright Start home visiting nurse, Sally Kangas, provided feedback to a government-led health education campaign's website that provides education and outreach on safe infant sleep. Volunteers were sought through an announcement by the National Center for Fatality Review and Prevention. Sally was asked to provide input on the layout of the website including titles of pages and links. Bright Start nurses like Sally serve at-risk mothers and their children up to age 3. Sally is the site coordinator for home visiting on the Pine Ridge Indian Reservation where SUID rates are higher than the state and national rates.
- DOH Community Health Nurses from Madison (Lake County) were able to convince the Madison Hospital to stop giving out baby boxes to new parents as a safe place for baby to sleep. The hospital is no longer promoting their use.
- The MCH team continued to support Levi Franz's (University of South Dakota medical student -4th year) Pathways Scholarship project on SIDS prevention. A member of the NPM #5 workgroup helped facilitate a survey of parents at the Community Health Center of the Black Hills. Levi will submit his research findings Spring of 2021.
- The Rapid City Community Health Office began piloting an addition to their Postpartum Tracking tool that they had been using with all postpartum moms. They added sleep questions similar to the ones in PRAMS to assess where baby is sleeping, how often the caregiver is placing the infant to sleep on their back, how often the caregiver bed-shares with their infant, and how often the infant sleeps with soft bedding. Answer choices included always, sometimes, or never. The questions were added to prompt a discussion on safe sleep practices. The office plans to continue asking the questions as a Continuous Quality Improvement project for next FY. The Rapid City office serves approximately 1,300 postpartum clients a year.

At the end of this reporting period the MCH Impact Team workgroup members assigned to each National or State performance Measure were asked to complete a data collection form. The data collection form was a checklist of the strategies that the program was to address during the grant year. The workgroup members rated the degree to which the strategies were implemented, and the percentage of completion is included as the ESM for each measure. In addition to this assessment for each measure, data were reported to provide a quantitative context for

each strategy. This ESM process allowed us to better report progress to date on all strategies. Data collection form can be found at the link below:
https://doh.sd.gov/documents/MCH/2020/DetailSheet_NPM5_FY20.pdf

DOH Strategic Plan Goal 2: Support life-long health for all South Dakotans

National Performance Measure 5:

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

Data Statement:

1. In 2019, the percentage of South Dakota infants placed to sleep on their backs was 86.6%. This did not yet reach the SD 2020 Target of 89.1%. It was a decrease from the previous year of 87.0% of infants being placed to sleep on their backs but the change was not significant. South Dakota ranks 7th in the U.S. and has a higher rate than the U.S. rate of 79.9%

2. In 2019, the percentage of South Dakota infants placed to sleep on a separate approved sleep surface was 40.5%. This did not yet reach the SD 2020 Target of 41.8%. It was a decrease from the previous year of 41.6% of infants being placed to sleep on a separate approved sleep surface but was not a significant change. South Dakota ranks 9th in the U.S. and has a higher rate than the U.S. rate of 35.9%

3. In 2019, the percentage of South Dakota infants placed to sleep without soft objects or loose bedding was 52.0%. This surpassed the SD 2020 target of 48.4%. It was an increase from the previous year of 46.9% of infants being placed to sleep without soft objects or loose bedding but was not a significant change. South Dakota ranks 20th in the U.S. and has a higher rate than the U.S. rate of 50.9%

The full-length South Dakota MCH Annual Data Summary can be found here:

https://doh.sd.gov/documents/MCH/2022_SDMCH_DataSummary.pdf

State Objective:

By June 30, 2020, increase the percent of infants from other races (not White or AI) placed to sleep on their backs from 86.2% (2016) to 89.9% (PRAMS)

State Objective Data Statement:

In 2019, 85.6% of South Dakota infants from other races (not non-Hispanic white or American Indian) were placed to sleep on their backs. This did not reach the 2020 target of 89.9%.

Strategies:

5.1. Engage and support collaboration among state agencies to promote education on the importance of safe sleep practices.

- NPM #5 workgroup facilitator e-mailed *Neighborhood Safety Network's* notice regarding the **inclined sleeper recalls** for 2019 to 4 DSS divisions: Behavioral Health, Developmental Disabilities, Policy and Strategy, and Child Protection Services as well as the Department of Education's Birth to Three program for field staff to share with their families/caregivers that take care of infants.
- Bonny Specker's (Epidemiologist with South Dakota State University's E. A. Martin Program) article *Safe Sleep Behaviors Among South Dakota Mothers and the Role of the Healthcare Provider* was published in SD Medicine in April 2020. The article is based on 2016 PRAMS data which determined that the role of the healthcare provider in talking to mothers was associated with greater compliance with some, but not all safe sleep recommendations. SD Medicine has approximately 2000 subscribers.

- MCH team collaborated with DSS Child Protection Services and DSS Economic Assistance departments to disperse SD Infant Death Review's client centered handout *Safe Sleep Practices Can Save Lives.* Over 3000 copies were distributed during customer contacts; with applications or renewal materials that are sent monthly to new moms and pregnant women; and were displayed in office lobbies.
- Peggy Seurer, member of the NPM #5 workgroup presented a breakout session on Safe Sleep at the Home Visiting Institute in October 2019. The Home Visiting Institute included staff from Early Head Start, tribal home visiting programs, and Bright Start home visiting. Peggy also had a booth at the SD LEADS conference in December 2019 and disseminated various Safe Sleep handouts to the attendees. SD LEADS conference was the first of its kind sponsored by the governor's office to energize and motivate women to be leaders in their communities.
- MCH Team collaborated with SD WIC to have 2 infant sleep questions added to the WIC Infant Assessment to facilitate discussion on safe sleep. The questions were: 1) Tell me about your baby's napping and bedtime routines. And 2) Tell me about where your baby is sleeping.
- MCH Team collaborated with the Governor's Office to promote safe sleep to parents of newborns by including the *Sleep Baby Safe and Snug* book (Charlie's Kids Foundation) in the governor's Strong Families mailings. These mailings go out to mom's who recently delivered a baby in SD. MCH funds paid for 2,460 books and 988 mailings in this fiscal year.
- NPM #5 workgroup facilitator compiled a list of on-line safe sleep resources for DOH health professionals to utilize with client's when they are unable to meet with the client in person (during COVID).

Challenges:

- Difficult to know what state agencies it makes sense to collaborate with. We need to think outside the box. Another challenge is the time and energy it takes to seek out new partners. Workgroup members had to split their time between their own job responsibilities and COVID responsibilities.

5.2. Implement strategies to increase awareness of the importance of safe sleep practices targeted to American Indians, dads, and grandparents.

- A 60-second radio spot addressing the early signs of pregnancy, prenatal care, and safe sleep, with emphasis on putting babies to sleep on their backs, on a firm surface alone, and room sharing, not bed sharing ran from October 7, 2019 through February 23, 2020. The primary audience was American Indian women of childbearing age (18-34) and while the buy was essentially a statewide schedule, the placement emphasis was in and around reservations and counties with high Indigenous populations. The flights pulsed on and off for 2-3 weeks and the relatively low budget was supplemented by an earned media requirement which allowed us to run nearly 1,800 spots on 9 stations with a frequency of 10.8 and gross rating points (GRPs) totaling 915.4—surpassing CDCs recommended best practice average of 800 GRPs per broadcast flight.
- Deb Kuehn, coordinator of the West River Child Death Review team, shared the client centered handout *Safe Sleep Practices Can Save Lives* with Native Women's Health and Sioux San IHS in Rapid City to utilize with their clients.
- MCH Team worked with their media agency to expand the number of culturally appropriate images (including Indigenous dads) in our image library for social media and print materials.
- Safe Sleep Facebook posts for this fiscal year (For Baby's Sake Facebook page) were culturally diverse and included Indigenous caregivers, dads, and grandparents. Refer to printout below.

POST IMAGE	TITLE	TYPE (Paid/Organic)	CUMULATIVE REACH	AVERAGE FREQUENCY
	SIDS prevention starts with safe sleep	PAID	17,144	4.39
	3 Key Ways Dads Can Help	ORGANIC	740	n/a
	11 Safe Sleep Guidelines	PAID	82,562	3.97
	Happy Grandparents Day	ORGANIC	736	n/a
	What Safe Sleep Looks Like (animation)	PAID	12,568	4.38

POST IMAGE	TITLE	TYPE (Paid/Organic)	CUMULATIVE REACH	AVERAGE FREQUENCY
	Room sharing is safe but bed sharing is NOT	PAID	9,800	2.77
	Happy Pappy Father's Day – Safe Sleep	ORGANIC	531	n/a
	Is My Crib Safe – (Url Share)	PAID	61,920	5.86
	Bright Start	PAID	21,252	4.87
	Bright Start	PAID	21,240	4.80
CUMULATIVE TOTALS ALL POSTS (unduplicated reach)			**119,331**	**7.94**

- Revision of the Safe Sleep section of For Baby's Sake website was put on HOLD due to MCH team being pulled into COVID response.
- Infant Death Review's client centered handout *Safe Sleep Practices Can Save Lives* was dispersed to Sanford, McKennan, and Monument Hospital's NICU, Labor and Delivery, and Newborn Nursery units to utilize in their discharge packets for newborn parents. It was also shared with the Family Practice Residency Program, Early Childhood Connections and Youth and Family Services all of Rapid City.
- An ad was placed in the October and November (2019) issues of SD Medicine Magazine with 5 ways providers can help assure more babies reach their first birthday.

- An ad was placed in the December 2019 Black Hills Parent magazine to promote safe infant sleep. Black Hills Parent magazine has a circulation of 10,000 copies.

Challenges:

- Lack of funding for television ads which were an effective way to share the safe sleep message in the past.
- Lack of time to work on strategies as team members were surged into DOH's COVID response

5.3. Collaborate with community partners to provide infant death review.

- SD has 2 regional death review teams that review all cause infant deaths post hospitalization up to age 1 year. Both teams are multidisciplinary and include members from forensic pathology, law enforcement (Police Departments, Sheriff's Departments, Division of Criminal Investigation, Bureau of Indian Affairs, FBI), EMS, Child Protection Services, States Attorney's offices, hospital staff from the 3 major hospitals in SD, Pine Ridge IHS, General Pediatricians, Child Abuse Pediatricians, and MCH staff from Great Plains Tribal Leaders Health Board.
- East River Child Death Review (CDR) team met twice in CY 2020 and reviewed a total of 15 post hospitalization infant deaths that occurred in a 44-county area. Eleven of these deaths had an ICD-10 code classification as Sudden Unexpected Infant Death (SUID).
- West River Child Death Review team met twice in CY 2020 and reviewed a total of 15 post hospitalization infant deaths that occurred in a 22-county area. Seven of these deaths were classified as SUIDs.
- NPM #5 facilitator met with newly hired DOH Injury Prevention Coordinator to discuss the process of death review and how the teams make recommendations for prevention.
- A data abstractor was hired in May of 2020 to work with the West River Child Death Review team (0.5 FTE) on data collection, abstraction, and prevention activities.
- The DOH is in the process of forming a multidisciplinary Preventable Death Committee that will review data and recommendations from CDR, NVDRS, and MMR and implement strategies to decrease mortality in our state. Update: the committee's first meeting was postponed due to COVID.

Challenges:

- Obtaining data from law enforcement agencies has been the biggest challenge for the death review process. SD does not have a state mandate for death review.

5.4. Develop Safe Sleep Process orientation for clerical staff in OCFS.

- A Safe Sleep Kit Distribution Orientation/Training Checklist was developed and placed into the Orientation

Module for Clerical on 5/18/2020. Clerical work in Community Health offices (76 total offices) across the state and assist with the Cribs for Kids distribution process.

5.5. Distribute Pack ‘n Plays to families who can’t afford a safe sleep environment.

- In CY 2020 the DOH partnered with the National Cribs for Kids program to distribute 751 safe sleep kits (includes a Pack ‘n Play) through their Community Health Offices and partners. This number is about 350 kits less than what is normally distributed.

Challenges:

- The price of Pack ‘n Plays from Cribs for Kids has gone up due to the tariffs placed on goods from China. This has decreased the number of units we can purchase for SD.
- Due to COVID, the distribution of safe sleep kits had to be altered as clients were not coming into Community Health offices for services. Community Health staff began doing safe sleep education over the phone and providing on-line resources to families who had internet access. Clients would then drive to their local office and meet a staff person at the door to receive their safe sleep kit. A few of the larger Community Health Offices continued to hold in-person safe sleep classes/kit distribution classes utilizing social distancing and mask wearing. Overall, the pandemic led to less safe sleep kits being distributed.

ESM: The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure implementation of infant safe sleep practices.

95% completion of identified strategies.

Perinatal/Infant Health - Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Perinatal/Infant Health Domain for the period October 1, 2021 through September 30, 2022. A notable need identified during the Needs Assessment process for this domain is continuing education and programming around infant safe sleep. Although SD's infant mortality rate had been steadily declining since 2009, in 2019 SD saw an increase in both white, non-Hispanic and American Indian, non-Hispanic infant deaths; and post neonatal and SUID mortality rates remain high. The selected priority remains relevant and is listed below along with the corresponding National Performance Measure:

Priority Need: Safe Sleep

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

ESM 1: Percentage of Child Death Review team members who scored above 80% on a post-test (training on root causes of infant mortality).

ESM 2: Percentage of daycares who respond to survey and indicate that they follow safe sleep guidelines.

ESM 3: Percentage of birthing hospitals that receive information on certification process and become safe sleep certified.

2021-2022 Objectives and Strategies

Reduce the number of SUID deaths related to unsafe sleep environment from 115/100,000 in 2017 to 104/100,000 by 2025 (NVSS) (revised objective).

Increase the percent of infants placed to sleep without soft objects or loose bedding from 52% in 2019 to 54.8% by 2025 (PRAMS)

Proposed Strategies:

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

- Continue to post safe sleep messages on For Baby's Sake Facebook page
- Continue to partner with AARP to post safe sleep messages on their Facebook page (for grandparents)
- Continue to place ads in parenting magazines and professional journals
- Provide safe sleep radio advertising in tribal communities

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

- Develop process for death review that is consistent with both East and West River review teams (met)
- Partner with the Center for Fatality Review and Prevention to train all team members on CDR process (met)
- Form a statewide prevention focused committee to turn death review data into strategies to prevent future deaths (met)

New activities

- Partner with the National Center for Fatality Review and Prevention to train CDR team members to incorporate discussion of upstream factors contributing to infant deaths.

- Work with Preventable Death Committee to find new ways of sharing information from CDR with the public.
- Work with Medical Examiners and law enforcement to provide infant death investigation and SUIDI form training to those that conduct the investigations.

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

- Partner with public schools' Family and Consumer Science Class life skills training curriculum to add a safe sleep module. (on hold)
- Partner with DSS/Child Care Services Early Childhood Education Centers to provide safe sleep training for non-licensed daycares. (revised)
- Partner with the Sioux Falls Public Health Department and Family Childcare Professionals of SD to provide safe sleep materials to in-home daycares. (revised)

After meeting several times during the current grant period, workgroup members decided to pivot and offer training and information on safe sleep to all daycare providers not just in-home or unlicensed providers. The group also felt focusing efforts on safe sleep education while families were still in the hospital (after birth of baby) would be a way to reach more caregivers. One way to do this would be to promote Safe Sleep Certification so all hospital staff receive safe sleep training based on the AAP's guidelines.

New activities

- Partner with DSS/Child Care Services Early Childhood Education Centers to provide safe sleep education to daycares.
- Partner with Cribs for Kids and SD birthing hospitals to promote safe sleep certification within their system. (Bronze, Silver, or Gold)

New Efforts

- Safe Sleep Messaging: build rapport with tribal public health leaders to gain knowledge on what type of messaging would be most impactful. Invite a family leader/advocate from the indigenous community to be part of the NPM #5 workgroup.

- Improve Death Review Process: focus on upstream root causes of infant mortality and begin quality assurance protocol.

- State-wide Injury Prevention: work with state Injury Prevention Coordinator and Preventable Death Committee to determine how best to use data from Child Death Review.

- Statewide Collaboration: partner with other state/local agencies and community members who are passionate about this priority and can affect change.

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

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

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

- Continue to promote infant immunization (as a strategy to decrease infant mortality) through For Baby's Sake website and Facebook page.
- Continue to promote infant growth and development screening in OCFS field offices and partner organizations for early recognition of delays and appropriate referrals to early intervention services.
- Continue to promote breastfeeding through social media and provide support for breastfeeding moms through partner agencies, DOH's Certified Lactation Counselors (CLCs) and WIC's breastfeeding peer counselors statewide.

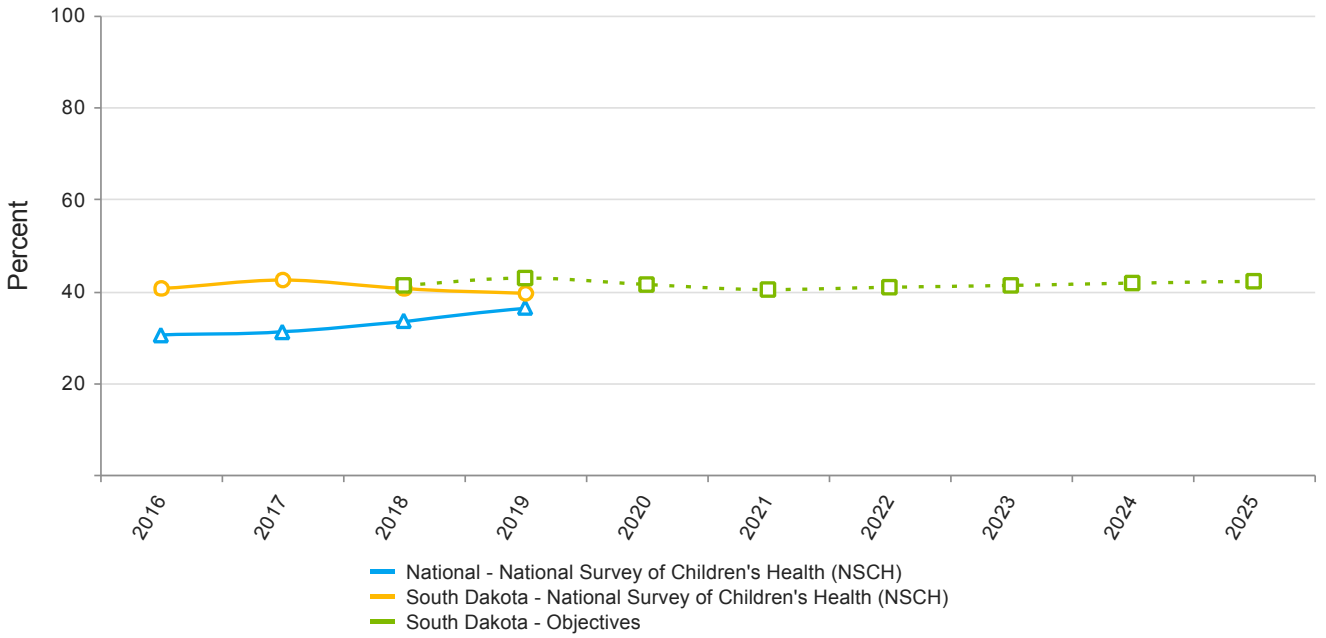
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.6 %	NPM 6

National Performance Measures

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



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			41.2	42.8	41.4
Annual Indicator		40.4	42.4	40.4	39.4
Numerator		12,135	10,542	8,655	9,910
Denominator		30,030	24,884	21,429	25,131
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	40.3	40.8	41.2	41.7	42.1	42.6

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	100	
Numerator	76	
Denominator	76	
Data Source	OCFS Community Health Offices	
Data Source Year	2019	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (South Dakota) - Child Health - Entry 1	
Priority Need	
Parenting Education and Support	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
Increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year from 33.2% (2017-18) to 36.5% by 2025 (NSCH)	
Strategies	
6.1: Develop and equitably disseminate a clear and consistent message to communicate the importance of developmental screening to families and community health providers.	
6.2: Create new and promote existing parenting resources to support healthy children and families	
6.3: Collaborate with partners to identify gaps in parenting education and support and reduce duplication of efforts	
ESMs	**Status**
ESM 6.1 - % of Community Health Offices that distribute tracking cards	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

Child Health - Annual Report

In Fiscal Year 2020 (FY20), the Child workgroup members participated in the meetings and activities related to the MCH Needs Assessment process. Beginning in March, workgroup members, South Dakota WIC (SD WIC) and Office Child and Family Services (OCFS) staff became actively involved in the COVID-19 response. The COVID-19 pandemic created some challenges in carrying out some of the year's planned activities, but progress was still able to be made in some areas.

During our 2015 MCH Needs Assessment two (2) state priority needs were identified that were inclusive of the child population:

- Improve early identification and referral for developmental delays; and
- Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization) and assure appropriate access to health services that are focused on families, women, infants, adolescents, and CYSHCN.

Under the National Performance/Domain framework, one (1) National Performance measure was chosen and one (1) State performance measure was identified and the objectives, strategies, and activities for each are identified within the State Action Plan framework. In addition to the performance measure activities there are other child health efforts that MCH team members support to assist in addressing child health priority needs. Efforts include:

- Promoting wellness visits with primary care providers
- Administering and promoting routine immunizations
- Educating families on the dangers of secondhand smoke
- Injury Prevention
- Suicide Prevention

At the end of this reporting period the MCH Impact Team workgroup members assigned to each national or state performance measure were asked to complete a data collection form. The data collection form was a checklist of the strategies that the program was to address during the grant year. The workgroup members rated the degree to which the strategies were implemented, and the percentage of completion is included as the ESM for each measure. In addition to this assessment for each measure, data was reported to provide a quantitative context for each strategy. This ESM process allowed us to better report progress to date on all strategies. Data collection forms can be found at the links below:

https://doh.sd.gov/documents/MCH/2020/DetailSheet_NPM6_FY20.pdf

https://doh.sd.gov/documents/MCH/2020/DetailSheet_SPM2_FY20.pdf

DOH Strategic Plan Goal 2: Support life-long health for all South Dakotans

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

Data Statement:

South Dakota did not reach the 2020 target of 41.4%, with 39.4% of children ages 9-35 months receiving a developmental screening using a parent-completed screening tool in 2017-18. This is a decrease from 42.4% in 2016-17. In 2018-2019, South Dakota was ranked 16th in the nation in percent of children receiving a developmental screening tool with a national rate of 36.4%.

The full-length South Dakota MCH Annual Data Summary can be found here:

https://doh.sd.gov/documents/MCH/2022_SDMCH_DataSummary.pdf

State Objective:

By June 30, 2020, increase the percent of children from non-metropolitan areas who have a developmental screening completed from 34.3% (2017-18) to 35.1%. (NSCH)

State Objective Data Statement:

The 2018-19 South Dakota rate of 26.4% did not meet the 2020 target of 35.1%. This rate among children from non-metropolitan areas is lower than the overall South Dakota rate of 39.4%. There is a data note for this indicator that the rate should be interpreted with caution because the confidence interval width is greater than 20% points.

Strategies:

6.1. Partner with other entities (Medicaid, Child Care, Birth to 3, Head Start, Center for Disabilities, etc.) to pursue the development and dissemination of a standard and consistent message to communicate importance of developmental screening

- Incorporated training and reminders for Office of Child and Family Services (OCFS) staff to connect families to the CDC Milestone Tracker app.
- Continued to offer online resources including confidential ASQ screening tool at https://doh.sd.gov/family/childhood/child-development.aspx
- Released a Child Health data brief to the statewide Needs Assessment partners providing information on developmental screening rates in the state.
- Established a diverse workgroup to provide input and support in carrying out the strategies outlined in the Child action plan.
- CYSHCN Director/Child Coordinator met quarterly (as the COVID 19 pandemic allowed) with Medicaid, state Child Interagency Workgroup (including Birth to 3), Developmental Disabilities Council, and Community of Practice State Team to discuss current projects and opportunities for collaboration

6.2. Partner with “Learn the Signs, Act Early” (LtSAE) champion to promote developmental screening within the state of South Dakota.

- The MCH and CYSHCN Directors met with the Learn the Signs, Act Early champion at South Dakota Parent Connection to establish a new connection and discuss ideas for future collaboration. The MCH Program, on behalf of the Department of Health, supported the South Dakota LtSAE champion in applying for and obtaining an AUCD/CDC grant to support recovery and resilience of statewide early childhood systems from COVID 19 impacts as it relates to early identification and intervention. A letter of support was provided by the Secretary of Health. The CYSHCN Director serves on the advisory committee for this project.

6.3. Provide ASQ and ASQ SE screenings at OCFS offices as per DOH policy.

- Provided training on administering ASQ and ASQ SE screenings to all new staff as part of their orientation. Encouraged staff to use the Brookes Publishing ASQ/ASQ-SE newsletters for continuing education.
- Collaborated with Bright Start Home Visiting to reduce duplication of or gaps in developmental screenings and referrals for evaluation.
- Disseminated a trifold developmental screening tracking card that can be ordered through the DOH central

ordering system. Cards are similar to immunization tracking cards and are given to parents for their records.

- During this reporting period OCFS staff facilitated the completion of 1,393 ASQs; 1,320 ASQ SEs; and completed interventions with 29 infants and children who needed further evaluation for potential developmental delays.
- Between October 2019 and September 2020, 94% of children enrolled in DOH's MIECHV program had a completed ASQ-3 at 18 months, an increase of 4% from the last reporting period.

Challenge: The Coronavirus pandemic created a substantial challenge for Community Health Offices to complete ASQs and ASQ SEs. The offices were unable to screen families in person for half of the grant year and had to create new methods of reaching families, including completing screenings over the phone and through the mail. The new methods also came with challenges, including a lack of response and interest from families. A third option of putting the screenings online was discussed but never came to fruition.

ESMs

The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to improve early identification and referral of developmental delays.

78% completion of identified strategies.

DOH Strategic Plan Goal 2: Support life-long health for all South Dakotans

State Performance Measure 2: *Percentage of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)*

Data Statement:

South Dakota did not reach the 2020 target of 32.0%, with 34.3% of children ages 2 to 5 years receiving WIC services with a BMI at or above the 85th percentile of children in 2020. This is an increase from the 2019 rate of 33.8% and a rate of 33.1% in 2017. It is important to note the number of children whose data was reported for this indicator in 2020 dropped to 2354 from 6797 in 2019. The cause of this discrepancy is still under review, but it may have something to do with WIC services switching to the phone during the COVID-19 pandemic and staff not able to obtain this information

State *Objective1:*

By June 30, 2020, decrease the percentage of students 5-6 years old with a BMI at or above the 85th percentile from 26.7% (2017) to 25.8% (School height/weight data)

State Objective 1 Data Statement:

In 2019, the percentage of students 5-6 years of age with a BMI at or above the 85th percentile was 34.9% However, this data is not comparable to other years. Due to COVID-19 and schools being closed, only 12200 were included in the total sample, compared to around 43000 in previous years. In 2018, the percentage of students 5-6 years of age with a BMI at or above the 85th percentile was 27.6% and this has not changed between 2015 and 2018. The 2017 rate was 26.7%.

State Objective 2:

By June 30, 2020 decrease the percentage of American Indian children ages 2 through 4 years receiving WIC services with a BMI at or above the 85th percentile (overweight or obese) from 42.5% (2017) to 41.0% (PedNSS)

State Objective 2 Data Statement:

In 2020, 45.9% of American Indian children ages 2 through 4 years receiving WIC services had a BMI at or above

the 85th percentile. South Dakota did not reach the 2020 target of 41.0% and there has been a significant increasing trend between 2016 and 2020 in the percent of American Indian children ages 2 through 4 receiving WIC with a BMI at or above the 85th percentile. The 2020 rate of 45.9% is greater than the statewide rate for all races of 34.3%. It is worth noting that the number of children whose data was reported for this indicator in 2020 dropped to 2354 from 6797 in 2019. The cause of this discrepancy is still under review, but it may have something to do with WIC services switching to the phone during the COVID-19 pandemic and staff not able to obtain this information.

Strategies:

S2.1. Engage and support collaboration among state agencies and community partners around nutrition and physical activity.

- Previous reporting period WIC and Head Start established a MOU to collaborate to reduce barriers for participants in both programs – such as providing services in a shared location, utilizing a common referral/release of Information form, and sharing of assessment data. During this reporting period this work has slow down due to staff utilizing their time on COVID-19 response and will start back up as soon as it is safe for both participants and staff.

- The SD DOH, Department of Game, Fish, and Parks, and South Dakota State University (SDSU) Extension continued the Park Rx program across the state. Currently 141 Healthcare Providers and every OCFS Community Health Office (total of 77) are participating in the Park RX program. A complete survey assessment or previous Park Prescription participants can be found here: https://healthysd.gov/park-rx-prescribe-a-day-in-the-park/

- DOH's Healthy SD Munch Code program developed a Vending and Snack Bar Munch Code toolkit and vending calculator. The Munch Code is a color coded labeling program designed to make it easier for people of all ages to choose healthier snacks on-the-go. GREEN foods and beverages are the healthiest options. You can eat a bunch! YELLOW foods and beverages have added sugar, fat, and calories. Be cautious and have just a little! RED foods and beverages are the highest in sugar, fat, and calories and the least healthy. Eat these occasionally but remember – not so much! There are 2 types of snacking environments where the Munch Code color system can be used:
    - Concession Stands – The Munch Code Healthy Concessions Toolkit provides a number of resources including a model policy for schools and community organizations. Toolkits were sent to eight organizations in 2019/2020.

  Vending Machines and Snack Bars – The SD Healthier Vending and Snack Bar (HVSB) program has worked with a total of 66 worksites since its start in 2013. The program is based on the SD HVSB standards which use the Munch Code color-coding system to categorize snack foods and drinks available for purchase in worksites. (The Munch Code standards are different for concession stands versus vending machines/snack bars.) The program is guided by the HVSB Toolkit which includes a model policy, policy implementation guide, project checklist, and ten additional appendices providing various tools and resources.

  https://healthysd.gov/category/munch-code+workplace/

- SDSU Extension (which provides nutrition education to 7 Native American communities in SD) and the SD WIC Program have begun discussions on possible areas of collaboration in serving these communities. Due to COVID all in-person cooking classes have stopped. Both SDSU Extension and SD WIC have worked together to allow virtual cooking classes as an option for nutrition education.

S2.2. Integrate nutrition and physical activity educational messages into health promotion efforts including social media and other communications.

- A program brochure which explains the WIC program, program eligibility, program benefits, and what to expect at your WIC appointment is in the process of being made available via a mobile application. WIC worked with a local marketing company to update sdwic.org library and it now includes information on physical activity for anyone accessing the website. Topics include limiting screen time, active play for kids & teens and physical activity guidelines.

- In previous reporting WIC has begun utilizing tele nutrition for follow up nutrition counseling appointments in 7 counties. The tele nutrition committee recently met and is considering expansion to other counties/offices and other types of WIC appointments. There has been discussion in regard to developing lesson plans specific for use with tele nutrition. The attempted pilots in previous reporting period unfortunately did not work out but SD WIC is currently look at a web-based tele-nutrition platform that will be rolled out within the next 6 months.

- The DOH and SDSU Extension led the Breastfeeding- Friendly Business Initiative to encourage worksites across the state to take an online pledge to support breastfeeding customers and employees. As of 09/30/2020 692 businesses had taken the Breastfeeding-Friendly Business Pledge and hung a 4" x 4" window cling stating *Breastfeeding Welcome Here!* Each worksite also received a kit that includes a variety of resources including the DOH Breastfeeding Support Model Policy. All materials are also available in digital format on the pledge site including the newest tool – the SD Employer Breastfeeding Accommodation Form. This form is communication tool between employer and employee to proactively work together to plan for breastfeeding accommodation needs upon return form maternity leave. https://healthysd.gov/category/breastfeeding+workplace/

- Partnered with DSS Medicaid to begin updating well-child letters. Medicaid well-child letters are sent out to participants annually to encourage participation and educate on annual well visits requirements. Medicaid Letter were broken down by the follow age groups, 0 to 3 years old, 4 to 9 years old, 10 to 12 years old and 13 + years old. Annual well-child letter for 4 to 5 years old encouraged participants to talk with their primary care provider about any questions regarding healthy eating and physical activity.
  - 4 to 9 year old - https://doh.sd.gov/documents/Family/Medicaid_WellVisit_Letter_4-9.pdf

S2.3. Facilitate the provision of technical assistance to childcare centers on the importance of increasing physical activity opportunities within their center.

- Through a partnership with Sanford Health's CHILD Services, 62 childcare programs received physical activity technical assistance (PATA) influencing over 5,318 children.
- The Department. of Social Services (DSS), Division of Child Care Services provided training to childcare centers on physical activity policy development and evidence-based strategies to create and environment supportive of increased physical activity.

S2.4. Provide Office of Child and Family Services (OFCS) staff with tips/strategies to approach the sensitive subject of weight with parents of overweight and obese children.

- Nutrition staff were provided training at the bi-annual nutrition training in Pierre by Sanford Fit that helped them learn to focus less on the topic of weight and more on keeping kids active and healthy.

Challenges: Limited time available for OFCS and SD WIC staff time to be focus on training outside of the COVID

response responsibilities.

ESM: The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to increase nutrition and physical activity education.

73% completion of identified strategies.

Child Health - Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Child Health Domain for the period October 1, 2021 through September 30, 2022. In the Child Health Domain, selected priorities and corresponding National Performance Measures or State Performance Measures are as follows:

Priority Need: Parenting education and support

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

ESM 6.1: Percent of community health offices that distribute tracking cards

2020-2021 Objective and Strategies

Objective: Increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year from 33.2% (2017-18) to 36.5% by 2025 (NSCH)

A New Plan

The MCH Child Domain will see many changes in the upcoming grant year. Many factors contributed to the need for these changes, including an office-wide services assessment that resulted in new and improved processes for service delivery. In addition, the need to focus on collaboration was recognized during the first year of implementation, as most of our work is accomplished through partnerships. Moving forward, the Child Domain will have an increased emphasis on parenting education and support, as well as a restructured approach to addressing developmental screening processes in the Community Health offices.

Proposed Strategies:

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

- Encourage Community Health staff to connect English and Spanish speaking families with needed technology to apps including CDC Milestone Tracker app, Bright by Text, Text4Baby
- Ensure community health offices have adequate hard copy resources such as trifold developmental screening cards and milestone tracking handouts to distribute to families
- Develop the ASQ and ASQ SE screening processes in Community Health Offices and identify opportunities for quality improvement
- Provide training to community health staff on early identification

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

- NPM 6 workgroup will identify parenting resources across the state and collaborate on promotion and dissemination to families
- Connect with medical providers, social workers, tribal communities, and community workers to identify additional parenting resources and ways to equitably promote them

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

- Collaborate with the DOH Home Visiting program and Community Health Offices to reduce duplication of and/or gaps in developmental screenings and referrals for evaluation between home visiting and other OCFS

programs

- Title V Child Health Coordinator will serve on the SD Developmental Disabilities Council, State Community of Practice Team, and additional workgroups as requested to boost collaboration with other entities and identify gaps in parenting education and support

New Approach to Evidence- Based Strategy Measures

The detail sheets originally developed for each National and State Performance Measure in FFY17 continued to be updated and utilized through FFY20 to capture program effectiveness. Beginning in FFY21, we will be taking a different approach to ESMs and measuring the effectiveness of our efforts based on technical assistance and training received from the MCHB Evidence Center.

New Efforts

- Increased involvement with ASQ and ASQ SE screenings in Community Health offices: The Office of Child and Family Services underwent a services assessment in 2020/2021 that resulted in an opportunity to give the Child Health Coordinator an increased presence with the ASQ screening processes in the Community Health Offices. The Child Coordinator will provide trainings on early identification and focus on quality improvement efforts to improve developmental screening rates.
- Staff Training: Training on early identification will be provided to Community Health staff. The Child Coordinator will also undergo training on ASQ and ASQ SE screenings and early identification.
- Parenting education and support: The MCH Program will work with partners to create new and promote existing parenting resources to parents. The NPM 6 workgroup has representation from different organizations as well as state agencies that work directly with families. Through input from our partners, we will determine what resources are needed for specific populations and tailor our approach based on need.

Ongoing Efforts Supported by MCH for the Child Domain

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

- School Health services, which include basic student health screening, vision screening, scoliosis screening, hearing screening, and health education, are provided at the request of contracting schools. Oral health screening is incorporated with WIC services. Funding supports interpreter services for non-English speaking families and children served.

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

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

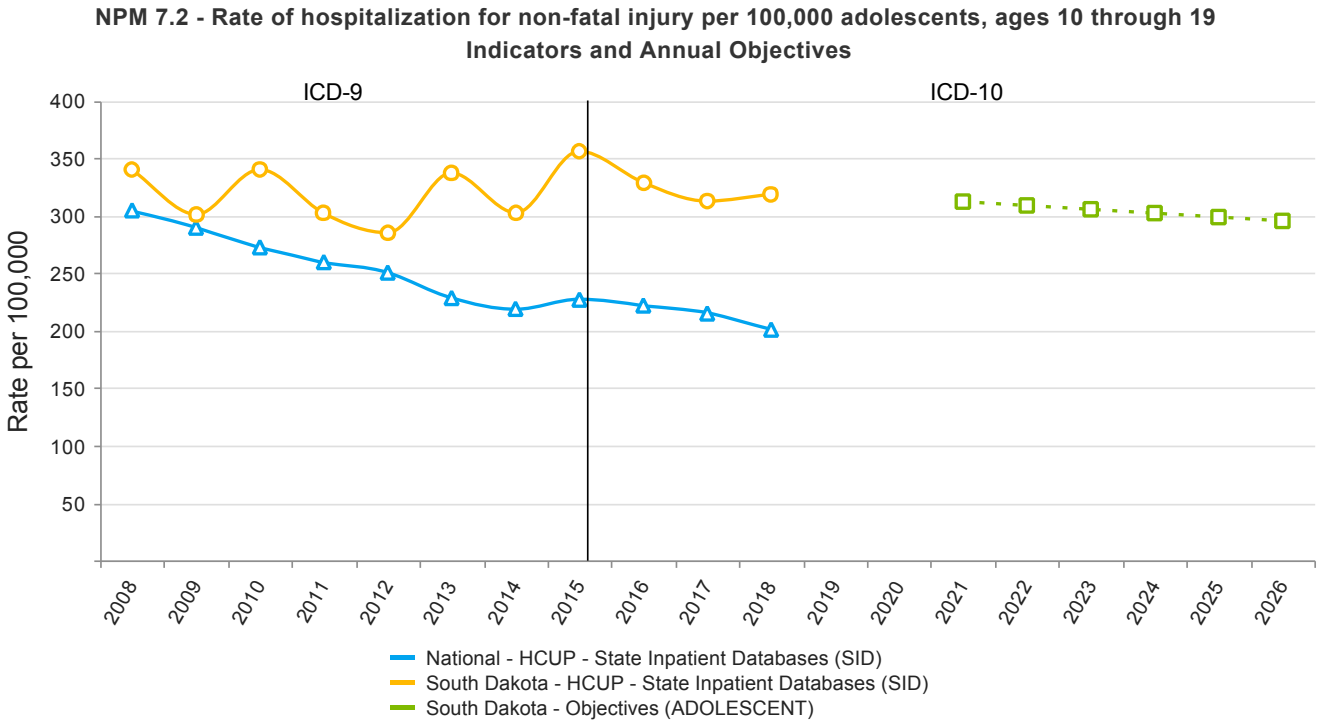
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2019	22.7	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	52.3	NPM 7.2 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	26.7	NPM 7.2 NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	33.1	NPM 7.2 NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.7 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	58.3 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.6 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	11.7 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	16.0 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	14.1 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	70.3 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	73.6 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	90.0 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	86.2 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	19.2	NPM 10

National Performance Measures



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

Federally Available Data			
Data Source: HCUP - State Inpatient Databases (SID)			
	2016	**2019**	**2020**
Annual Objective	337.2		
Annual Indicator	335.0	313.0	318.8
Numerator	379	363	378
Denominator	113,144	115,978	118,556
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	312.1	308.8	305.4	302.1	298.7	295.4

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	60.0	120.0	180.0	240.0	300.0	300.0

State Performance Measures

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 45.6% in 2020 to 50.2% in 2026.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.1	46.5	47.0	47.4	47.9	48.4

State Action Plan Table

State Action Plan Table (South Dakota) - Adolescent Health - Entry 1	
Priority Need	
Mental Health/Suicide Prevention	
NPM	
NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	
Objectives	
Decrease the adolescent suicide rate among 15 through 19-year olds from 29.2 per 100,000 (2016-18) to 26.3 in 2025 (NVSS).	
Decrease the percentage of 9th-12th graders who attempted suicide in the past 12 months from 12.3% in 2019 to 9.0% in 2025 (YRBS).	
Strategies	
7.2.1: Promote evidence-based programs and practices that increase protection from suicide risk.	
7.2.2: Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens.	
7.2.3: Develop and disseminate equitable and accessible Suicide Prevention education material, resources and messaging.	
7.2.4: Develop partnerships with diverse, multi-sector local and state agencies to address youth mental health and suicide prevention among all South Dakota youth.	
ESMs	**Status**
ESM 7.2.1 - # of students trained in teen Mental Health First Aid	Active
NOMs	
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

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

Priority Need

Healthy Relationships

SPM

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 45.6% in 2020 to 50.2% in 2026.

Objectives

Decrease the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics from 14.2% to 12.8% by 2025 (EHR NetSmart).

Decrease the South Dakota teen birth rate, ages 15 through 19, from 20.4/1000 in 2018 to 18.4/1000 in 2025 (NVSS)

Strategies

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

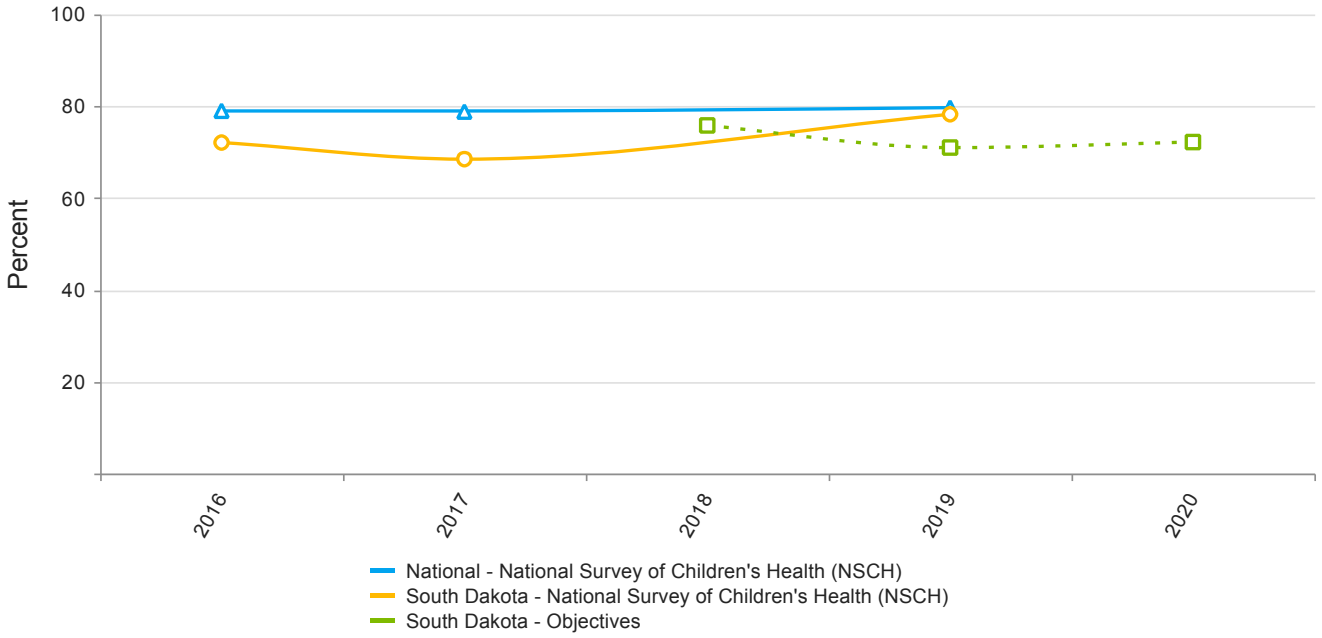
1.2: Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens.

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

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

2016-2020: National Performance Measures

2016-2020: NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			75.7	70.9	72.1
Annual Indicator		72.1	68.5	68.5	78.2
Numerator		46,184	46,371	46,371	52,192
Denominator		64,019	67,737	67,737	66,746
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 10.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to increase the percent of adolescents with an annual preventive medical visit.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			100	100
Annual Indicator			77.8	78.7
Numerator			70	59
Denominator			90	75
Data Source			DOH detail sheets	DOH detail sheets
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Adolescent Health - Annual Report

At the start of this grant cycle, workgroup members participated in meetings and activities related to the MCH Needs Assessment process. Beginning in March 2020 workgroup members became actively involved in the Department of Health's COVID responses. Despite these alternative job responsibilities, the adolescent workgroups continued addressing strategies on the current state action plans. The results of these efforts are described below.

During our 2015 MCH Needs Assessment three (3) state priority needs were identified that were inclusive of the adolescent population:

- Improve and assure appropriate access to health services that are focused on families, women, infants, adolescents, and CYSHCN
- Provide positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries; dietary habits; tobacco use, alcohol use, other drug utilization)
- Promote oral health for all populations

Under the National Performance/Domain framework, 1 National Performance Measure was chosen, and the objectives, strategies, and activities are identified within the State Action Plan framework. In addition to the National Performance Measure activities there are other adolescent efforts that MCH team members support to assist in addressing adolescent health priority needs. Efforts included:

- Suicide Prevention: partnered with Helpline Center to offer youth suicide prevention education throughout the state. The Helpline Center provides a 24/7 statewide crisis line, teen crisis texting support, Youth Mental Health First Aid training, teen Mental Health First Aid training, Suicide Prevention Training for primary care providers and training for high school faculty on teen suicide prevention/intervention.

- Suicide Prevention: partnered with Department of Social Services BeThe1SD campaign and promoted suicide prevention to youth councils throughout SD. Each youth council developed their own suicide prevention activity for their council/community. Guidance and resources such as posters, brochures, referral cards, and wrist keychains to promote the National Suicide Prevention Lifeline were provided to each youth council.

- Adolescent Injury Prevention: partnered with SD Office of Public Safety to disseminate and promote an injury prevention toolkit to reduce child and adolescent injury. The toolkit provides education on car seat guidelines and encourages seatbelt use. The importance of seatbelt usage was also promoted via social media posts, infographics, phone holders, and window clings. New materials were developed to target parents and youth on injury prevention including an infographic that discussed what parents could do to help prevent teen car accidents in South Dakota and a phone silicone card holder that displayed the message "Someone Needs you. Buckle up. Drivesafesd.com. These materials were disseminated to local community health clinic, non-profits that serve youth and schools.

- Reduction of Risky Behaviors and Making Healthy Choices: partnered with SD Family Planning Program (SDFPP) to provide services to low income individuals including identifying a reproductive life plan that is unique to each client. The SDFPP encourages family participation in the minor's decision to seek services, and counsels clients on how to resist attempts to coerce them into engaging in sexual activities.

- Immunization Programs: DOH's Disease Intervention Specialists visit all enrolled vaccination clinics across the state annually to review immunization coverage rates and provide technical assistance on how to improve coverage rates. The Immunization Program sends enrolled clinics a letter with their coverage rates, the state coverage rates, and the national rates three times a year. This serves as a reminder to keep working on improving immunization coverage.
  The Office of Child and Family Services' community health nurses (OCFS) conduct an audit of all incoming Kindergarten and 6th grade student immunization records to ensure they meet the states minimum

immunization requirements for school entry. The OCFS works directly with the schools to check every student's record. If a child is not up to date, the school is informed that the student needs additional immunizations. School-based clinics for influenza vaccine, adolescent Tdap, Meningococcal, and HPV vaccine are conducted by Community Health Nurses. Nurses also travel to Hutterite colonies to provide on-site vaccination clinics and promote/provide adolescent vaccines to this often vaccine hesitant population.

At the end of this reporting period the MCH Impact Team workgroup members assigned to each national or state performance measure were asked to complete a data collection form. The data collection form was a checklist of the strategies that the program was to address during the grant year. The workgroup members rated the degree to which the strategies were implemented, and the percentage of completion is included as the ESM for each measure. In addition to this assessment for each measure, data was reported to provide a quantitative context for each strategy. This ESM process allowed us to better report progress to date on all strategies. Data collection form can be found at the link below:

https://doh.sd.gov/documents/MCH/2020/DetailSheet_NPM10_FY20.pdf

DOH Strategic Plan Goal 1: Improve the quality, accessibility, and effective use of health care

National Performance Measure 10: *Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.*

Data Statement:

In 2019, 78.2% of adolescents in South Dakota ages 12 through 17 received a preventive medical visit in the past year. There was a working change to the NSCH in 2018 that did not allow 2018 data to be provided or compared with other years of data.
The 2019 rate surpassed the 2020 target of 70.9% and was higher than the 2016-2017 rate of 68.5%. The change from the base year rate of 72.1% was not significant. South Dakota ranks 29th nationally.

The full-length South Dakota MCH Annual Data Summary can be found here:

https://doh.sd.gov/documents/MCH/2022_SDMCH_DataSummary.pdf

The annual data summary this year looks ahead to the emerging priorities from the 2020 Statewide Needs Assessment and focuses on injury prevention and healthy relationships for adolescents. It does not cover data trends relating to NPM 10.

State Objective 1:

By June 30, 2020, increase the immunization rate (%) for the >1 dose of meningococcal vaccine for adolescents 13-17 years of age from 74.5% (2017) to 75.7% (NIS)

State Objective 1 Data Statement:

South Dakota exceeded the 2020 target of 75.7% and there has been a significant increase between 2015 and 2019 in the immunization rate for >1 meningococcal vaccine among adolescents 13-17 years of age. The rate increased from 55.5% in 2015 to 86.2% in 2019. Despite this improvement, in 2019 South Dakota was ranked 36th nationally for meningococcal vaccine rate among adolescents and the U.S. rate was 88.9%.

State Objective 2:

By June 30, 2020, increase the percent of adolescents (14-18 years of age) who smoke that enroll in the Quit Line from 0.43% (2018) to 0.50% (QuitLine and YRBS)

State Objective 2 Data Statement:

South Dakota did not meet the 2020 goal of 0.50% of adolescents who smoke enrolling in the Quit Line. The 2020 data showed 0.39% of adolescents who smoked enrolled in the Quit Line. This was compared to a rate of 0.43% in 2018 and 0.61% in 2019. However, it should be noted that 2015 YRBS data was used in the 2015-2018 estimates, while 2019 YRBS data was used for the 2019-2020 estimates.

Strategies:

10.1. Partner with state and non-state agencies to promote yearly well adolescent preventive medical visits

- Partnered with DSS Medicaid to begin updating well-child letters. Medicaid well-child letters are sent out to participants annually to encourage participation and educate on annual well visits requirements. Medicaid Letter were broken down by the follow age groups, 0 to 3 years old, 4 to 9 years old, 10 to 12 years old and 13 + years old.

Medicaid Infographics can be found here:

- 10 to 12 year old - https://doh.sd.gov/documents/Family/Medicaid_WellVisit_Letter_10-12.pdf
- 13 to 20 year old - https://doh.sd.gov/documents/Family/Medicaid_WellVisit_Letter_13andUp.pdf

- Partnered with SD Medicaid to obtain data specific to the number of adolescent preventive medical visits completed yearly. Medicaid data was reported as follows:

  AWC-CH: Adolescent Well-Care Visits

  - 2017 Reported Rate was 32%
  - 2018 Reported Rate was 32%
  - 2019 Reported Rate was 32%
  - 2019 national average was 50.6%

  IMA-CH: Immunization coverage for Adolescents

  - 2017 – Calculated but not reported
  - 2018 – 34% (without DOH SDIIS data) 57% (with DOH SDIIS data). Medicaid is looking at utilizing data from the South Dakota Immunization Information System (SDIIS) in the future
  - 2019- 62.50% (with SDIIS data)
  - 2019 National average 78.6%

- Collaborated with SD Dept of Health Medical Consultant, Dr. Poppinga, on key planning areas for adolescent health strategies.
- MCH Adolescent Coordinator continued to correspond with SD's only adolescent health specialist, Dr. Barondeau, to discuss what current adolescent health topics he is focusing on and to gather a greater understanding of resources that could be utilized in a medical provider office.

Challenges:

- Meeting with outside partners were limited during this reporting period due to response needed for the COVID pandemic.

10.2. Identify and implement ways to promote yearly adolescent visit

- SD DOH of Health created social media post educating on the importance of making Adolescent Health and Adolescent Well Visits a priority during COVID. Some example of posts are:

Adolescent Health
The adolescent years are critical for teens' current and future health. Good health enables #adolescents to learn and grow. https://www.hhs.gov/ash/oah/facts-and-stats/picture-of-adolescent-health/index.html

Adolescent Health
As adolescents grow and change, they may face issues like maintaining healthy relationships, developing positive mental and physical health, and avoiding substance use. Learn more about #AdolescentDevelopment: https://www.hhs.gov/ash/oah/adolescent-development/index.html

- Continued partnering with SD Family Planning program and local non-profits to distribute a flier entitled "Adolescent Health Check Up".
- The DOH Community Health Offices continued to display laminated "Adolescent Health Check Up" fliers and distributed fliers to clients.
- Created a tab for "youth and young adults" on the South Dakota Department of health website. Developed a sub-tab of "Adolescent Well Visits" and linked 10 informational sites with Adolescent well visit resources for youth and parents of youth.
    - https://doh.sd.gov/family/Youth/
    - https://doh.sd.gov/family/Youth/wellvisits.aspx

- 'Well-Child Visits Do Double Duty" Magazine Ad was published in South Dakota Medical Journal in August and September 2020.

Challenge: Promoting yearly well visits directly to adolescents or through adolescent peer to peer sharing/educating.

10.3. Encourage individual and family engagement.

- New Adolescent Health Platform - **Cõr Health + Wellbeing** launched at the end of 2019 on Facebook and Instagram. **Cõr Health + Wellbeing was created to provide health and wellness support to South Dakota youth, young adults, and parents.** Our goal is to break down those hard-to-talk-about topics like stress, depression, suicide, STDs, and reproductive health and provide talking points, strategies, and tips for making those conversations less awkward. Cõr is about giving youth, young adults and parents the tools they need to make positive decisions and take responsibility for their ongoing health and wellbeing.. Can be found:www.facebook.com/corhealthsd and www.instagram.com/corhealthsd.

Key areas addressed during this reporting period:

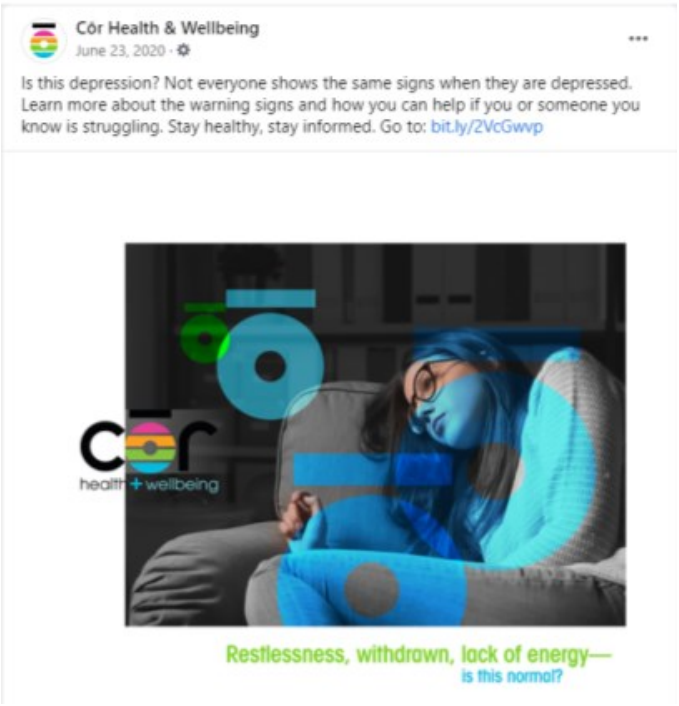
- Preventative Visits/Physical Health:

Cōr Health & Wellbeing
January 30, 2020 ·

So many things affect the balance of your overall health - your Cōr Health. How you handle stress, how often you visit the doctor for regular check-ups or preventative screenings - it's a lot to manage. But we can help you sort it out.

Cōr Health what's it about?

- Mental Health:



  - Motor Vehicle Injury Prevention –

- Applied for a new grant through FYSB for a Competitive Sexual Risk Avoidance Education (CSRAE) Grant – received that grant September 30th, 2020. Funding will give MCH and SRAE a chance to work together in creating a Youth Action Council for the new priorities of Healthy Relationship and Suicide Prevention.

10.4. Target messaging regarding tobacco cessation coaching for adolescents

- The SD Tobacco Control Program has been educating providers, parents, youth and young adults about the

dangers of e-cigarettes through a social media campaign and print ads in SD Medical Journals and parenting magazines. The campaign focuses on the harms to youth, pregnant women, non-tobacco using adults and how to talk to adolescent about e-cigs and JUULing.

- An educational webinar on e-cigarettes and vaping is available for educators and students, which could be used in classrooms, at teacher in-services or PTA meetings. Since November 2018 the webinar has been viewed 352 times. To view: https://www.youtube.com/watch?v=RMWJOk70PIo&feature=youtu.be

- The South Dakota QuitLine is available for any SD tobacco users age 13 and older (including those who vape) to assist with quitting. Individuals can enroll by calling 1-866-737-8487 or at SDQuitLine.com. SD Tobacco Control Program broadcasted an ad entitled "What happens when you call?" which educated users on what would happen when they reach out to the SD QuitLine.

- OCFS field staff helped disseminate information on the following SD Tobacco Control Programs to agencies serving youth and schools.

  1) **Teens Against Tobacco Use (TATU)** is a tobacco prevention program (which includes e-cigarettes) designed to help teens teach younger children about the hazards of tobacco use and the benefits of making healthy choices,

  2) **Life Skills** training and curriculum for schools is a proven, highly effective, substance abuse prevention program. Life Skills has recently added an e-cigarette component to the curriculum,

  3) **Catch My Breath E-Cigarette & JUUL Prevention Program**, which is available for free to any elementary, middle or high school.

Challenge: Staying current with vaping products; especially those targeted to youth.

10.5. Promote 6th grade vaccination requirements

- Provided the Department of Education 6th grade vaccination requirement information to distribute statewide to local school districts.
- Partnered with Medicaid to promote adolescent vaccinations by sending reminder cards to Medicaid enrolled
- Presented to Department of Education and providers on vaccinations during COVID
- Data from the 2018 and 2019 National Immunization Survey for adolescents (13-17 years old) shows an increase in vaccinations among South Dakota youth.

	2018	2019
1 or more Tdap	86.6%	90%
1 or more MCV4	85.3%	86.2%
Up to date on HPV	49.5%	61.2%

- SD DOH of Health created social media post educating parents and youth on the importance of adolescent vaccines.

Adolescent Vaccines
What #vaccines do #adolescents need? Starting at age 11 or 12, the CDC recommends the Meningococcal, HPV, Tdap, and Influenza vaccines for almost all children.
https://www.hhs.gov/ash/oah/adolescent-development/physical-health-and-nutrition/vaccines/what-vaccines-do-adolescents-need/index.html

Challenge: Vaccine hesitation from families.

ESMs

The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to increase the percent of adolescents with an annual preventive medical visit.

79% completion of identified strategies.

Adolescent Health – Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Adolescent Health Domain for the period October 1, 2021 through September 30th, 2022. Priority needs identified through the 2020 Needs Assessment process in this domain were: mental health, suicide prevention, and healthy relationships.

PRIORITY: Mental Health/Suicide Prevention

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

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

2020-2021 Objectives and Strategies

Decrease the adolescent suicide rate among 15 through 19-year olds from 29.2 per 100,000 (2016-2018) to 26.3 in 2025 (NVSS).

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

Proposed Strategies

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

- Provide Youth Mental Health First Aid Training
- Provide Question Persuade Refer (QPR) trainings for high school staff
- Provide teen Mental Health First Aid Training
- Provide and promote Text4Hope - Teen Crisis Texting Support

Suicide Prevention Trainings: Title V will continue to partner with Helpline Center to provide suicide prevention trainings across the state. A new training in the previous reporting period was teen Mental Health First Aid Training. The Helpline Center Suicide Prevention Director attended a virtual instructor training and completed the prevention training in one school. In the upcoming grant year, Title V will work to expand this training to two schools.

Additional Suicide Prevention Trainings provided with this partnership will be:

- Youth Mental Health First Aid Training
- Question Persuade Refer trainings for high school staff

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

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

- Develop and promote PYD training for organizations working with diverse youth on suicide prevention/mental health.
- Collaborate with Youth Advisory Council that focuses on adolescent priorities and provide activities that emphasize health equity and integrating youth voice throughout
- *NEW* Develop an assessment tool for Positive Youth Development activities.

In the previous grant year, Title V worked with a MPH Student to develop a youth advisory council plan. After receiving additional funds, (see the General Department SRAE paragraph below) Title V partnered with the Lutheran Social Services (LSS) to develop a youth advisory council. The first council meeting was December 2020. The council will look at both adolescent MCH priorities - Healthy Relationships and Suicide Prevention/Mental Health. In the upcoming grant year, Title V will continue to partner with LSS and young adults to coordinate PYD activities and continue striving for the youth voice throughout adolescent programming. A new strategy for Positive Youth Development will be to develop an assessment tool for PYD activities.

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

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

Cor Health SD: In the previous grant period Title V worked with their marketing department to develop suicide prevention, mental health, and COVID-19 prevention posts for Cor Health Platforms – Facebook and Instagram.

www.facebook.com/corhealthsd

www.instagram.com/corhealthsd

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

Parent Suicide Prevention Training: Currently Title V is working on a suicide prevention and mental health informational training for parents of youth. The training will be disseminated during the 2021/2022 school year through the following communication platforms: school newsletters, Cor Health, Dept of Health You tube, and MCH Newsletters. During this grant period Title V will continue to promote this training to parents.

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

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

PRIORITY: Healthy Relationships

SPM 1 – Improve young peoples' (10 to 24 years) relationships by increasing the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 45.6% in 2020 to 50.2% by 2026.

2020-2021 Objectives and Strategies

Decrease the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics from 14.2% to 12.8% by 2025 (EHR NetSmart).

Decrease the South Dakota teen pregnancy rate for ages 15 - 19 years old from 20.4/1,000 in 2018 to 18.4/1,000 in 2025 (NVSS).

Proposed Strategies

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

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

In the upcoming report period, the previous strategy of 'collaborate with existing SRAE and PREP Programs serving diverse populations will expand to include SD Family Planning Program, Rape Prevention Education and General Department SRAE.

General Department SRAE grant: This new grant will expand the reach of Teen pregnancy prevention education to

areas with high teen birth rates and high STD rates. SRAE funding teaches youth participants to voluntarily refrain from non-marital sexual activity. The target population for this programming focuses on Native American and vulnerable youth between the ages of 10 to 13 years old living in rural South Dakota.

Healthy Relationships Youth Evaluation: In the upcoming report period, a new activity added for the Healthy Relationship priority is to develop an evaluation plan for MCH programs and other healthy relationship grants and activities. Title V will work with an evaluation center to review healthy relationship priorities and also five other healthy relationship grants: Personal Responsibility Education Program (PREP), Title V Sexual Risk Avoidance Education (SRAE), General Departmental Sexual Risk Avoidance Education, Rape Prevention Education, Title X Family Planning Program. They will review program strategies, objectives and indicators to align youth programming, resources and improve each individual program but also impact on youth and collective effectiveness.

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

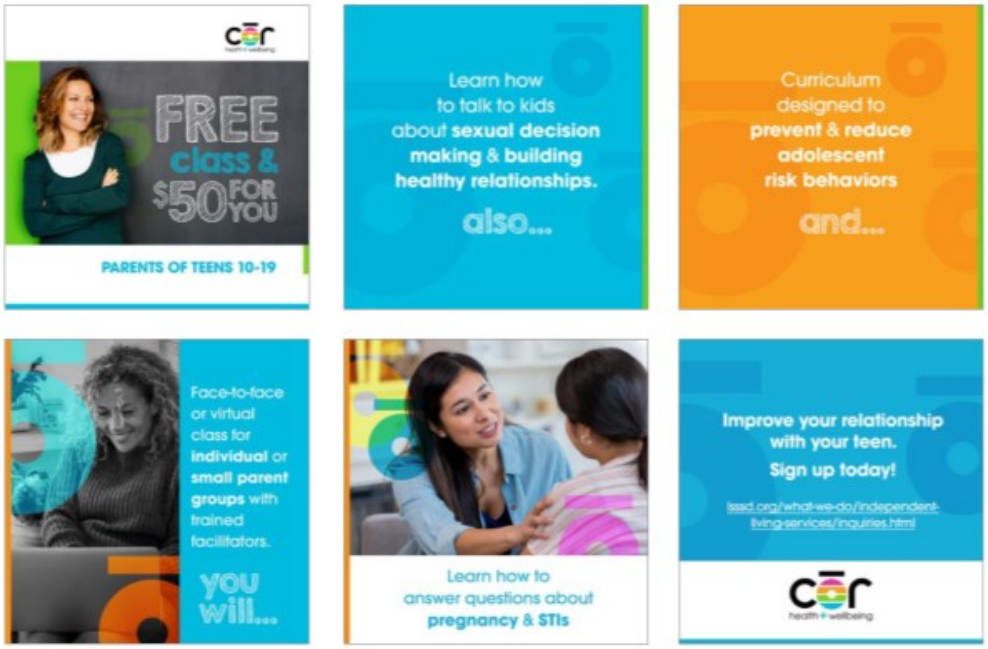
- Develop and promote PYD trainings for those working with diverse youth on healthy relationships
- Collaborate with Youth Advisory Council that focuses on adolescent priorities and provide activities that emphasize health equity and integrating youth voice throughout.
- *NEW* Develop an assessment tool for Positive Youth Development activities.

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

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

- (Completed) Develop promoting Parent – Teen Communication Messaging on Cor Health social media platforms.
- *NEW* Develop and promote Healthy Relationship, STI prevention and pregnancy prevention messaging for Cor Health Social Media.
- Utilize TRAIN platform to disseminate trainings and materials accessible to diverse parents and organizations working with young people 10 to 24 including vulnerable/underserved youth.

Parent-Teen Communication: Title V worked with Hot Pink marketing company to develop 6 carousels for the parent-teen communication campaign. The purpose of the parent-teen communication campaign was to raise awareness among South Dakota parents as what they can do to promote healthy relationships with their teens, and where to find programs and tools to support ongoing healthy communication with teens and young adults. Some key messaging included: 3 ways to ease the tension with your teen; 3 tips to talking with teens' Parent Power! What you say to your teen matters; 4 ways to listen to your teen, and practice being positive. It Works! For the final post, Title V collaborated with the FYSB Personal Responsibility Education Program (PREP) program and developed a social media post to promote the Families Talking together class. Families Talking together is a class for parents to reduce adolescent sexual risk behaviors and focuses on parent-adolescent communication, monitoring and supervision and relationship building activities. Here is the example of the Family Talking Together carousel that was on COR Health SD social media pages.



In the current reporting period Title V will continue to promote the parent-teen communication campaign. Since the development of the parent-teen communication messaging is complete that activity has ended and new strategy of – 'Develop and promote Healthy Relationship, STI prevention and pregnancy prevention messaging for Cor Health Social Media.' will begin for the upcoming reporting period.

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

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

Ongoing Efforts Supported by MCH for the Adolescent Domain:

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

- Continue to work with Family Planning Program, Rape Prevention Education Program, Department of Social Services and Department of Education to promote adolescent messaging to parents, youth and young adults.

- Continue to collaborate with 76 OCFS Community Health Offices located in 61 of SD's 66 counties that provide public health services to this Adolescent population such as contracting with local schools for Community Health Nurses to provide preventive health screenings and student health education. Education includes growth and development, injury prevention and suicide prevention for middle and high-schools aged students.

Children with Special Health Care Needs

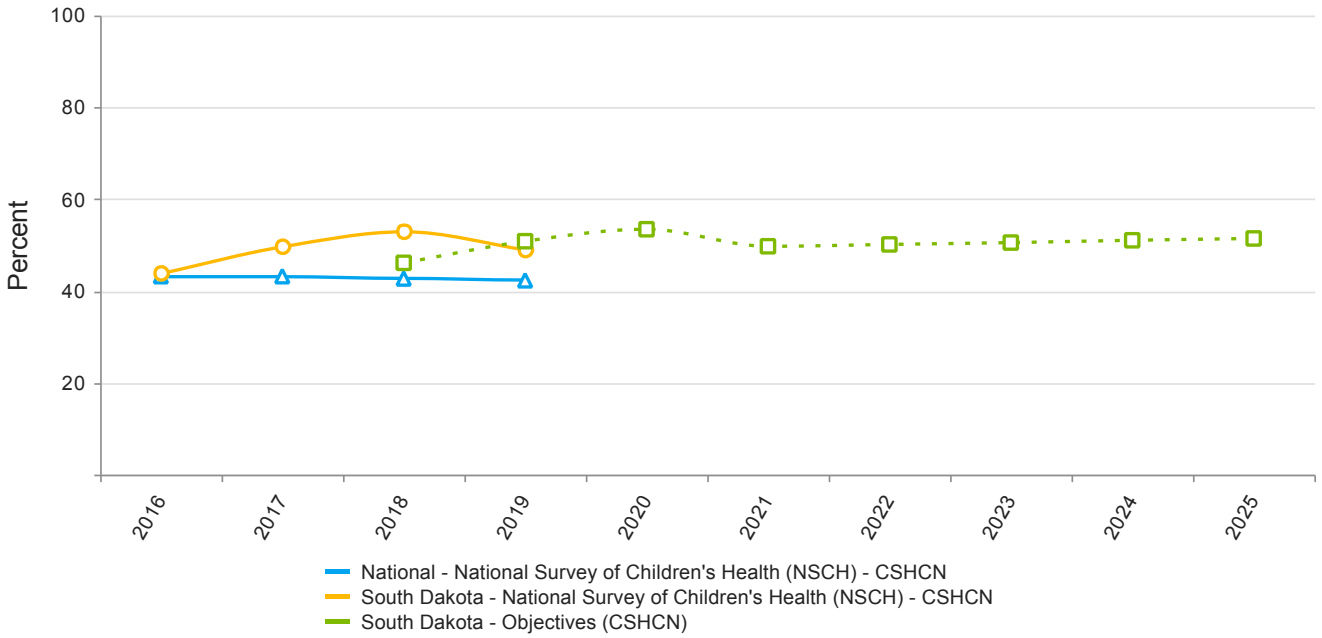
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.7 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	58.3 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.6 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	2.4 %	NPM 11

National Performance Measures

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

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			46.1	50.8	53.4
Annual Indicator		43.9	49.6	53.0	48.8
Numerator		14,361	16,789	18,568	17,763
Denominator		32,704	33,876	35,046	36,404
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	49.7	50.1	50.5	51.0	51.4	51.9

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	100	
Numerator	30	
Denominator	30	
Data Source	SDSU Population Health	
Data Source Year	2020	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (South Dakota) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Access to Care and Services	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
Increase the percentage of CYSHCN who report receiving care in a well-functioning system from 16.3% (2017-18) to 17.8% by 2025 (NSCH)	
Strategies	
11.1: Enhance equitable family access to needed supports and services.	
11.2: Identify and implement strategies to equitably advance medical home components for families of CYSHCN through access to family centered care coordination.	
11.3: Coordinate the state newborn screening infrastructure focused on equitable testing and access to follow up services.	
ESMs	**Status**
ESM 11.1 - % of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

Children with Special Health Care Needs - Annual Report

In Fiscal Year 2020 (FY20), the South Dakota Children and Youth with Special Healthcare Needs (CYSHCN) Program continued its focus on improving access to family-centered care and services for CYSHCN and their families. The COVID-19 pandemic created some challenges in carrying out some of the year's planned activities, but progress was still able to be made in some areas.

During our 2015 MCH Needs Assessment one (1) state priority need was identified to address under the Children and Youth with Special Health Care Needs Domain:

- Improve and assure appropriate access to health services that are focused on families, women, infants, adolescents, and Children and Youth with Special Health Care Needs (CYSHCN).

However, state priority needs identified under child and adolescent health domains also are a need of CYSHCN and include:

- Improve early identification and referral of developmental delays
- Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)
- Promote oral health for all populations

Under the National Performance Measure/Domain framework, one (1) National Performance Measure was chosen and the objectives, strategies, activities are identified within the State Action Plan framework.

At the end of this reporting period the MCH Impact Team workgroup members assigned to each national or state performance measure were asked to complete a data collection form. The data collection form was a checklist of the strategies that the program was to address during the grant year. The workgroup members rated the degree to which the strategies were implemented, and the percentage of completion is included as the ESM for each measure. In addition to this assessment for each measure, data was reported to provide a quantitative context for each strategy. This ESM process allowed us to better report progress to date on all strategies. Data collection form can be found at the link below:

https://doh.sd.gov/documents/MCH/2020/DetailSheet_NPM11_FY20.pdf

DOH Strategic Plan Goal 1: Improve the quality, accessibility, and effective use of health care

National Performance Measure 11: *Percent of children with and without special health care needs having a medical home*

Data Statement:

Percent of children ***with*** special health care needs having a medical home: South Dakota did not exceed the 2020 target of 53.4%. This new target was set after SD surpassed its previous target of 50.8% with 53.0% of children *with* special health care needs having a medical home in 2017-2018. From 2018-2019, 48.8% of children *with* special health care needs had a medical home. South Dakota ranked 7th in the nation with a U.S. rate of 42.3%. The change from the base year (2016) to this year is not significant.

Percent of children ***without*** special health care needs having a medical home: South Dakota surpassed the 2020 target of 54.0% with 55.2% of children *without* special health care needs having a medical home in 2018-2019. In 2018-2019 South Dakota was ranked 7th in the nation with a significantly higher rate than the U.S. rate of 49%.

The full-length South Dakota MCH Annual Data Summary can be found here:

https://doh.sd.gov/documents/MCH/2022_SDMCH_DataSummary.pdf

State Objective 1:

By June 30, 2020, increase the percentage of CYSHCN who report receiving care in a well-functioning system from 15.6% (2016-17) to 16.0% (NSCH)

State Objective 1 Data Statement:

In 2019 South Dakota exceeded the 2019 target of 16.0% with 16.3% of children with special health care needs receiving care in a well-functioning system. A new annual target was set at 16.5%. South Dakota did not reach the target of 16.5% with 15.7% of children with special health care needs receiving care in a well-functioning system from 2018-2019. South Dakota was ranked 22nd and is higher than the U.S. rate of 14.1%.

State Objective 2:

By June 30, 2020, 99.0% of all infants whose newborn screening test results are outside the normal limits for a newborn screening disorder will receive prompt and appropriate follow-up testing. (Newborn Screening Program)

State Objective 2 Data Statement:

South Dakota exceeded the 2020 target of 99.0% with 99.5% of infants whose newborn screening test results were outside the normal limits and received prompt and appropriate follow-up testing. The 2019 rate was 99.4%. There has been no significant trend between 2015 and 2019.

Strategies:

11.1. Enhance family access to needed supports and services

- Continued interagency agreement with Department of Human Services (DHS) to support respite care services across the state. Respite care can be especially important to families of CYSHCN, and through our interagency agreement with DHS, 638 children/adults were served during this reporting period.
- Contracted with Sanford Health to support the provision of genetics outreach clinics in the western part of the state. With this provision, Sanford provides the services of a geneticist and a genetics counselor by conducting 8
  1-day outreach clinics in Rapid City, SD per calendar year. A total of 41 individuals were served by this outreach in Fiscal Year 2020.
- Provided financial assistance through our direct service reimbursement program, Health KiCC, to low income families to assist with the cost of medical treatment. A total of 23 clients were served through Health KiCC during this reporting period. During this reporting period, two clients aged out of the program and one family chose not to re-enroll, leaving 20 clients enrolled at the end of the grant year.
- Met with the developmental screening workgroup to discuss progress on developmental screening and areas of improvement.
- The DOH Health Home Program was discontinued on September 30, 2020. The program was serving one individual at the time of discontinuation.
- In January 2020, the DOH and Sanford Health launched a Patient Navigation Program at the Sanford Children's Hospital in Sioux Falls, SD. Within this program, MCH funds support a Registered Nurse Patient Navigator who is stationed in the Children's Hospital and provides extensive care coordination for patients and their families. The program is currently at capacity with 30 participants, and plans are in place to add a Nurse Practitioner to the program in FY21 which will increase program capacity to 60 participants during the program's second year. The program also involves an ongoing comprehensive third-party evaluation provided by South Dakota State University (SDSU) Population Health to inform ongoing program planning. In addition,

MCH funds were used to provide Tito Care telehealth units to all 30 program participants to increase accessibility and communication with the Patient Navigator and decrease trips to the clinic for medically vulnerable patients during the COVID-19 pandemic.

Challenges:

Due to the COVID 19 pandemic, Sanford Health did not provide genetics outreach services from March 2020 through May 2020.

The CYSHCN program had planned to present to the state's Administrative Rules committee to complete the phase out of the Health KiCC program, however, staff became extensively involved in addressing the COVID 19 pandemic, so these plans were postponed.

The CYSHCN Program met with a Department of Health Consultant at Avera Health early in 2020 to initiate conversations to establish a care coordination program within the Avera Health System. However, the program was not able to schedule any additional meetings with Avera in 2020 due to both Department of Health and Avera staff focusing on the COVID 19 pandemic.

11.2. Strengthen statewide capacity for parent/family training and support.

- The CYSHCN Director began serving on the SD Developmental Disabilities Council in August, 2020. The Council is comprised of family advocates and self-advocates, as well as representatives and professionals from many different organizations that support individuals with developmental disabilities. The Council designates funding to various organizations in the state that are working to further the mission of assisting people with intellectual and developmental disabilities and their families to achieve the quality of life they desire.
- The CYSHCN Director also began serving on the South Dakota Supporting Families Community of Practice state team, which focuses on the Charting the LifeCourse framework and identifies state-specific innovation areas for integrating and implementing Charting the LifeCourse tools and practices.
- The CYSHCN and WIC Directors met virtually with the Project Director at the SD Statewide Family Engagement Center to discuss developing a new family engagement initiative in the Office of Child and Family Services. Plans were made for the Project Director to travel to speak in person to the Office of Child and Family Services (OCFS) leadership team to familiarize them with the Center's work and how we can collaborate on future projects.
- OCFS's MCH Director served as advisory board member on the *South Dakota Statewide Family Engagement Center* grant which is a five-year effort to connect families, schools and communities to help all children to be successful from cradle to career. The MCH Director served in this role until February 2020.

Challenges:

The COVID-19 pandemic presented a challenge in scheduling a visit from the SD Statewide Family Engagement Center Project Director. The CYSHCN and WIC Directors were able to meet with the project director virtually but plans to have the director visit and speak to the OCFS leadership team were continually postponed and rescheduled, with plans for a visit eventually put on hold indefinitely. The leadership team was unable to meet with the Project Director virtually due to extensive focus on the COVID-19 pandemic. The pandemic also pulled staff from the Office of Child and Family Services to work in the COVID Call Center, conduct case investigations, and do contact tracing which further postponed any new family engagement and training projects.

11.3. Coordinate the newborn screening infrastructure to address: (a) contract laboratory for newborn screening of all SD births; (b) medical consultants to address appropriate testing and treatment for presumptive positive; and (c)

birth certificate match and short-term follow-up to ensure all babies are screened.

During this grant period, longtime Newborn Screening Coordinator, Lucy Fossen, retired and a new Newborn Screening Program Manager, Lauren Pierce, began in June 2020. The SD newborn screening program continued to utilize a contract newborn screening laboratory, the State Hygienic Laboratory at the University of Iowa (SHL). SHL provides regional newborn screening testing services and initial notifications to 4 state newborn screening programs. To ensure every infant born in SD has a newborn screening completed (SDCL 34:24:16-25), the contract laboratory sends newborn screening reports electronically through a match process which are linked to the infant's birth certificate via a secure web-based software application known as the Electronic Vital Records and Screening System (EVRSS). This system has the ability to identify infants who may have missed, or the parents have refused the newborn screening. Infant hearing screening results are reported directly into EVRSS as hospitals file birth certificates.

During this grant period, the MCH team continued to partner with SHL for newborn screening testing and destruction of specimen collection cards.

- SHL reported 97.9% of newborn screening results for CY18 were provided to SD healthcare providers <= 7 days of age.
- Newborn Screening Program Manager participated in Iowa SHL's monthly partnership calls among the four state newborn screening programs; Alaska, Iowa, North Dakota, and South Dakota.
- NBS Program Manager met with NBS follow-up nurse, Sharina Tveit, to undergo orientation to the follow-up program and procedures.
- NBS Program Manager attended the 2020 Virtual APHL Newborn Screening Symposium.
- During this grant period, 99.5% (11,827/11,889) of the birth certificates had matching newborn screening laboratory results.
- During this grant period, 613 infants had either presumptive positive or borderline newborn screening test, contact was lost with 2 infants, lost contact and 1 infant's parent/guardian refused to pursue diagnostics.

11.4. Implement a quality improvement effort in the newborn screening program to include: (a) maintain less than 1% rate of unacceptable newborn screening specimens due to improper collection; (b) the percentage of time critical newborn screening results that are reported within 5 days of birth; and (c) sharing Early Hearing Detection and Intervention (EHDI) data with the SD EHDI Collaborative in an effort to reduce lost to follow-up rates.

- During this reporting period the unacceptable specimen rate increased to 1.6%.
- During this reporting period the percentage of time-critical results reported within 5 days of birth was 94.0%.
- The percentage of birth certificate's matched to the newborn screening laboratory report was 99.5% (11,827/11,889).
- The percentage of non-critical screening results reported within 7 days of birth was 88.9%.
- MCH Newborn Screening program provided best practices and specimen rejection criteria education to hospitals demonstrating poor quality newborn screening specimen rates.

Challenges:

Despite the many challenges caused by the COVID-19 pandemic, the metabolic newborn screening rate remained high at 99.5%. Poor quality newborn screening specimen rates continued to increase and consistently fall above the program goal of less than 1.0% among submitters statewide. The newborn hearing screening rate decreased from 96.0% to 94.2%, which may be due to the COVID-19 pandemic. Another challenge is that there are no state mandates regarding EHDI reporting or performance of infant hearing screening in South Dakota.

ESM: The degree to which the South Dakota Title V program has implemented evidence-based or informed

strategies to assure access to a medical home.

83% completion of identified strategies

Children with Special Health Care Needs- Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Children and Youth with Special Health Care Needs (CYSHCN) Health Domain for the period October 1, 2021 through September 30, 2022. In the CYSHCN Domain, selected priorities and corresponding National Performance Measures or State Performance Measures are as follows:

Priority: Access to care and services

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

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

2021-2022 Objective and Strategies

Objective: Increase the percentage of CYSHCN who report receiving care in a well-functioning system from 16.3% (2017-2018) to 17.8% by 2025 (NSCH)

Proposed Strategies:

11.1: Enhance equitable family access to needed supports and services

- Provide financial support to DHS respite care program for families of CYSHCN and refer families to the program to enhance equitable access to respite services across the state.
- Provide financial support for operational costs of genetics outreach clinics in Rapid City, SD through partnership with Sanford Health and cover the cost of travel from Sioux Falls to Rapid City for the geneticists and genetics counselors to provide access to these services on the Western side of the state.
- Partner with DSS to support equitable provision of special needs car seats
- Explore additional opportunities to link families of CYSHCN to needed resources in our state. The CYSHCN Director will continue to work closely with partners to identify new and existing resources available to families in South Dakota.
- Provide financial support to low income families of CYSHCN through Health KiCC program while continuing to phase the program and explore alternative resources for remaining participants.

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

- Partner with Sanford Health to provide care coordination services for families of children with complex medical conditions at Sanford Children's Hospital.
- Collect and review data from Sanford Children's Patient Navigation Program to identify needs and health disparities and inform program planning.
- Explore new opportunities for expansion of care coordination services in the state, including opportunities for linking families of newborns and infants with special health care needs to medical homes.

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

- Contract with the Iowa State Hygienic Laboratory for the newborn screening and initial follow up of all South Dakota births.

- Partner with Sanford Children's Specialty Clinic to contract medical consultants, genetics counselors, and a follow up nurse to address equitable and appropriate testing, treatment, and follow up for out-of-range results and presumptive positive cases.

New Approach to Evidence- Based Strategy Measures

The detail sheets originally developed for each National and State Performance Measure in FFY17 continued to be updated and utilized through FFY20 to capture program effectiveness. Beginning in FFY21, we will be taking a different approach to ESMs and measuring the effectiveness of our efforts based on technical assistance and training received from the MCHB Evidence Center.

New Efforts

- *Sanford Patient Navigation Program:* In 2021, this program plans to expand to include a Certified Nurse Practitioner (CNP). This will allow the program to expand to a second and possibly a third cohort. Cohorts are approximately 30 clients.

- *Equitable promotion of services:* The CYSHCN Program will work with our partners to ensure resources are promoted to all populations and reach people where they are.

- *Linking families to resources:* The CYSHCN Program will continue to reach out to family organizations, medical entities, and other state organizations to create a more comprehensive list of the resources available for families of CYSHCN in South Dakota and will move forward with equitable promotion and dissemination.

Ongoing Efforts Supported by MCH for the CYSHCN Domain

- The CYSHCN Program will continue to pursue additional opportunities to provide care coordination in South Dakota.

- The CYSHCN Program works with the Department of Social Services to equitably promote the provision of special needs car seats. This effort will continue to involve looking at how the program is currently being promoted and identifying opportunities to reach all families, including those who do not have access to the internet. The CYSHCN Program will also work with other entities we partner with to identify ways to promote the services more equitably.

- The South Dakota Early Hearing Detection and Intervention (EDHI) Collaborative, a partnership between the University of South Dakota and the South Dakota Department of Health State EHDI program, along with other partners including the South Dakota School for the Deaf was established in 2015. The SD EDHI Collaborative works to improve early identification of hearing loss in children and promote early intervention services for children and their families across the state of South Dakota. The efforts of the SD EDHI Collaborative are funded through a Health Resources Administration and Services grant through the University of South Dakota with Department of Health state EHDI program support.

- The South Dakota EHDI Collaborative continues to modify the tele-audiology infrastructure. Presently, there is one tele-audiology clinic located in Winner, SD. Clinics are also being developed at Sanford Aberdeen and Hot Springs, SD. Tele-audiology sites are geographically located in areas of high lost to follow-up rates and sites may be modified according to usage. At these sites, infants have been identified with permanent hearing loss in a timely manner and connected with resources and support within the state such as the Birth to Three program

and the South Dakota School for the Deaf.

- The Newborn Screening Program Manager participates in monthly quad-state meetings with the Iowa State Hygienic Laboratory, the Iowa Newborn Screening Program, the Alaska Newborn Screening Program, and the North Dakota Newborn Screening Program. These meetings bring together the four state programs that utilize the Iowa State Hygienic Laboratory for newborn screening processing to network, work through emerging issues, and collaborate.

- The Newborn Screening Advisory Committee was reinstated in 2021. The committee is made up of members that represent hospitals, laboratories, health care professionals, and families. The committee will be asked to provide detailed advice and guidance on Spinal Muscular Atrophy (SMA) and Pompe disease to assist SD DOH in making informed decisions about how to proceed with adding each disorder to the newborn screening panel.

- The CYSHCN Director facilitates the MCH workgroup specific to NPM 6 – parent completed developmental screenings. The CYSHCN program supports the cost of early identification and referral of children with possible developmental delays via the purchase of Ages & Stages Developmental Screening instruments and staff time to refer families for further evaluation if a concern is identified on the screening.

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

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

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

Cross-Cutting/Systems Building

State Performance Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	5.0	6.0	7.0	7.0	7.0

State Action Plan Table

State Action Plan Table (South Dakota) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Data Sharing and Collaboration
SPM
SPM 2 - The extent to which data equity principles have been implemented in SD MCH data projects
Objectives
Increase the number of data sharing projects accomplished from zero to seven by September 30, 2025.
Increase the number of new partners that we collaborate with on data projects from zero to five by September 30, 2025.
Strategies
2.1: Provide access to timely, reliable data so that partners and communities can use it in their own efforts to advance equity.
2.2: Develop reports that highlight health inequities across programs and issue areas.
2.3: Analyze de-identified data to assess social determinants of health and other underlying factors that play a role in morbidity and mortality.
2.4: Increase collaboration around American Indian data between state and tribal partners.

2016-2020: State Performance Measures

2016-2020: SPM 4 - MCH data are analyzed and disseminated

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		Yes	0	0	0
Annual Indicator	Yes	Yes	Yes	Yes	Yes
Numerator					
Denominator					
Data Source	NA	NA	NA	NA	NA
Data Source Year	NA	NA	NA	NA	NA
Provisional or Final ?	Final	Final	Final	Final	Final

Cross-Cutting/Systems Builiding - Annual Report

Cross-cutting/Systems building Domain:

Priority Need: Improve state and local surveillance, data collection, and evaluation capacity.

SPM 4: MCH data are analyzed and disseminated

During our 2015 MCH Needs Assessment one (1) state priority need was identified to address under the Cross-cutting/Systems building Domain:

- Improve state and local surveillance, data collection, and evaluation capacity.

The intent of this State Performance Measure is to build and expand our state MCH data capacity to support our Title V program efforts and contribute to data-driven decision making in our MCH programs and within our partner agencies.

Objective: By June 30, 2020, 100% of data for MCH objectives and strategies are identified, collected and analyzed for use in MCH needs assessment and program planning.

At the end of this reporting period the MCH Impact Team workgroup members assigned to each national or state performance measure were asked to complete a data collection form. The data collection form was a checklist of the strategies that the program was to address during the grant year. The workgroup members rated the degree to which the strategies were implemented, and the percentage of completion is included as the ESM for each measure. Quantitative measures are included in the narrative for each strategy and identified by QM. This ESM process allowed us to better report progress to date on all strategies. Data collection forms can be found at the links below:

https://doh.sd.gov/documents/MCH/2020/DetailSheet_SPM4_FY20.pdf

Strategies:

S4.1 Review all data sets available and identify any gaps

- During this reporting period the MCH team continued to review all data sets pertinent to the needs assessment process. This included new data sources such as the partner survey, youth survey, and community survey, along with federally available data and other secondary data sources.

- The MCH Epidemiologist and nurse abstractor continued to look at maternal mortality data and pursue the establishment of the SD Maternal Mortality Review Committee.

- The MCH contracted epidemiologist (Bonny Specker) continued to review the Federally Available Data that supports the MCHBG measures, including newly available SD CDC PRAMS data. MCH staff reviewed infant mortality, family planning, home visiting, and sexual violence data to gain a well-rounded perspective on MCH populations in the state.

S4.2 Identify data collection methods to address gaps

- To address the gaps in data for our needs assessment, the needs assessment contractor and MCH epidemiologist created a data collection plan.

- Data collection was based on many different data sources and methods.
  The final data projects that were used to inform the needs assessment included the following:
  - Partner Survey
  - Community Survey
  - Partner Meetings
  - Youth Survey
  - Focus groups with targeted populations

  - During the reporting period, the needs assessment team continued to review this data and produce final reports. The data was then shared with the needs assessment project team. Based on all data collected, they chose 10-15 priorities for each population domain. The MCH Epidemiologist created a prioritization matrix for each population domain which had needs assessment advisory committee members rank priority areas according to eight criteria. The criteria focused on the significance to public health, the ability to impact the issue, and the capacity to address the issue. Rankings for each priority were converted into a composite score. The 5 to 7 highest scores were the priorities that were carried over to meetings with partners where they were able to narrow each domain area to two priorities with a dot voting method.

  - The MCH team identified the need for more robust maternal mortality data. Vital records data on maternal deaths was already being reported when a woman died 42 days or less after pregnancy. This timeframe was expanded to mirror national recommendations of reviewing records of women who died up to 1 year after pregnancy. Women's death records were also linked to birth and fetal death records to identify additional information. The MCH Epidemiologist reviewed CDC Pregnancy Mortality Surveillance System Data from 2016 and 2018 maternal mortality vital records data. The nurse abstractor began to abstract 2018 vital records data into the CDC MMRIA system.

Challenges:

- South Dakota does not have a state mandate for maternal death review. Memorandums of understanding need to be in place with each entity providing records to the state for maternal mortality review.

S4.3 Implement new data collection efforts as needed

- As part of the needs assessment process, the MCH team used a variety of new data collection methods to identify unmet health needs. Over 70 statewide MCH partners took a survey that gave the MCH team information about the top health priorities of our partners and those that they serve. Over 650 South Dakota youth in grades 5-12 responded to a survey that gathered information about the health needs and priorities of youth. The needs assessment team also disseminated a community survey and over 1,000 residents of South Dakota responded to give feedback on the needs of MCH populations. Additionally, four focus groups from across the state were held to identify needs from specific populations including single parents, co-parents from a rural area, Native American women, and youth. The MCH team continued to work on finalizing these reports and began disseminating the information to staff and partners. Data was disseminated through several methods listed in strategy 4.4 of this report.

- In addition to maternal mortality data, the MCH team recognizes the importance of looking at maternal morbidity data to understand the challenges that pregnant women and postpartum women face. The DOH partnered with the Department of Social Services Medicaid Program on a data linkage project. This project, which was supported by IBM, gave technical assistance to DOH and SD Medicaid to look at best practices for data review, quality improvement initiatives, and programmatic planning around maternal mortality and severe maternal morbidity. A work plan for reviewing Medicaid claims data was the result of the project. The MCH Epidemiologist will continue to work with the DSS Data Analyst on data analysis and possible linkage with vital records data.

- An Annual MCH Block Grant Data Summary was completed that included (for each National Performance and Outcome Measure) a 5-year trend analysis, South Dakota national rankings, South Dakota and U.S. rates from the Federally Available Data (FAD) worksheets, the most recent South Dakota rate, and the South Dakota rate for the previous year. The report also showed the Healthy People 2020 goal, the South Dakota 2026 goal and a description of how that goal was set.

- During this reporting period, SD 2018 PRAMS data was available. 2018 data was analyzed and distributed through several fact sheets, infographics, and reports listed in strategy 4.4. The PRAMS supplement data on opioid use and disability was also reported. Due to small numbers, these reports will not be shared until the supplement data collection is complete and there is more data to analyze. This new data will be very valuable to our understanding of attitudes and behaviors around maternal and infant health in our state.

- New PRAMS reports for Tribal partners were created. Although Tribal affiliation is not asked on PRAMS, SDSU and DOH wanted to be able to report more representative data to the tribes. Working with Great Plains Tribal Chairmen's Health Board, the PRAMS data analyst created reports for each of the nine American Indian Tribes in South Dakota that included American Indian women in reservation counties. Meetings were then set up with Tribal Health Directors to give them the reports and explain how they could be used in grant applications or program planning.

S4.4 Develop and disseminate fact sheets on findings

Documents:

- South Dakota Infant Death Review: 2013-2018, October 2019
- South Dakota PRAMS WIC Final Report, December 2019
- South Dakota 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties for Crow Creek Sioux Tribe, January 2020
- South Dakota 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties for Cheyenne River Sioux Tribe, January 2020
- South Dakota 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties for Flandreau Santee Sioux Tribe, January 2020
- South Dakota 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties for Lower Brule Sioux Tribe, January 2020
- South Dakota 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties for Oglala Sioux Tribe, January 2020
- South Dakota 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties for Rosebud Sioux Tribe, January 2020
- South Dakota 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties for Standing Rock Sioux Tribe, January 2020
- South Dakota 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties for Sisseton Wahpeton Sioux Tribe, January 2020
- South Dakota 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties for Yankton Sioux Tribe, January 2020
- South Dakota 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties for Urban Indian Health, January 2020
- South Dakota 2017-2018 PRAMS Surveillance Data Report for American Indian Mothers by Reservation Counties for Great Plains Tribal Chairman Health Board, January 2020
- South Dakota 2018 PRAMS Final Report, January 2020
- South Dakota PRAMS Survey Data Report, February 2020
- South Dakota PRAMS Disability Report, February 2020
- South Dakota PRAMS Opiate Report, February 2020

Peer-reviewed Publications:

- Specker BL, Minett M, Beare T, Poppinga N, Carpenter M, Munger J, Strasser K, Ahrendt L. Safe sleep behaviors among South Dakota mothers and the role of the health care provider. South Dakota Med, 73:152-162, 2020
- Sanderson L, Carpenter M, Poppinga N, Strasser K, Ahrendt L, Specker B. Obesity before pregnancy and adverse health conditions and birth outcomes in South Dakota. SD Medicine, ***in press***

Presentations:

- 'Infant Death Review', 2013-2018, Statewide Infant Death Review Meeting, October 2019 (Beare)
- 'South Dakota Infant Mortality', Statewide Infant Death Review Meeting, October 2019 (Strasser)
- 'Maternal Mortality and 2017 Pregnancy Risk Assessment Monitoring System (PRAMS)', presentation to Perinatal Quality Collaborative Meeting, November 2019 (Strasser)
- 'Gestational Diabetes in South Dakota', Zoom presentation recorded for community health nurse training, May 2020 (Strasser)
- 'South Dakota PRAMS', Zoom presentation to Great Plains Tribal Chairman Health Board Maternal Child

Health and Epidemiology departments, July 2020

- 'Office of Child and Family Services Needs Assessment', Zoom presentation to Tribal Consultation Meeting, July 2020 (Strasser)
- 'South Dakota PRAMS', Zoom presentation to Urban Indian Health, August 2020
- 'South Dakota PRAMS', Zoom presentation to Great Plains Tribal Chairman Health Board Birth to 1,000 Days Interagency Forum, September 2020
- 'South Dakota Maternal Morbidity and Mortality', Zoom presentation to South Dakota Public Health Association, September 2020 (Strasser)

<u>One-pagers:</u>

- 2018 Infant Death Review Infographic, October 2019
- Alcohol Intake in Women of Childbearing Age, South Dakota, 2018, December 2019
- South Dakota, 2018: Maternal Oral Health, December 2019
- South Dakota, 2018: Get Mothers in for Prenatal Care (PNC) Early and Often, December 2019
- Preconception Care, South Dakota, 2018, December 2019
- Postpartum Care, South Dakota, 2018, December 2019
- Health Insurance, South Dakota, 2018, December 2019
- Pre-pregnancy Body Mass Index (BMI) South Dakota, 2018, December 2019
- Smoking During Pregnancy, South Dakota, 2018, December 2019
- Breastfeeding in South Dakota, 2018, December 2019
- Adverse Childhood Experiences (ACEs), South Dakota, 2018, December 2019
- Abuse Before & During Pregnancy: South Dakota, 2018, December 2019
- Safe Sleep, South Dakota PRAMS 2018, January 2020
- Teen Pregnancy Rates, 2014-2018, April 2020
- South Dakota Electronic Vapor Product Use, July 2020

Cross-Cutting/Systems Building – Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Cross-Cutting/Systems Building Domain for the period October 1, 2021 through September 30th, 2022. In the Cross-Cutting/Systems Building Domain, selected priorities and the corresponding State Performance Measure are as follows:

Priority: Data sharing and collaboration

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

ESM: 2.1 Number of times the data dashboard is accessed

ESM: 2.2 Number of reports or data briefs used that highlight health disparities or inequities.

ESM: 2.3 % of SD maternal deaths that are reviewed by the MMRC

2021-2026 Objectives and Strategies:

Objective:

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

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

Proposed strategies:

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

- MCH Data Use Survey
  The MCH data survey was sent out in the April MCH newsletter. It was also sent out to MCH domain leaders so that their workgroup members could distribute it to additional partners. Thirty-two partners responded to the survey. Overall, partners wanted more data at a county and local level, and wanted data shared through dashboards. This and other information from the survey will be used to inform work for the next year. This activity was removed from this year's action plan since it was completed.

- Data dashboard with MCH data
  The MCH epi and OCFS data analyst took a Tableau training so they would have the skills needed to create a data dashboard. They are currently working on an infant mortality data dashboard and will create a larger dashboard with overall MCH outcomes and data specific to each of the current NPMs and SPMs.

- MCH Newsletter The MCH newsletters were sent out quarterly to over 200 MCH partners. The newsletter included a "Data Bytes" section that highlighted MCH data and new reports. The MCH team will continue to use this newsletter to communicate new data reports and other projects happening in the data sharing and collaboration work group.

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

- Updated Infant mortality report The MCH Epidemiologist, OCFS data analyst, and infant domain leader reviewed other states' child death review/infant mortality reports to brainstorm what a new South Dakota report could look like. They liked Louisiana's last Child Death Review report and were able to meet with two of the staff who had worked on this report. The Louisiana staff answered questions the South Dakota staff had around data reporting and gave helpful tips about how to visualize the data and include special sections such as considerations for CYSHCN, health disparities, and data to action. The analyst for the infant death review data is looking at additional variables to model Louisiana's analysis. The MCH Epidemiologist, data analyst, and MCH team will continue to work on creating an updated infant mortality report over the next year.

- Update MCH data briefs This activity was not started during this reporting period but will continue to be an activity for the next year. The goal is to update MCH data briefs that were first created during the needs assessment. This would give partners and the public smaller snapshots at the data for MCH population domains.

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

- Medicaid maternal morbidity data DOH Maternal Child Health Director and MCH Epidemiologist were part of a team with SD Department of Social Services (DSS) to analyze Medicaid data for causes leading to maternal mortality and severe maternal morbidity. The DSS data analyst presented an analysis of Medicaid claims data that showed claims corresponding to maternal morbidity. The MCH Epi and DSS data analyst will continue to review the claims data, looking at it by risk factors such as obesity, substance use, and history of mental health and think about how it could be shared to potentially impact programmatic change.

- SD Maternal Mortality Review Committee A new maternal mortality abstractor began with South Dakota in April 2021. SD DOH is in final stages of signing data sharing agreements with the three major health systems in the state so that the abstractor will have access to medical records. The new abstractor is signed up with the MMRIA platform and has started abstracting cases with data from vital records and the state's Health Information Exchange. The maternal mortality abstractor, MCH Epi and MCH/Title V Director all participated in the MMRIA user meeting held in April. The team hopes to hold its first meeting in the fall of 2021 and review 2018 cases. During this reporting year they also hope to review 2019 cases.

New Efforts:

- AMCHP MCH Epi Intern: The MCH epi applied to host an MCH epi intern for the summer of 2021 and was matched with a Masters of Epidemiology student from Emory. This project will focus on creating a plan for officewide data reporting and visualization that includes overarching MCH outcomes and program specific data. The intern will research the outcomes (e.g. reduce obesity, reduce youth suicide, and increase breastfeeding rates) to find the best data sources and indicators for each outcome. The intern will also decide how to report that data (e.g. at state or county level, by race/ethnicity, by other demographic characteristics, etc.) and give recommendations for data visualizations for both an internal facing (DOH) and public facing dashboard. If time allows, the MCH epi would also like the intern to research South Dakota's data on social determinants of health and how that might factor into a data dashboard to give context to the disparities.

- Maternal and Child Health Policy Innovations
  South Dakota was selected to participate in the National Academy for State Health Policy Maternal and Child Health Policy Innovations Program. A group of 8 states will work over the next two years to build state capacity to address maternal mortality for Medicaid-eligible pregnant and parenting women. The MCH Epi will be a member of the South Dakota team to provide data support. The SD team will be researching and working on possible policy changes around value-based payments and pregnancy as a qualifying condition for the home health program.

- Office of Child and Family Services Assessment of Services
  The Office of Child and Family Services underwent a multi-year services assessment with Health Management Associates to understand how to make services more accessible to clients, sustainable, and equitable for South Dakotans. Workgroups were formed around organizational structure, external partnerships, program data, financial data, CQI and evaluation, digital services delivery, and communications. The MCH epi lead the program data work group and participated in CQI and evaluation. HMA will be providing their recommendations for implementation and the MCH epi will lead tasks for the program data workgroup over the next few years. Many of these recommendations align with existing strategies and activities on the SPM2 action plan, such as displaying data on dashboards and developing new reports.

- Nutrition Education Marketing Plan for WIC
  Each year the SD WIC program drafts and follows a Nutrition Education Marketing Plan (NEMP) that is utilized in the community health offices across the state. It consists of a needs assessment, goal setting, and evaluation for those providing WIC services. As recommendations from the OCFS services assessment are finalized, the MCH epi is going to be revising this plan so that it is an office wide plan for implementing WIC goals and MCH goals through the community health offices. For example, the plan will contain staff goals and evaluation around safe sleep (the infant domain priority) and sexual health education (state performance

measure for adolescents). It will be changed from a yearly plan to a 3-year plan, allowing for more time to carry out activities and evaluate the plans. Another goal is that OCFS priorities will continue to align across programs and staff will see how their work contributes to outcomes across the office, including within the MCH program.

- South Dakota Preventable Death Committee
  SD DOH formed a multi-disciplinary group with both state government partners and other statewide agencies to look at preventable deaths across the lifespan. This group looks at infant, child, and maternal deaths, along with those deaths identified through SD National Violent Death Reporting System. The goal is to identify common causes or risks for death across age groups to inform prevention efforts with partners. The MCH Epidemiologist reports on maternal deaths and the infant and women's MCH domain leader represents the infant and child deaths. During the next reporting year, they will continue to hold meetings and find prevention efforts that can be supported across the state in coordination with partners.

- Equity in SD MCH data
  This year the MCH data sharing and collaboration workgroup talked about ways to measure their work. Out of this conversation came the idea that their focus is around equity in data sharing and collaboration. During the next reporting year, this workgroup will begin to measure its work to the extent to which data equity principles have been implemented in SD MCH data projects. The workgroup has decided on a set of 6 guiding principles for equity in data and will use these guidelines as the framework and evaluation for data activities. The workgroup members will also use a scoring tool created by the MCH Epidemiologist to measure and track implementation over time.

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

- *PRAMS*: MCH continues to conduct CDC Pregnancy Risk Assessment Monitoring System (PRAMS) through a contract with South Dakota State University. PRAMS data is a vital piece to understanding the attitudes and behaviors of the maternal and child health population. 2019 PRAMS data will be available and strategies for data sharing and dissemination will follow the strategies highlighted in the SPM 2 action plan.

III.F. Public Input

The Department of Health (DOH) made the FY 2022 MCH block grant priorities and action plans available for public review and comment via the DOH website, MCH Newsletter audience of over 235 members, and targeted outreach to over 100 partners. MCH Team members were asked to share with any partners that would be involved in MCH activities and initiatives. These team members and partners then in turn shared the summary via Facebook pages, websites, listservs, newsletters, and email. A few of the partners reached were SD Parent Connection and the families they serve, Infant Death Review team members, Newborn Metabolic Screening program partners, Newborn Hearing Screening program partners, parent focus group participants, Birth to 3 Early Intervention families and providers, Dept. of Social Services Child Care Services, Personal Responsibility Education Program partner, and Developmental Disabilities Council members. In addition, the summary was provided to DOH field offices to display for clients to request, review, and provide comments on the state plan. The public comment posting can be found here

https://doh.sd.gov/documents/MCH/2021/FY22_MCHGrant_PublicComment.pdf.

The DOH received four responses to the request for public comment, an increase from previous years. Each domain received tips on collaboration opportunities with other entities in the state doing similar work. Other suggestions included improving messaging and outreach for safe sleep, creating systems to match families to accessible resources across domains, and increasing evaluation of services and programs to ensure programs and activities are impacting identified upstream factors.

The MCH Director responded directly to each commenter and encouraged their ongoing input and participation in planning and implementation efforts. The MCH Team also met to talk through the comments and determine where change is needed in each domain's action plan. In addition, the MCH Team discussed methods of improving communication with partners and the public to foster a greater understanding of Title V activities and collaborations as well as to further promote community involvement in these activities.

The MCH program's daily interactions with the MCH population and partners is an effective means for the MCH program to respond to any identified areas of need and build those recommendations into the annual plan. The DOH also utilizes various task forces and workgroups to gather input from partners regarding MCH activities and potential needs including the Immunization workgroup, Parent Connection follow-up surveys, and WIC participant surveys.

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

III.G. Technical Assistance

Technical Assistance

In the last year, the MCH domain leaders, WIC central office staff and MCH Director and CYSHCN Director have participated in a variety of trainings and technical assistance offered through the MCHB Workforce Development Center. Specifically, the virtual skills trainings on health equity and family engagement; Building Expertise in Administration and Management and AMCHP Leadership Lab training for the MCH and CYSHCN Directors; and in the summer of 2021 will gather a team to participate in change management and adaptive leadership in-state training. In the coming year, more training on systems of care development, community and family engagement and evidenced-based practice are all areas of need for continued development by MCH staff and partners.

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

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

Supporting Document #01 - cor_april-june_2021_post-list_v1c.pdf

Supporting Document #02 - FBS_KeepMomBabySafe.pdf

Supporting Document #03 - Well Visits Documents.pdf

Supporting Document #04 - Sanford Patient Navigation Program.pdf

Supporting Document #05 - OCFS Vision.pdf

VI. Organizational Chart

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

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: South Dakota

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,319,160	
A. Preventive and Primary Care for Children	$ 702,573	(30.2%)
B. Children with Special Health Care Needs	$ 729,458	(31.4%)
C. Title V Administrative Costs	$ 120,432	(5.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,552,463	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,035,794	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 13,485	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 700,263	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,749,542	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 4,068,702	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 20,895,980	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 24,964,682	

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

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,147,032		$ 1,730,405	
A. Preventive and Primary Care for Children	$ 680,000	(31.7%)	$ 524,214	(30.2%)
B. Children with Special Health Care Needs	$ 670,000	(31.2%)	$ 544,274	(31.4%)
C. Title V Administrative Costs	$ 85,881	(4%)	$ 89,858	(5.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,435,881		$ 1,158,346	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,611,368		$ 1,637,090	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 149,570		$ 21,313	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,224,994		$ 1,106,777	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,985,932		$ 2,765,180	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 5,132,964		$ 4,495,585	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 19,703,960		$ 21,177,769	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 24,836,924		$ 25,673,354	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 159,943	$ 136,832
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 215,259
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,428	$ 147,719
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 276,251	$ 199,444
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,010,338	$ 958,555
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 110,098
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 184,817
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,000,000	$ 1,460,474
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 16,500,000	$ 17,597,038
Department of Justice > Office of Violence Against Women > DOJ Sexual Assault Training		$ 167,533

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Due to staff responding to the COVID 19 pandemic, work time was allocated to COVID 19 efforts. Clinics were closed and some programs were not able to complete planned activities.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Due to staff responding to the COVID 19 pandemic, work time was allocated to COVID 19 efforts. Clinics were closed and some programs were not able to complete planned activities.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Due to staff responding to the COVID 19 pandemic, work time was allocated to COVID 19 efforts. Clinics were closed and some programs were not able to complete planned activities.	
4.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Due to staff responding to the COVID 19 pandemic, work time was allocated to COVID 19 efforts. Clinics were closed and some programs were not able to complete planned activities.	

Data Alerts: None

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

State: South Dakota

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 351,651	$ 262,379
2. Infants < 1 year	$ 269,422	$ 201,025
3. Children 1 through 21 Years	$ 702,573	$ 524,214
4. CSHCN	$ 729,458	$ 544,274
5. All Others	$ 145,624	$ 108,655
Federal Total of Individuals Served	$ 2,198,728	$ 1,640,547

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 316,721	$ 737,868
2. Infants < 1 year	$ 242,660	$ 736,189
3. Children 1 through 21 Years	$ 530,011	$ 908,193
4. CSHCN	$ 550,293	$ 300,943
5. All Others	$ 109,857	$ 81,987
Non-Federal Total of Individuals Served	$ 1,749,542	$ 2,765,180
Federal State MCH Block Grant Partnership Total	$ 3,948,270	$ 4,405,727

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: FFY20 expenditures reported without administrative costs.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: FFY20 expenditures reported without administrative costs.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: South Dakota

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 41,944	$ 31,296
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 41,944	$ 31,296
2. Enabling Services	$ 1,320,923	$ 985,586
3. Public Health Services and Systems	$ 956,293	$ 713,523
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 25,486
Physician/Office Services		$ 2,940
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 1,893
Laboratory Services		$ 842
Other		
Targeted Case Management		$ 135
Direct Services Line 4 Expended Total		$ 31,296
Federal Total	$ 2,319,160	$ 1,730,405

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 979,849	$ 1,728,737
3. Public Health Services and Systems	$ 639,895	$ 1,036,443
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 1,619,744	$ 2,765,180

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

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

State: South Dakota

Total Births by Occurrence: 11,889 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	11,827 (99.5%)	307	20	19 (95.0%)

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

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Infant Hearing Screening	11,204 (94.2%)	394	25	8 (32.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Long-term follow up was discontinued July 1, 2015. South Dakota does not monitor infants post confirmed diagnosis.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2020**
	Column Name:	**Data Source Year Notes**
	Field Note: 10/1/2019 through 9/30/2020	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: One confirmed case moved out of state and lost contact.	
3.	**Field Name:**	**Infant Hearing Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number referred for treatment is less than the number of confirmed cases. This is due to the 2020 data not yet being complete. Additionally, referral to early intervention service data is not available to the DOH.	

Data Alerts: None

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

State: South Dakota

Annual Report Year 2020

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

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	2,097	29.0	0.0	68.0	3.0	0.0
2. Infants < 1 Year of Age	4,793	29.0	0.0	68.0	3.0	0.0
3. Children 1 through 21 Years of Age	20,186	25.0	0.0	69.0	5.0	1.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	726	44.0	0.0	53.0	3.0	0.0
4. Others	8,716	8.0	0.0	84.0	8.0	0.0
Total	35,792					

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

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	11,449	Yes	11,449	27.0	3,091	2,097
2. Infants < 1 Year of Age	12,223	Yes	12,223	100.0	12,223	4,793
3. Children 1 through 21 Years of Age	252,639	Yes	252,639	73.0	184,426	20,186
3a. Children with Special Health Care Needs 0 through 21 years of age^	45,515	Yes	45,515	70.0	31,861	726
4. Others	620,035	Yes	620,035	44.0	272,815	8,716

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Prenatal Health Review clients + MCH case managed clients + post-partum visits to women not risk assessed during pregnancy = 1346 1346+ 751 Cribs for Kids Safe Sleep kits distributed (with education provided) = 2097 *This is the first year Cribs for Kids Safe Sleep kits have been included in this count	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: 613 infants receiving follow up after a positive newborn screen + 69 infants vaccinated at Community Health Offices + 751 Cribs for Kids safe sleep kits distributed + 3360 infants enrolled in WIC whose parents received safe sleep education. *Form 5a Infants count is significantly higher than in previous reporting cycles due to the increase in services being counted. Previously, only infant vaccinations in Community Health Offices were counted.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: 11,799 Individuals vaccinated at Community Health Offices + 4331 suicide hotline calls + 3452 individuals receiving ASQ and ASQ SE screenings at Community Health Offices (all screenings and interventions billed to MCH)+ 604 individuals receiving ASQ and ASQ SE screenings at PHA offices (all screenings billed to MCH except those billed to Medicaid). *Due to data limitations, Community health office and PHA data includes infant count **Count is significantly higher than last year's count due to more services being included in this count	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: 23 Health KiCC clients served + 638 clients served through respite program + 30 clients served in Sanford Care Coordination Program + 35 special needs car seats funded *5a CYSHCN count is lower than in previous reporting cycles due to discontinued health education/referral assistance/care coordination via Family 2 Family provider	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: 8716 adults vaccinated at Community Health Offices	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: 988 Strong Families Envelopes + 5a count 2097 = 3085 *Count is significantly lower than last reporting period due to discontinuation of parent/infant Bright Start Welcome boxes and no longer reporting # of PRAMS surveys distributed and Medicaid letters to new mothers Not included in count due to possible duplication is 36,581 page views on the For Baby's Sake website and Facebook page.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: Newborn screening is a service available to 100% of infants born in South Dakota. During annual report year 2020, 11,826 infants were screened out of 11,887 total births. Total count from 5a is 4793 (not included in 5b count due to duplication)	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: 10839 student contact at schools + immunizations from Immunization Program 153,884 + 41 individuals served through Sanford genetics outreach + 5A suicide hotline count 4331 = 169,095 *Not included due to duplication: 5A individuals vaccinated at community health offices, 178925 hits to adolescent websites, 993 hits on well visit promotion with Medicaid and third party payers, hotline youth mental health Also not counted: QPR (suicide prevention) trainings to teachers and agencies that provide service to children- 9 trainings completed	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: NSCH data shows 17.2% of SD children are CYSHCN. 5b count 184,950 x .172 = 31,811 / 45515 = 70%	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: # reached within Immunization Program = 264,688 + 6323 family planning visits = 271,011	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: South Dakota

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	10,775	7,575	377	657	1,483	220	9	412	42
Title V Served	4,191	2,099	196	476	1,045	128	16	231	0
Eligible for Title XIX	3,771	1,700	220	253	1,457	102	39	0	0
2. Total Infants in State	11,985	8,535	351	765	1,467	217	5	645	0
Title V Served	11,985	8,535	351	765	1,467	217	5	645	0
Eligible for Title XIX	4,817	2,262	316	316	1,775	109	38	0	1

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: South Dakota

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 305-3064	(800) 305-3064
2. State MCH Toll-Free "Hotline" Name	Bright Start	Bright Start
3. Name of Contact Person for State MCH "Hotline"	Jennifer Folliard	Jennifer Folliard (see note 2)
4. Contact Person's Telephone Number	(605) 367-5374	(605) 367-5374
5. Number of Calls Received on the State MCH "Hotline"		1,038

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	National Suicide Prevention Lifeline and Text4Hope	National Suicide Prevention Lifeline and Text4Hope
2. Number of Calls on Other Toll-Free "Hotlines"		4,331
3. State Title V Program Website Address	doh.sd.gov/family	doh.sd.gov/family
4. Number of Hits to the State Title V Program Website		69,196
5. State Title V Social Media Websites	See note 1b for list	See note 1a for list
6. Number of Hits to the State Title V Program Social Media Websites		199,178

Form Notes for Form 7:

1a. Social Media Websites Annual Report Year 2020:
www.ForBabySakeSD.com -16,555 page views
www.Facebook.com/ForBabySakeSD -20,026 page consumptions
http://doh.sd.gov/family/wic -2088 page views
http://doh.sd.gov/family/pregnancy/family-planning.aspx -1486 page views
www.SDWIC.org -112,559 page views
https://www.facebook.com/SouthDakotaWIC/ -14,205 page consumptions
https://healthysd.gov/category/munch-code+workplace/ - 635 Pageviews*
www.instagram.com/corhealthsd - 150,560 people reached **
www.facebook.com/corhealthsd 28,221 page consumptions
https://doh.sd.gov/statistics/infant-mortality/ - 873 Pageviews
https://doh.sd.gov/family/pregnancy/perinatal.aspx - 577 Pageviews
https://doh.sd.gov/statistics/maternalmortality.aspx? - 799 Pageviews
https://doh.sd.gov/family/Youth/ - 144 Pageviews
https://doh.sd.gov/statistics/prams.aspx? - 1,010 Pageviews
*This page will no longer be reported on by Title V after FY20 due to new priorities
**Due to data limitations, Instagram data is based on number reached with paid promotion of posts. This number is not included in the count in Form 7.B.6

1b. Application Year Social Media Websites:
www.ForBabySakeSD.com
www.Facebook.com/ForBabySakeSD
http://doh.sd.gov/family/wic
http://doh.sd.gov/family/pregnancy/family-planning.aspx
www.SDWIC.org
https://www.facebook.com/SouthDakotaWIC/
https://doh.sd.gov/statistics/infant-mortality/
https://doh.sd.gov/family/pregnancy/perinatal.aspx
www.instagram.com/corhealthsd
www.facebook.com/corhealthsd
https://doh.sd.gov/statistics/maternalmortality.aspx?
https://doh.sd.gov/family/Youth/
https://doh.sd.gov/statistics/prams.aspx?

2. Jennifer Folliard, MCH Director, became the contact person for the State MCH Hotline in April 2020. The previous MCH Director, Scarlett Bierne, was the contact person from October 2019 through February 12, 2020.

Form 8
State MCH and CSHCN Directors Contact Information

State: South Dakota

1. Title V Maternal and Child Health (MCH) Director	
Name	Jennifer Folliard
Title	MCH Director
Address 1	4101 W 38th St.
Address 2	
City/State/Zip	Sioux Falls / SD / 57106
Telephone	(605) 367-5374
Extension	
Email	jennifer.folliard@state.sd.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Whitney Brunner
Title	CYSHCN Director
Address 1	615 E 4th St
Address 2	
City/State/Zip	Pierre / SD / 57501
Telephone	(605) 773-4749
Extension	
Email	whitney.brunner@state.sd.us

3. State Family or Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: South Dakota

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Mental Health/Substance Misuse	New
2.	Safe Sleep	Revised
3.	Parenting Education and Support	New
4.	Mental Health/Suicide Prevention	New
5.	Access to Care and Services	Revised
6.	Healthy Relationships	New
7.	Data Sharing and Collaboration	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Mental Health/Substance Abuse	New
2.	Safe Sleep	Revised
3.	Parenting Education and Support	New
4.	Mental Health/Suicide Prevention	New
5.	Access to Care and Services	Revised
6.	Healthy Relationships	New
7.	Data Sharing and Collaboration	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: South Dakota

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	77.7 %	0.4 %	8,816	11,341
2018	77.5 %	0.4 %	9,118	11,769
2017	76.0 %	0.4 %	9,103	11,978
2016	76.8 %	0.4 %	9,326	12,149
2015	76.6 %	0.4 %	9,301	12,144
2014	76.4 %	0.4 %	9,248	12,103
2013	72.3 %	0.4 %	8,693	12,021
2012	70.6 %	0.4 %	8,367	11,843
2011	69.9 %	0.4 %	8,120	11,622
2010	71.2 %	0.4 %	8,255	11,596
2009	67.3 %	0.4 %	7,919	11,760

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	57.1	7.2	64	11,207
2017	47.0	6.5	53	11,286
2016	40.4	6.0	46	11,399
2015	39.4	6.9	33	8,385
2014	47.7	6.6	53	11,122
2013	45.5	6.5	50	10,987
2012	33.1	5.5	36	10,873
2011	35.4	5.8	38	10,743
2010	40.7	6.2	43	10,555
2009	56.5	7.3	61	10,796
2008	40.8	6.2	44	10,780

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	16.6	5.3	10	60,087
2014_2018	16.4	5.2	10	60,921

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	7.0 %	0.2 %	802	11,444
2018	6.6 %	0.2 %	789	11,886
2017	6.9 %	0.2 %	835	12,126
2016	6.8 %	0.2 %	830	12,275
2015	6.1 %	0.2 %	754	12,328
2014	6.5 %	0.2 %	804	12,280
2013	6.3 %	0.2 %	766	12,237
2012	6.2 %	0.2 %	748	12,098
2011	6.3 %	0.2 %	744	11,839
2010	6.8 %	0.2 %	806	11,801
2009	5.8 %	0.2 %	696	11,929

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	9.6 %	0.3 %	1,093	11,444
2018	9.4 %	0.3 %	1,122	11,882
2017	9.3 %	0.3 %	1,125	12,121
2016	9.0 %	0.3 %	1,098	12,268
2015	8.5 %	0.3 %	1,053	12,325
2014	8.5 %	0.3 %	1,040	12,268
2013	8.1 %	0.3 %	993	12,221
2012	7.8 %	0.2 %	946	12,084
2011	7.9 %	0.3 %	940	11,832
2010	8.6 %	0.3 %	1,013	11,788
2009	7.9 %	0.3 %	944	11,912

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	27.8 %	0.4 %	3,177	11,444
2018	25.6 %	0.4 %	3,046	11,882
2017	25.3 %	0.4 %	3,063	12,121
2016	24.6 %	0.4 %	3,023	12,268
2015	23.7 %	0.4 %	2,917	12,325
2014	24.0 %	0.4 %	2,948	12,268
2013	22.9 %	0.4 %	2,795	12,221
2012	22.3 %	0.4 %	2,696	12,084
2011	23.5 %	0.4 %	2,781	11,832
2010	24.7 %	0.4 %	2,906	11,788
2009	26.1 %	0.4 %	3,106	11,912

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	3.0 %			
2018/Q4-2019/Q3	3.0 %			
2018/Q3-2019/Q2	3.0 %			
2018/Q2-2019/Q1	3.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	3.0 %			
2016/Q4-2017/Q3	3.0 %			
2016/Q3-2017/Q2	3.0 %			
2016/Q2-2017/Q1	3.0 %			
2016/Q1-2016/Q4	3.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	4.6	0.6	55	11,919
2017	7.8	0.8	95	12,177
2016	5.7	0.7	70	12,319
2015	6.8	0.7	84	12,374
2014	6.3	0.7	78	12,326
2013	6.4	0.7	79	12,292
2012	8.8	0.9	107	12,147
2011	6.3	0.7	75	11,882
2010	8.4	0.9	100	11,864
2009	5.8	0.7	69	11,962

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	5.9	0.7	70	11,893
2017	7.7	0.8	94	12,134
2016	4.9	0.6	60	12,275
2015	7.3	0.8	90	12,336
2014	5.7	0.7	70	12,283
2013	6.5	0.7	79	12,248
2012	8.3	0.8	101	12,104
2011	6.1	0.7	72	11,846
2010	7.1	0.8	84	11,811
2009	6.7	0.8	80	11,934

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	2.9	0.5	35	11,893
2017	5.5	0.7	67	12,134
2016	2.5	0.5	31	12,275
2015	4.8	0.6	59	12,336
2014	3.3	0.5	41	12,283
2013	3.9	0.6	48	12,248
2012	5.5	0.7	67	12,104
2011	3.6	0.6	43	11,846
2010	4.8	0.6	57	11,811
2009	3.8	0.6	45	11,934

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2018	2.9	0.5	35	11,893
2017	2.2	0.4	27	12,134
2016	2.4	0.4	29	12,275
2015	2.5	0.5	31	12,336
2014	2.4	0.4	29	12,283
2013	2.5	0.5	31	12,248
2012	2.8	0.5	34	12,104
2011	2.4	0.5	29	11,846
2010	2.3	0.4	27	11,811
2009	2.9	0.5	35	11,934

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	92.5 ϟ	27.9 ϟ	11 ϟ	11,893 ϟ
2017	255.5	45.9	31	12,134
2016	97.8 ϟ	28.2 ϟ	12 ϟ	12,275 ϟ
2015	178.3	38.1	22	12,336
2014	138.4 ϟ	33.6 ϟ	17 ϟ	12,283 ϟ
2013	212.3	41.7	26	12,248
2012	214.8	42.2	26	12,104
2011	168.8	37.8	20	11,846
2010	211.7	42.4	25	11,811
2009	167.6	37.5	20	11,934

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	168.2	37.6	20	11,893
2017	115.4	30.9	14	12,134
2016	122.2	31.6	15	12,275
2015	218.9	42.2	27	12,336
2014	114.0	30.5	14	12,283
2013	130.6	32.7	16	12,248
2012	90.9	27.4	11	12,104
2011	92.9	28.0	11	11,846
2010	118.5	31.7	14	11,811
2009	134.1	33.5	16	11,934

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.8 %	1.1 %	1,156	10,715
2018	8.2 %	1.0 %	913	11,086
2017	8.3 %	1.0 %	919	11,073

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	1.4	0.4	15	11,024
2017	1.7	0.4	19	11,354
2016	1.8	0.4	21	11,528
2015	1.6	0.4	14	8,555
2014	1.6	0.4	18	11,255
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	1.3	0.4	14	10,849
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR
2008	NR	NR	NR	NR

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	8.6 %	1.2 %	16,737	195,087
2017_2018	8.4 %	1.3 %	16,330	193,439
2016_2017	8.7 %	1.2 %	16,828	193,935
2016	9.6 %	1.4 %	18,332	191,693

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	22.7	4.5	25	110,116
2018	20.8	4.3	23	110,785
2017	29.1	5.2	32	109,874
2016	29.2	5.2	32	109,629
2015	24.7	4.8	27	109,091
2014	26.7	5.0	29	108,445
2013	25.1	4.8	27	107,646
2012	31.3	5.4	33	105,530
2011	21.1	4.5	22	104,150
2010	20.3	4.4	21	103,502
2009	24.6	4.9	25	101,525

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	52.3	6.7	62	118,466
2018	54.8	6.8	65	118,556
2017	51.7	6.7	60	115,978
2016	63.7	7.5	73	114,680
2015	56.6	7.1	64	113,106
2014	37.0	5.7	42	113,630
2013	44.5	6.3	50	112,318
2012	44.0	6.3	49	111,395
2011	43.7	6.3	49	112,012
2010	56.5	7.1	63	111,588
2009	65.2	7.6	73	111,893

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	26.7	3.9	46	172,083
2016_2018	29.8	4.2	51	171,187
2015_2017	24.1	3.8	41	170,094
2014_2016	23.4	3.7	40	171,242
2013_2015	14.5	2.9	25	171,823
2012_2014	19.1	3.3	33	172,681
2011_2013	17.4	3.2	30	172,774
2010_2012	24.3	3.8	42	172,983
2009_2011	29.3	4.1	51	173,766
2008_2010	33.2	4.4	58	174,643
2007_2009	35.1	4.5	62	176,399

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	33.1	4.4	57	172,083
2016_2018	29.2	4.1	50	171,187
2015_2017	30.0	4.2	51	170,094
2014_2016	28.0	4.1	48	171,242
2013_2015	29.1	4.1	50	171,823
2012_2014	22.6	3.6	39	172,681
2011_2013	22.0	3.6	38	172,774
2010_2012	20.8	3.5	36	172,983
2009_2011	24.2	3.7	42	173,766
2008_2010	28.6	4.1	50	174,643
2007_2009	24.9	3.8	44	176,399

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	17.2 %	1.5 %	36,404	211,616
2017_2018	16.6 %	1.5 %	35,046	211,653
2016_2017	16.1 %	1.3 %	33,876	210,513
2016	15.7 %	1.4 %	32,704	208,339

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	15.7 %	3.3 %	5,705	36,404
2017_2018	16.3 %	3.9 %	5,708	35,046
2016_2017	15.6 %	3.8 %	5,296	33,876
2016	9.6 %	1.9 %	3,144	32,704

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.2 %	0.8 %	3,863	172,694
2017_2018	1.3 %	0.4 %	2,259	173,786
2016_2017	1.5 %	0.5 %	2,649	171,841
2016	2.0 %	0.8 %	3,263	166,826

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	7.0 %	1.0 %	11,981	170,586
2017_2018	6.5 %	1.1 %	11,164	172,611
2016_2017	6.5 %	1.0 %	10,997	170,388
2016	7.0 %	0.9 %	11,719	166,311

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	58.3 %	6.2 %	11,586	19,858
2017_2018	66.8 %	6.6 %	12,005	17,965
2016_2017	60.9 %	5.9 %	10,629	17,449
2016	51.8 %	7.0 %	8,075	15,596

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	91.6 %	1.1 %	192,700	210,359
2017_2018	93.7 %	1.0 %	197,336	210,705
2016_2017	93.7 %	0.9 %	196,224	209,466
2016	92.7 %	1.1 %	191,296	206,419

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	16.0 %	0.5 %	1,004	6,269
2016	17.1 %	0.5 %	1,156	6,771
2014	17.1 %	0.5 %	884	5,179
2012	14.8 %	0.4 %	1,190	8,020
2010	17.3 %	0.4 %	1,363	7,884
2008	16.1 %	0.4 %	1,121	6,946

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	14.1 %	0.9 %	5,256	37,324
2015	14.7 %	1.3 %	5,550	37,746
2013	11.9 %	1.1 %	4,509	37,874
2011	9.8 %	1.0 %	3,812	38,957
2009	9.5 %	1.0 %	3,662	38,353
2007	9.0 %	1.2 %	3,680	40,789
2005	10.4 %	1.1 %	4,285	41,028

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	11.7 %	2.0 %	10,480	89,317
2017_2018	11.9 %	2.3 %	10,969	91,796
2016_2017	13.6 %	2.3 %	11,680	86,126
2016	13.0 %	2.2 %	10,488	80,613

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	5.7 %	0.9 %	12,368	215,236
2018	5.2 %	0.7 %	11,133	214,180
2017	6.1 %	1.0 %	12,936	212,391
2016	4.3 %	0.8 %	9,120	213,902
2015	7.4 %	1.3 %	15,401	209,556
2014	7.3 %	1.2 %	15,285	209,494
2013	7.3 %	1.0 %	14,974	205,982
2012	3.9 %	0.8 %	7,869	204,137
2011	5.7 %	0.8 %	11,454	202,877
2010	7.1 %	1.2 %	14,562	204,414
2009	6.7 %	0.9 %	13,342	199,435

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	68.9 %	3.8 %	9,000	12,000
2015	72.2 %	3.9 %	9,000	13,000
2014	73.4 %	3.3 %	9,000	13,000
2013	64.7 %	4.1 %	8,000	13,000
2012	73.6 %	4.2 %	9,000	12,000
2011	68.7 %	4.8 %	8,000	12,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	70.3 %	1.9 %	145,068	206,356
2018_2019	67.2 %	2.2 %	136,681	203,394
2017_2018	64.4 %	2.0 %	128,145	198,957
2016_2017	63.2 %	2.4 %	125,737	199,014
2015_2016	70.8 %	2.0 %	139,014	196,236
2014_2015	64.4 %	2.4 %	124,290	192,937
2013_2014	68.5 %	2.1 %	131,211	191,596
2012_2013	73.2 %	3.3 %	140,455	192,009
2011_2012	58.2 %	2.6 %	107,634	184,949
2010_2011	53.7 %	4.6 %	100,976	188,037
2009_2010	56.5 %	2.6 %	95,462	168,959

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	73.6 %	3.0 %	43,186	58,689
2018	68.7 %	2.9 %	39,413	57,365
2017	63.2 %	3.2 %	35,462	56,124
2016	55.9 %	3.4 %	30,966	55,423
2015	46.0 %	3.2 %	25,628	55,733

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	90.0 %	2.1 %	52,846	58,689
2018	86.6 %	2.2 %	49,689	57,365
2017	79.5 %	2.8 %	44,628	56,124
2016	79.4 %	2.9 %	43,986	55,423
2015	72.4 %	2.9 %	40,325	55,733
2014	75.0 %	3.0 %	41,570	55,439
2013	70.0 %	3.3 %	38,650	55,198
2012	65.9 %	3.3 %	35,845	54,368
2011	54.4 %	5.2 %	29,467	54,183
2010	52.5 %	3.2 %	29,225	55,702
2009	39.6 %	3.4 %	22,002	55,527

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	86.2 %	2.4 %	50,619	58,689
2018	85.3 %	2.2 %	48,920	57,365
2017	74.5 %	2.9 %	41,838	56,124
2016	65.7 %	3.2 %	36,400	55,423
2015	55.5 %	3.2 %	30,918	55,733
2014	57.0 %	3.4 %	31,618	55,439
2013	51.7 %	3.4 %	28,523	55,198
2012	40.0 %	3.5 %	21,743	54,368
2011	37.4 %	4.8 %	20,280	54,183
2010	30.9 %	3.0 %	17,198	55,702
2009	24.9 %	2.9 %	13,838	55,527

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	19.2	0.8	536	27,955
2018	20.4	0.9	565	27,707
2017	22.6	0.9	614	27,226
2016	25.1	1.0	681	27,149
2015	26.5	1.0	720	27,214
2014	26.7	1.0	735	27,483
2013	29.4	1.0	812	27,650
2012	33.5	1.1	929	27,747
2011	34.3	1.1	964	28,066
2010	34.8	1.1	975	28,045
2009	38.7	1.2	1,092	28,228

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	12.6 %	1.1 %	1,338	10,618
2018	13.0 %	1.2 %	1,435	11,037
2017	14.3 %	1.2 %	1,604	11,203

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.4 %	0.7 %	5,106	211,616
2017_2018	2.9 %	0.7 %	6,216	211,542
2016_2017	3.1 %	0.7 %	6,559	210,083
2016	2.3 %	0.7 %	4,772	207,703

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: South Dakota

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

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					79.6
Annual Indicator				77.6	70.4
Numerator				110,174	101,908
Denominator				141,888	144,765
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.1	74.5	75.9	77.2	78.6	79.9

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective	92.4	89.3	89.1
Annual Indicator	87.6	87.0	86.6
Numerator	9,793	9,485	9,150
Denominator	11,174	10,900	10,566
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	88.2	88.9	92.4	89.3	89.1
Annual Indicator	86.7	91.7			
Numerator	9,607	10,013			
Denominator	11,078	10,922			
Data Source	SD PRAMS LIke Survey	SD PRAMS Like Survey			
Data Source Year	2014	2016			
Provisional or Final ?	Final	Final			

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	87.0	87.2	87.4	87.6	87.9	88.1

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		39.2	41.8
Annual Indicator	38.4	41.6	40.5
Numerator	4,014	4,380	4,136
Denominator	10,466	10,533	10,223
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			39.2	41.8
Annual Indicator	26			
Numerator	2,821			
Denominator	10,844			
Data Source	SD PRAMS Like Survey			
Data Source Year	2016			
Provisional or Final ?	Final			

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	41.5	41.9	42.4	42.9	43.4	43.9

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		48.4	48.4
Annual Indicator	48.2	46.9	52.0
Numerator	5,069	4,923	5,339
Denominator	10,516	10,495	10,267
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			48.4	48.4
Annual Indicator	44.7			
Numerator	4,681			
Denominator	10,472			
Data Source	SD PRAMS Like Survey			
Data Source Year	2016			
Provisional or Final ?	Final			

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	52.9	53.4	53.9	54.4	54.8	55.3

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			41.2	42.8	41.4
Annual Indicator		40.4	42.4	40.4	39.4
Numerator		12,135	10,542	8,655	9,910
Denominator		30,030	24,884	21,429	25,131
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	40.3	40.8	41.2	41.7	42.1	42.6

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: HCUP - State Inpatient Databases (SID)			
	2016	**2019**	**2020**
Annual Objective	337.2		
Annual Indicator	335.0	313.0	318.8
Numerator	379	363	378
Denominator	113,144	115,978	118,556
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	312.1	308.8	305.4	302.1	298.7	295.4

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			46.1	50.8	53.4
Annual Indicator		43.9	49.6	53.0	48.8
Numerator		14,361	16,789	18,568	17,763
Denominator		32,704	33,876	35,046	36,404
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	49.7	50.1	50.5	51.0	51.4	51.9

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: South Dakota

2016-2020: NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			75.7	70.9	72.1
Annual Indicator		72.1	68.5	68.5	78.2
Numerator		46,184	46,371	46,371	52,192
Denominator		64,019	67,737	67,737	66,746
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: South Dakota

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 45.6% in 2020 to 50.2% in 2026.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.1	46.5	47.0	47.4	47.9	48.4

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	5.0	6.0	7.0	7.0	7.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - Percentage of children, ages 2-5, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		29.4	32.1	32	31.4
Annual Indicator	36.1	33.1	33.1	33.9	34.3
Numerator	1,868	2,415	2,171	3,236	807
Denominator	5,179	7,295	6,562	9,545	2,354
Data Source	FAD NOM 20 WIC data	PedNss	PedNSS	PedNSS	PedNSS
Data Source Year	2014	2016	2017	2018	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 4 - MCH data are analyzed and disseminated

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		Yes	0	0	0
Annual Indicator	Yes	Yes	Yes	Yes	Yes
Numerator					
Denominator					
Data Source	NA	NA	NA	NA	NA
Data Source Year	NA	NA	NA	NA	NA
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: South Dakota

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	100	
Numerator	4,596	
Denominator	4,596	
Data Source	SD WIC IT	
Data Source Year	2019	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	10	
Numerator	495	
Denominator	4,954	
Data Source	SD WIC IT	
Data Source Year	2020	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.2 - % of daycares who respond to survey and indicate that they follow safe sleep guidelines

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	100	
Numerator	76	
Denominator	76	
Data Source	OCFS Community Health Offices	
Data Source Year	2019	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	60.0	120.0	180.0	240.0	300.0	300.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	100	
Numerator	30	
Denominator	30	
Data Source	SDSU Population Health	
Data Source Year	2020	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure that all women are aware of the importance of annual well women visits.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			100	100
Annual Indicator			76.2	68.5
Numerator			48	37
Denominator			63	54
Data Source			DOH detail sheets	DOH detail sheets
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.3 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure implementation of infant safe sleep practices.

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			100	100
Annual Indicator			80	95
Numerator			48	57
Denominator			60	60
Data Source			DOH detail sheets	DOH detail sheets
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 6.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to improve early identification and referral of developmental delays.

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			100	100
Annual Indicator			88.9	77.8
Numerator			32	14
Denominator			36	18
Data Source			DOH detail sheets	DOH detail sheets
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 10.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to increase the percent of adolescents with an annual preventive medical visit.

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			100	100
Annual Indicator			77.8	78.7
Numerator			70	59
Denominator			90	75
Data Source			DOH detail sheets	DOH detail sheets
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure access to a medical home.

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			100	100
Annual Indicator			83.3	83.3
Numerator			30	10
Denominator			36	12
Data Source			DOH detail sheets	DOH detail sheets
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: South Dakota

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 45.6% in 2020 to 50.2% in 2026.
Population Domain(s) – Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Improve young peoples' (10 to 24 years) relationships by increasing education and support, STI prevention, and pregnancy prevention.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of individuals answering “very true” to the entry survey question: “I would talk to a trusted adult (for example, a family member, teacher, counselor, coach, etc.) if someone I am dating or going out with makes me uncomfortable, hurts me, or.....</td></tr>
<tr><td>Denominator:</td><td>total # of individuals who completed the above question on the entry survey</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>SRAE and PREP entry survey</td></tr>
<tr><td>Significance:</td><td>Relationships are an important part of adolescent development. Adolescence is a time for young people to explore and develop relationships by connecting with peers, parents, teachers, or a romantic partner. These relationships might be healthy or unhealthy, and can be emotional, physical, or sexual. A comprehensive approach of covering education and support for healthy relationships, STI prevention, and teen pregnancy prevention is key to achieving healthy relationships in adolescence.</td></tr>
</table>

SPM 2 - The extent to which data equity principles have been implemented in SD MCH data projects
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increased data sharing and collaboration
Definition:	**Unit Type:** Count **Unit Number:** 7 **Numerator:** Number of data sharing projects **Denominator:**
Data Sources and Data Issues:	Count of the number of new data sharing projects completed by the DOH and partners on this SPM
Significance:	Data sharing and collaboration are evidence-based strategies for improving health equity. Disaggregated data that is available to communities can lead to a better understanding of local conditions and help monitor progress toward achieving health equity. Linking data sets and sharing resources across sectors will lead to a more robust understanding of the health of South Dakotans. Data sharing and collaboration were common themes during the needs assessment process across all population domains, thus making it ideal for the cross-cutting state performance measure.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - Percentage of children, ages 2-5, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Promote positive child and youth development to reduce morbidity and mortality
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of children aged 2 to 5 years receiving WIC with a BMI at or above 85th percentile (overweight or obese) **Denominator:** # of children aged 2 to 5 years receiving WIC
Healthy People 2020 Objective:	NWS-10.1: Reduce the proportion of children aged 2 to 5 years who are considered obese
Data Sources and Data Issues:	PedNSS
Significance:	Body weight is related to health status and good nutrition is important to the growth and development of children. Children who are at a healthy weight are less likely to develop chronic diseases and more likely to be at a healthy weight as an adult.

2016-2020: SPM 4 - MCH data are analyzed and disseminated
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Improve state and local surveillance, data collection, and evaluation capacity
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** (# of reports developed and disseminated) **Denominator:**
Data Sources and Data Issues:	N/A
Significance:	Important for program to make data driven decisions and collaborate with partners.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: South Dakota

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: South Dakota

ESM 1.1 - % of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Address mental health in women by measuring the percentage of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening **Denominator:** # of positive PHQ 2 generated from the WIC assessment
Data Sources and Data Issues:	code added to the state's Time Keeping System for a PHQ 9 screening
Significance:	A Pregnancy and Postpartum WIC Assessment provides a critical opportunity to identify mental health needs and improve subsequent maternal and infant outcomes by providing appropriate referrals to address mental health issues.

ESM 1.2 - % of WIC clients whose PHQ 9 score met criteria for a referral and were referred
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Address mental health in women by measuring the percentage of WIC clients whose PHQ 9 score met criteria for a referral and were referred
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of WIC clients whose PHQ 9 score met criteria for a referral and were referred **Denominator:** # of WIC clients whose PHQ 9 score met criteria for a referral
Data Sources and Data Issues:	Statistics kept by Community Health Offices
Significance:	A Pregnancy and Postpartum WIC Assessment provides a critical opportunity to identify mental health needs and improve subsequent maternal and infant outcomes by providing appropriate referrals to address mental health issues.

ESM 5.1 - % of Child Death Review (CDR) team members who scored above 80% on a post-test
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Determine the effectiveness of training provided to CDR team members by measuring the % of team members who scored above 80% on a training post-test.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of CDR team members who scored above 80% on a post-test **Denominator:** # of CDR team members who took post-test
Data Sources and Data Issues:	Manual tally of post-test scores
Significance:	By measuring the effectiveness of training on upstream root causes of infant death, we have more confidence in a review team's ability to recommend ways to prevent deaths from occurring instead of responding to the deaths.

ESM 5.2 - % of daycares who respond to survey and indicate that they follow safe sleep guidelines
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Collaborate with diverse, multi-sector organizations/agencies to promote safe sleep by providing safe sleep materials to daycares and measuring the % of daycares who respond to a survey and indicate they follow safe sleep guidelines</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of daycares who respond to survey and indicate they follow safe sleep guidelines</td></tr>
<tr><td>Denominator:</td><td># of daycares who respond to survey</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Survey distributed to daycares</td></tr>
<tr><td>Significance:</td><td>Through this measure we can determine whether the training/education provided to daycares across the state was effective in increasing a provider’s confidence in following safe sleep guidelines within their home or a daycare center.</td></tr>
</table>

ESM 5.3 - % of birthing hospitals that receive information on certification process that become safe sleep certified NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the % of birthing hospitals that become safe sleep certified after receiving information on the certification process
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of birthing hospitals in SD that receive information on Cribs for Kids safe sleep certification process that become safe sleep certified **Denominator:** # of birthing hospitals in SD that receive information on Cribs for Kids safe sleep certification process
Data Sources and Data Issues:	Manual count of SD birthing hospitals that become safe sleep certified after receiving information on Cribs for Kids safe sleep certification process.
Evidence-based/informed strategy:	The evidence for this strategy falls under “Caregiver+Provider+Hospital without Quality Improvement (Moderate Evidence) “appear to be effective as the majority of the studies had favorable results” in the National Performance Measure 5 Safe Sleep Evidence Review from the Women’s and Children’s Health Policy Center at John Hopkins University (2017). NICHQ’s study states “Statewide implementation of hospital policy intervention to increase knowledge among health care professionals has resulted in significant reductions in infants found in unsafe sleep situations while in the hospital. (Infant Safe Sleep Interventions, 1990 -2015: A Review. J community Health. 2016) Cribs for Kids National Safe Sleep Hospital Certification Program includes: • Developing safe sleep policy statement incorporating the AAP’s Infant Safe Sleep guidelines • Training staff on safe sleep guidelines, hospital safe sleep policy, and the importance of modeling safe sleep for parents • Educating parents on the importance of safe sleep practices and implementing these practices in the hospital setting.
Significance:	This measure is significant because it demonstrates that hospital systems (who become safe sleep certified) have met Cribs for Kids standards of providing evidence based strategies in their policies, in safe sleep training for staff and with their education provided to new families.

ESM 6.1 - % of Community Health Offices that distribute tracking cards
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Provide parenting education on developmental screening by providing trifold developmental screening tracking cards at Community Health Offices
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of Community Health Offices that distribute tracking cards **Denominator:** # of Community Health Offices
Data Sources and Data Issues:	Reporting from Community Health Offices
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. There are many electronic options available for parents and caregivers to track a child's development, however, not every family has access to the required technology to utilize these apps. It is important that community health offices continue to distribute developmental screening tracking cards and other hard copy resources to ensure all populations have an effective means to track the development of the children in their care.

ESM 7.2.1 - # of students trained in teen Mental Health First Aid
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	Address suicide prevention and mental health in adolescents by promoting evidence-based programs and practices that increase protection from suicide risk
Definition:	**Unit Type:** Count **Unit Number:** 300 **Numerator:** # of students trained in teen Mental Health First Aid **Denominator:**
Data Sources and Data Issues:	# of class participants reported by training facilitator to have completed the teen mental health first aid curriculum
Significance:	New evidence-based curriculum for youth that teaches high school students how to identify, understand and respond to signs and symptoms of mental health or substance abuse. Education is important in this area because during Adolescence 1 in 5 youth has had a serious mental health disorder at some point in their life and 50% of all mental illnesses begins by age 14 and 75% by the mid-20s(Mental Health First Aid). This training gives students the skills to have supportive conversations with their friends and get a responsible and trusted adult to take over as necessary.

ESM 11.1 - % of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Improve access to care and services for CYSHCN by measuring the effectiveness of the Sanford Care Coordination Program.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services **Denominator:** # of families enrolled in care coordination services
Data Sources and Data Issues:	pre-care coordination and post-care coordination surveys of clients provided by South Dakota State University Population Health
Significance:	The AAP specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. By measuring the effectiveness of the Sanford Care Coordination Program, the CYSHCN program can tailor services provided to close gaps in care and increase the percentage of families that experience an improvement in obtaining needed referrals to care and/or services. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure that all women are aware of the importance of annual well women visits.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Promote preconception/inter-conception health and promote oral health
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Rating on implementation of each strategy on a scale of one to three. Each rating is added together for a combined score. **Denominator:** Total number of strategies multiplied by three (highest rating possible)
Data Sources and Data Issues:	South Dakota MCH developed data collection form
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes.

2016-2020: ESM 5.3 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure implementation of infant safe sleep practices.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Reduce infant mortality
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Rating on implementation of each strategy on a scale of one to three. Each rating is added together for a combined score.</td></tr><tr><td>**Denominator:**</td><td>Total number of strategies multiplied by three (highest rating possible)</td></tr></table>
Data Sources and Data Issues:	South Dakota MCH developed data collection form
Significance:	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side or stomach sleep positions, the AAP has long recommended the back to sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment to include use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing) and without loose bedding.

2016-2020: ESM 6.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to improve early identification and referral of developmental delays.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Improve early identification and referral of developmental delays.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Rating on implementation of each strategy on a scale of one to three. Each rating is added together for a combined score.</td></tr>
<tr><td>Denominator:</td><td>Total number of strategies multiplied by three (highest rating possible).</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>South Dakota MCH developed data collection form.</td></tr>
<tr><td>Significance:</td><td>Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low.</td></tr>
</table>

2016-2020: ESM 10.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to increase the percent of adolescents with an annual preventive medical visit.
2016-2020: NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Improve and assure appropriate access to health services and promote positive child and youth development to reduce morbidity and mortality; and promote oral health</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Rating on implementation of each strategy on a scale of one to three. Each rating is added together for a combined score.</td></tr>
<tr><td>Denominator:</td><td>Total number of strategies multiplied by three (highest rating possible)</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>South Dakota MCH developed data collection form</td></tr>
<tr><td>Significance:</td><td>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors, such as unsafe sexual activity, unsafe driving, and substance use, is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. An annual preventive well visit may help adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. The Bright Futures guidelines recommend that adolescents have an annual checkup from age 11 through 21. The visit should cover a comprehensive set of preventive services, such as a physical examination, immunizations, and discussion of health-related behaviors including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.</td></tr>
</table>

2016-2020: ESM 11.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure access to a medical home.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and children and youth with special health care needs.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Rating on implementation of each strategy on a scale of one to three. Each rating is added together for a combined score.</td></tr><tr><td>**Denominator:**</td><td>Total number of strategies multiplied by three (highest rating possible)</td></tr></table>
Data Sources and Data Issues:	South Dakota MCH developed data collection form
Significance:	The AAP specific seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

Form 11
Other State Data

State: South Dakota

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: South Dakota

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Monthly	1		
2) Vital Records Death	Yes	Yes	Monthly	1	Yes	• Infant Birth
3) Medicaid	Yes	No	Annually	12	No	
4) WIC	Yes	Yes	More often than monthly	6	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	6	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	6	Yes	
7) Hospital Discharge	Yes	Yes	Semi-Annually	6	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	12	Yes	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) Pregnancy Mortality Surveillance System	Yes	Yes	Annually	36	Yes	
10) Fatality Review Case Reporting System	Yes	Yes	More often than monthly	0	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None