Maternal and Child Health Services Title V Block Grant

South Dakota

FY 2018 Application/ FY 2016 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

600 East Capitol Avenue | Pierre, SD 57501 P605.773.3361 F605.773.5683

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

June 26, 2017

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 2018 South Dakota Maternal and Child Health Block Grant application and annual report. Should you have any questions concerning this application, please contact Scarlett Bierne at 605.773.4439.

Sincerely,

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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

I.E. Application/Annual Report Executive Summary

After the completion of the 2017 Application and Annual Report, the SD MCH Team was realigned as the newly formed MCH Impact Team. Under this new re-design, MCH workgroups were established for each NPM & SPM. Each of these workgroups were assigned Impact Team Co-leads as well as an MCH Facilitator, in order to maximize effectiveness and ensure accountability. By making this change and moving from two large workgroups to twelve smaller workgroups, MCH team members were more able to closely align their MCH programmatic efforts and strategies to better focus on specific MCH measures and outcomes. These smaller workgroups were tasked with meeting in between the scheduled quarterly MCH Impact meetings in order to implement strategies and ensure that MCH activities moved forward on an ongoing basis. Also, partnership building and collaboration through the MCH Impact Team is deemed high priority in order to enhance outreach and improve outcomes. The workgroups are empowered to add external or interagency partners in order to expand reach and share resources.

In addition, the SD MCH Program had the opportunity to strengthen its MCH infrastructure by realigning job duties of current FTE into new MCH positions. These additions include an MCH Nurse Coordinator position whose primary focus centers on maternal, perinatal and infant health and also leads the SD CoIIN and infant mortality efforts. The second addition to the MCH Team is the MCH Child & Adolescent Coordinator position, which focuses primarily on the child and adolescent health domains as well as coordinating the SD Personal Responsibility Education Program (PREP) and Abstinence grant work activities for the state. Furthermore, an MCH Epidemiologist position has been added to the Office of Child & Family Services. This position will serve as the main contact for MCH data and will work closely with interagency partner, SDSU EA Martin.

The SD MCH State Action Plan reflects the SD DOH 2015-2020 Strategic Plan in order to link SD DOH and MCH programmatic goals and strategies. The results of this effort was the development of the South Dakota Maternal Child Health Office Plan which can be found on the SD DOH website at http://doh.sd.gov/documents/family/MaternalChildHealthPlan.pdf

The guiding strategies for this MCH Office Plan include: (1) enhancing internal and external partnerships to address Maternal Child Health priorities; (2) Utilizing Department of Health communications and social media platforms to enhance education and awareness; (3) Maintaining DOH infrastructure/workforce in order to provide education and outreach to clients and providers; and (4) Maintaining data and epidemiology support to assist with collection and analysis of data.

Below is a table showing where the MCH National and State Performance Measures align with the DOH Goals.

	DOH Goal 1 *Improve the Quality, Accessibility, and Effective Use of Healthcare*	DOH Goal 2 *Support Life-long Health for All South Dakotans*	DOH Goal 3 *Prepare for, Respond to, and Prevent Health Threats*	DOH Goal 4 *Develop and Strengthen Strategic Partnerships to Improve Public Health*	DOH Goal 5 *Maximize the Effectiveness and Strengthen the Infrastructure of the Dept. of Health*
Women/Maternal Health					
NPM 1	•				
SPM 3		•			
Perinatal Infant Health					
NPM 5		•			
Child Health					
NPM 6		•			
SPM 2		•			
Adolescent Health					
NPM 7		•			
NPM 10	•				
SPM 1				•	
Children with Special Health Care Needs					
NPM 11	•				
Cross-Cutting/Life Course					
NPM 13		•			
NPM 14		•			
SPM 4					•

The sections below highlight progress toward our measures as well as a brief description of strategies for the coming year.

Domain: Women/Maternal Health

The priority need is promoting preconception and inter-conception health. Overarching objectives/strategies are aimed at increased awareness of overall preventive medical care and risk factors that affect maternal and child wellness.

NPM 1: Percent of women ages 18-44 with a past year preventative medical visit.

Progress: Although we did not reach our 2015 target of 70.1% there is a significant increase over the last five years in the percent of women with a past year preventive visit with a 2015 rate of 69.8%. In 2014, SD was ranked 17th in the nation for the highest percent of women with a preventive visit.

Strategies:

- Outreach/collaborate with insurance providers to promote women well visits and reminder strategies
- Make resources available to women including what to expect at a well visit

Domain: Perinatal/Infant Health

The priority need is the reduction of infant mortality. Overarching objectives/strategies are aimed at increased awareness of safe sleep practices as well as other factors that affect infant mortality.

NPM 5: Percent of infants placed to sleep on their backs

Progress: The SD 2014 rate of 86.7% is greater than the HP 2020 target of 75.9%.
Strategies:

- Provide training to interpreters to promote education on the importance of safe sleep practices to participants who are non-English speaking
- Implement strategies to increase awareness of the importance of safe sleep practices targeted to American Indians, dads, and grandparents
- Train law enforcement on use of Sudden Unexplained Infant Death Investigation (SUIDI) reporting forms

Domain: Child Health

The priority need is promoting positive child and youth development to reduce morbidity and mortality. Overarching objectives/strategies are aimed at increased awareness of importance of developmental screening and early identification of concerns and risk factors that affect positive child and youth development.

NPM 6: Percent of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool

Progress: The most recent percent of children (10-71 months of age) receiving a developmental screening tool was 23.5% in 2011-2012. This rate was significantly lower than the US rate in similar years and is below the HP 2020 target of 24.9%. There has been no significant trend between 2007 and 2012.
Strategies:

- Facilitate the completion of developmental screenings and anticipatory guidance for clients served by the DOH

Domain: Adolescent Health

The priority need is to improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN; and promote positive child and youth development to reduce morbidity and mortality. Overarching objectives/strategies are aimed at preventing adolescent injuries, suicides, and motor vehicle deaths through awareness of importance of preventive service visits and healthy life style choices.

NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Progress: Rate of hospitalization for non-fatal injury per 100,000 ***children ages 0 through 9*** The SD 2014 rate of 210.6/100,000 is above the 2014 Objective of 180.6/100,000. There has been no significant trend between 2007 and 2014. In 2013, SD was ranked 36th (out of 43) in the nation in rate of hospitalization for non-fatal injury for children ages 0 through 9 years.
Rate of hospitalization for non-fatal injury per 100,000 ***adolescents ages 10 through 19:*** The SD 2014 rate of 335.0/100,000 met the 2014 Objective of 335.0/100,000 and there has been a significant decrease in this rate between 2010 and 2014 (399.6 to 335.0/100,000). In 2013, SD was ranked 42nd (out of 43) in the nation in rate of hospitalization for non-fatal injury for children ages 10 through 19 years.
Strategies:

- Explore a collaborative website for adolescent health information

NPM 10: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year

Progress: Although the 2011/12 rate of 72.6% is below the 2014 Objective of 73.0% and the HP 2020 target of 75.6%, the percent is significantly lower than the US rate in 2011/12. There has been a significant increase in the percent of adolescents with a preventive medical visit from 66.7% in 2003 to 72.6% in 2011/12.
Strategies:

- Outreach/collaborate with insurance providers to promote adolescent well visits and reminder strategies

- Provide resources for providers on Bright Futures guidelines and the value of provider one-on-one time with adolescents
- Implementation of 6th grade vaccination requirements
- Target messaging regarding tobacco cessation coaching for adolescents

Domain: Children and Youth with Special Health Care Needs

The priority need is to improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN. Overarching objectives/strategies are aimed at the early identification and treatment of newborns with metabolic disorders and increasing the number of children with and without special health care needs having a medical home.

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

Progress: Percent of children ***with*** special health care needs having a medical home: The SD 2011/12 rate of 52.7% was higher, but not significantly higher, than the US rate during the same time period. There has been no significant trend between 2007 and 2011/12.

NPM 11: Percent of children ***without*** special health care needs having a medical home: The SD 2011/12 rate of 63.2% was significantly higher than the US 2011/12 rate and close to the HP 2020 target of 63.3%. However, there has been a significant decrease in the percent of children without special health care needs who have a medical home between 2007 and 2011/12.

Strategies:

- Provide information and education to primary care providers, pediatric specialists, and community providers on medical home model
- Assist families of children and youth with special health care needs with costs incurred as a result of their child's chronic health condition that are not covered by other sources
- Coordinate the newborn screening infrastructure

Domain: Cross-cutting/Life Course

The priority needs are promoting oral health for all populations; promote positive child and youth development to reduce morbidity and mortality; and improve state and local surveillance, data collection, and evaluation capacity. Overarching objectives/strategies are aimed at increased awareness of importance of oral health across the life span; dangers of tobacco use; and importance of data to support program efforts.

NPM 13A: Percent of women who had a dental visit during pregnancy

Progress: In 2014, it is estimated that 47.0% of women had a dental visit during pregnancy. This is slightly less than the HP 2020 target of 49.0%.

Strategies:

- Enhance oral health messaging via DOH media platforms to increase public awareness

NPM 13B: Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Progress: In 2011/12, 77.8% of infants and children received a preventive dental visit. This is less than the HP 2020 target of 86.2%. There has been a significant decrease in the percent between 2007 (80.7%) and 2011/12. In 2007, SD was ranked 16th in the nation for the highest percent of infants and children receiving a dental visit in the past year.

Strategies:

- Provide oral health information to new mothers through the Bright Start Welcome Box
- Conduct Oral Health Basic Screening Survey of 3rd graders

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NPM 14A: Percent of women who smoke during pregnancy

Progress: The SD 2015 rate of 14.0% is slightly higher than the 2015 Objective of 13.7% and is higher than the HP 2020 target of 1.4%. There has been a significant downward trend over the last five years with 16.9% of pregnant women smoking in 2011. In 2014, SD ranked 35th (out of 46) in the nation in the lowest percent of women who smoke during pregnancy

Strategies:

- Include smoking cessation and promote tobacco free environment message via DOH media platforms

NPM 14B: Percent of children who live in households where someone smokes

Progress: The SD 2011/12 rate of 27.5% is higher than the HP 2020 target of 23.6%. There has been a significant downward trend since 2003 when 34.9% of children lived in a household where someone smoked. In 2007, SD ranked 16th in the nation in the lowest percent of children who live in households where someone smokes.

Strategies:

- Include smoking cessation and promote tobacco free environment message via DOH media platforms

During FFY 2018 we will continue to develop and/or implement the following overarching strategies across the domains:

- Maintain DOH infrastructure/workforce in order to provide education and outreach to our populations;
- Collaborate with partners to support and strengthen efforts across multiple state agencies/programs;
- Develop MCH website pages to promote services and resources;
- Develop messaging to be utilized in multiple formats;
- Disseminate and utilize MCH data to support efforts and identify areas for improvement/change; and
- Continue to support outreach to disparate populations.

More detail about strategies and activities can be found in the Block Grant Report/Application.

II. Components of the Application/Annual Report

II.A. Overview of the State

II.A. Overview of the State

South Dakota is one of the nation's most rural states. According to the 2014 U.S. Census, there are 835,175 persons living within its 75,885 square miles – an average population density of 11.2 people per square mile. Only nine of South Dakota's 66 counties have a population of 20,000 or more. The remaining counties are either rural (23 counties) or frontier (34 counties). Twenty-six percent of the state's population lives in a frontier county. Much like some of its surrounding states, despite falling populations in rural counties, the overall population of South Dakota is increasing (percent increase from 2010 to 2014 was 4.8%). Of the state's total population, 85.7% are White, 8.9% are Native American, and the remaining 5.4% are classified as some other race.

According to 2015 population estimates from the US Census Bureau, 24.6% of the state's population are children (under the age of 18) while 7.1% are age 4 or younger. Roughly 37% (37.0%) of the state's female population is considered to be of childbearing age (age 15 through 44). In 2015, there were 12,587 resident pregnancies (26 of those were to women not in the 15-44 year age range). Pregnancies are estimated by totaling resident pregnancies producing at least one live birth, fetal deaths, and abortions.

The economic status of individuals in the state, particularly in the Native American population, is a major barrier to accessing services. The following table provides data from the U.S. Census Bureau related to poverty levels for all people as well as children ages 0-17 by county for selected reservation counties in South Dakota.

	All people in poverty (2013)	**Children ages 0-17 in poverty (2013)**
United States	15.8%	22.2%
South Dakota	14.0%	18.6%
Cheyenne River Reservation - Dewey County - Ziebach County	28.7% 48.7%	35.4% 55.4%
Crow Creek Reservation - Buffalo County	41.0%	47.5%
Rosebud Reservation - Todd County	44.0%	51.1%
Pine Ridge Reservation - Oglala Sioux County (formerly Shannon Co.)	55.1%	53.4%
Standing Rock Reservation - Corson County	43.0%	53.4%

Access to primary care providers is limited in the state. As of May 31, 2017, there were 4,080 physician (includes physician in other states who provide telemedicine services in state) and 604 physician assistants licensed in the

state. As of May 31, 2017, there were 876 actively licensed nurse practitioners and 36 actively licensed nurse midwives in South Dakota. About two-thirds of the state is designated by the federal government as a Health Professional Shortage Area (HPSA).

Another factor to consider is transportation to access services. For some, this means traveling great distances (over 50 miles) to see a primary care provider and even further to see a specialist. The majority of specialists and children's hospitals are 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. On Indian reservations, this problem is further complicated by the lack of a reliable transportation system. The DOH CSHS program does reimburse travel expenses incurred when traveling for specialty care for eligible CYSHCNs.

South Dakota has 49 general community hospitals, of which 38 are critical access hospitals (CAHs). There are five federally qualified health centers (FQHCs) with 32 delivery sites and 60 rural health clinics. There are five Indian Health Services (IHS) hospitals in South Dakota, of which only two provide routine obstetrical services. Recruitment and retention of primary care providers is a significant challenge for the Aberdeen Area IHS on South Dakota reservations. Housing and schools are problems South Dakota reservations face when recruiting healthcare providers. In addition, many providers do not want to go to South Dakota IHS facilities because the service area does not provide a full range of health care services (i.e., surgery, obstetrics, etc.) and providers do not want to lose competencies.

Projections indicate that thousands of additional healthcare workers will be needed in the healthcare industry in South Dakota in the near future. In addition, there will be a substantial decrease in the number of high school graduates in our state. At the same time as the number of young people decreases, the number of elderly is increasing significantly. By the year 2025, South Dakota is projected to have the 9th highest portion of elderly nationally. In order to begin to address these needs, the South Dakota Healthcare Workforce Initiative, a collaborative effort between DOH, DOE, the Department of Labor, and the Board of Regents, has been implemented. The overall goal of this initiative is to address healthcare workforce issues in South Dakota and to work toward ensuring a competent and qualified healthcare workforce that meets the needs of all South Dakota citizens.

The MCH program continues to identify ways to address challenges such as Native American disparities; educating participants on program requirements and resources; finding adequately trained/prepared individuals for workforce, especially in remote counties and reservation communities; decreased funding; impact of ACA; and appropriately working with cultural differences and beliefs. Due to the high staff turnover rate within IHS and tribal programs, it is difficult to build sustained relationships and continuity to coordinate partnerships/efforts. The DOH remains committed to fostering relationships with both IHS staff and tribal government/tribal health to discuss MCH services on South Dakota Indian reservations. In addition, the DOH continues to struggle with how to best address the challenge of not being the lead agency on numerous MCH initiatives/measures, including how to best blend the grant requirements and funding without having duplication of efforts and services.

In January 2016, the DOH released its 2015-2020 Strategic Plan. The strategic plan provides a road map for the future of the DOH 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 the DOH 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 strategic planning workgroup included both central and field office staff and both administrators and program staff. An internal SWOT analysis was sent to all DOH employees to get input regarding strengths, weaknesses, opportunities, and threats of the department. In addition, an external SWOT was sent to partners (i.e., healthcare providers, health organizations/ associations, legislators, IHS/tribal representatives, medical/nursing schools,

philanthropic foundations, other state agencies) to get input regarding the strengths, weaknesses, opportunities, and threats of South Dakota's public health system.

The strategic plan consists of the DOH vision (Healthy People, Healthy Communities, Healthy South Dakota), mission (to promote, protect and improve the health of every South Dakotan) and guiding principles (serve with integrity and respect, eliminate health disparities, demonstrate leadership and accountability, focus on prevention and outcomes, leverage partnerships, and promote innovation). The strategic plan was updated in January 2017 and includes the following goals and objectives:

Goal 1 – Improve the quality, accessibility, and effective use of healthcare
A. Promote the right care at the right time in the right setting
B. Sustain healthcare services across South Dakota
C. Provide effective oversight and assistance to assure quality healthcare facilities, professionals, and services

Goal 2 – Support life-long health for South Dakotans
A. Reduce infant mortality and improve the health of infants, children, and adolescents
B. Increase prevention activities to reduce injuries
C. Prevent and reduce the burden of chronic disease

Goal 3 – Prepare for, respond to, and prevent public health threats
A. Prevent and control infectious disease
B. Build and maintain State Public Health Laboratory capacity and ensure a culture of biosafety
C. Identify the top hazardous environmental conditions in South Dakota that negatively impact human health
D. Strengthen South Dakota's response to current and emerging public health threats
E. Prevent injury and illness through effective education and regulation

Goal 4 – Develop and strengthen strategic partnerships to improve public health
A. Reduce completed and attempted suicides through statewide and local efforts
B. Reduce the health impact of substance abuse and mental health disorders
C. Reduce health disparities of at-risk populations through innovative and collaborative efforts

Goal 5 – Maximize the effectiveness and strengthen the infrastructure of the Department of Health
A. Increase effective communication
B. Promote a culture of organizational excellence
C. Leverage resources to accomplish the Department of Health's mission

Each objective has key strategies to help guide DOH activities. There are also 33 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/.

During the 2017 legislative session there were several bills which passed that impact the MCH population in South Dakota.

- SB 1 makes enhancements to the Prescription Drug Monitoring Program (PDMP) including providing for integration of PDMP into electronic medical records to allow for near immediate access to PDMP data by providers. Requires dispensers to submit information to the PDMP at least every 24-hours instead of weekly as is currently required. Requires any prescriber or dispenser with a controlled substance registration issued by the

DOH to be registered with the PDMP.

- SB 61 removes the requirement for a nurse practitioner (NP) or nurse midwife (NM) to have a written collaborative agreement in place with a physician to practice in the state (NPs/NMs with less than 1,040 hours of practice must still have a written collaborative agreement with a physician, NP or NM).
- SB 136 establishes a 5-member Board of Certified Professional Midwives (CPM) and requires any individual practicing as a CPM or student to be licensed by the Board. Establishes a scope of practice, defines education requirements, defines unprofessional conduct, and provides for enforcement authority against those persons found in violation. CPMs provide care of the low-risk mother-baby unit in an out-of-hospital setting. Low-risk is defined as a pregnancy that is anticipated to be problem free based on an assessment of the woman's past medical history and ongoing assessment throughout pregnancy, labor, delivery, and postpartum care. The board is required to review birth registration and reportable information for each out-of-hospital birth for evaluation and quality management purposes and the CPM must report any neonatal or maternal mortality in a patient for whom the CPM cared for during the perinatal period to the board within 48 hours of the death.

In May 2011, Governor Daugaard appointed a Task Force on Infant Mortality to study the state's infant mortality rate and how to reduce it. First Lady Linda Daugaard served as the task force chair. The recommendations and accompanying strategies of the Task Force were intended as a starting point for action by state government, health care providers, hospitals, tribes, parents, communities, and others to reduce infant mortality and improve infant health in South Dakota. Initial recommendations that continue to drive the focus of current activities included: (1) improve access to early, comprehensive prenatal care; (2) promote awareness and implementation of safe sleep practices; (3) develop community-based systems of support for families; (4) conduct statewide education campaigns to reduce infant mortality; (5) develop resources for health professionals specific to infant mortality prevention; and (6) improve data collection and analysis. A copy of the Task Force final report from 2012 can be found at: http://doh.sd.gov/infant-mortality/.

The department continues to promote infant mortality prevention messaging through social media platforms and statewide media campaigns. Culturally appropriate messaging has been developed for outlets serving Native American populations. Key messaging has focused on early recognition of pregnancy, early and adequate prenatal care, infant safe sleep, and tobacco cessation. A recent campaign challenged grandparents to help families start new infant safe sleep traditions. Pregnant women are a priority population of the SD QuitLine for tobacco prevention/cessation. Recent campaigns included additional sessions for pregnant women and expanded services for postpartum women to provide support and incentives to quit and stay quit. Another partner, Medicaid, has also expanded services to pregnant women who were not previously eligible due to citizenship status.

The Department of Health has provided funding since 2012 for the Cribs for Kids program. DOH partners with several Tribal communities to reach underserved populations; with DSS to reach child care providers; and with the Teddy Bear Den, an incentive program serving the low-income population in South Dakota's largest city. Six birthing hospitals have established independent Cribs for Kids services as a result of collaboration with DOH.

First Lady Linda Daugaard continues to champion infant mortality awareness and prevention efforts. In 2015 she obtained pledges from all 24 birthing hospitals in South Dakota to reduce early elective deliveries. The For Baby's Sake web site and media platform http://forbabysakesd.com/ content has been expanded beyond initial key messaging to promote preconception health, vaccinations, breastfeeding, and emerging public health threats such as Zika.

Key to efforts has been improved data collection through the support of statewide infant death review and the funding of a statewide CDC PRAMS survey in 2017. The DOH supported a PRAMS-like survey in 2014 and again in 2016 to gather data to drive program strategies and measure outcomes. Data briefs and infographics will be developed

and disseminated to partners on topics such as pregnant women and tobacco use, breastfeeding, prenatal care and infant death review. A recent ad was placed in the S.D. Medical Journal encouraging provider awareness of barriers to early prenatal care identified by survey participants.

The Primary Care Task Force Oversight Committee was established in 2013 to monitor implementation of the recommendations of the 2012 Governor's Primary Care Task Force. The original Task Force was appointed to consider and make recommendations to ensure accessibility to primary care for all South Dakotans, particularly in rural areas of the state and developed recommendations around five specific areas: (1) capacity of healthcare educational programs; (2) quality rural health experiences; (3) recruitment and retention; (4) innovative primary care models; and (5) accountability and oversight. Some key accomplishments include:

- $2.2 million for expansion of the School of Medicine class size by 15 students per year (60 total);
- Physician assistant program capacity expanded from 20 students (10 resident/ 10 non-resident) to 25 students (20 resident/5 non-resident students);
- Secured general fund appropriations to support payments to South Dakota providers serving as preceptors to PA and NP students. Preceptors serve as mentors for medical, PA, and NP students and give personal instruction, training, and supervision to the student;
- $205,000 in start-up funding for a rural family medicine residency track to add 6 additional family medicine residency slots in the state;
- Funding for Frontier and Rural Medicine (FARM) Program included in Sanford School of Medicine (SSOM) expansions. FARM is a rural training track program which provides up to nine 3rd year medical students with a 9-month clinical training in a rural community; and
- Provided funding for Rural Experiences for Health Professions Students (REHPS) program for 24 students in 12 rural or frontier communities. REHPS provides first and second year medical, PA, NP, pharmacy, clinical psychology, masters of social works, and medical laboratory students with experience in a rural setting with the ultimate goal of increasing the number of medical professionals who practice in rural and frontier communities in South Dakota.

Information on the Primary Care Task Force Oversight Committee can be found at http://doh.sd.gov/PrimaryCare/.

The DOH was awarded a *Prescription Drug Overdose: Data-Driven Prevention Initiative* planning grant from CDC to support/build efforts to track and understand the full impact of opioid use and abuse in South Dakota. There are two required strategies:

- Planning strategy – An Advisory Committee has been formed to conduct needs assessment of potential data sources, key stakeholders and gaps. Membership includes DOH, DSS, SD State Medical Association, SD Pharmacy Association, Board of Medical and Osteopathic Examiners, Board of Pharmacy, Attorney General Office, SD Association of Healthcare Organizations, IHS, tribal health, Volunteers of America (treatment/community support), and legislators. The advisory committee has met three times and is currently completing the needs assessment. An initial draft of the strategic plan to address identified needs and strengthen the state's capacity to prevent misuse and abuse of opioids will be developed by late fall 2017.

Data strategy – The DOH is working with partners to enhance and integrate current surveillance efforts for more accurate, timely data (i.e., death certificates, Prescription Drug Monitoring Program, hospital discharge data, Medicaid/ 3rd party payer data, Health Link (hub for data sharing)).

II.B. Five Year Needs Assessment Summary and Updates

FY 2018 Application/FY 2016 Annual Report Update

II.B. Five Year Needs Assessment Summary

PROCESS UPDATES

After the completion of the 2015 Annual Report and 2017 Application, the MCH Team was realigned as the MCH Impact Team. Under this umbrella group, workgroups were established for each NPM and SPM. Each workgroup was assigned co-leads as well as an MCH Facilitator. By going from two large workgroups to twelve, team members were able to more closely align their program/work efforts with specific measures and strategies. These workgroups were asked to meet in-between quarterly large workgroup meetings to ensure implementation of strategies. No new SPMs were identified or changed. At this time no ESMs were changed. It is intended that the MCH Impact Team will review the ESMs during the 2018 Application year to ensure the measures are more accurately reflecting progress toward the identified strategies and objectives. While preparing our annual report updates and reviewing data, it was identified that some of our objectives did not have clearly defined numerators and denominators. Upon further review of what data could and could not be captured, some objectives were edited or removed.

In addition, the DOH contracts with an epi group to continually analyze our available data and develop fact sheets/articles based on their findings. This information is shared with our Impact Team and partners for information sharing and program planning purposes.

During the 2018 Application year, the DOH will be developing a MCH website and assessing the MCH Hotline to ensure families and providers have access to information about the Title V program and services and information available that impact the maternal and child health population.

TITLE V PROGRAM CAPACITY UPDATES

The MCH infrastructure continues to change and strengthen as we review job duties as positions are vacated and realign programs and priorities prior to requesting new hires. This past year a position opened that had been dedicated to CYSHCN and Infant Death Review Coordination. This position was changed to a MCH Nurse Coordinator position to address infant mortality, pregnant women, infants, and coordinate Infant Death Review. Another position that supported community health services was utilized to create a MCH Child/Adolescent Coordinator position. This position will facilitate the work under the MCH child and adolescent health domains as well as coordinate the PREP and Abstinence grants.

As a part of the State FY18 budget and the 2017 Legislative session, two FTEs were requested by the Office of Child and Family Services. Both FTEs were approved and are in the process of being hired. One is an MCH Epidemiologist to work with data, program evaluation, and improvement. The other position is an eWIC Coordinator to lead the efforts of WIC electronic benefits implementation and integrity. The level of Executive Management support for the MCH program is evident in the provision for change and additional staff to implement change.

AGENCY CAPACITY UPDATES

The DOH operates the Bright Start program in 12 counties (Pennington, Butte, Lawrence, Oglala Lakota, Bennett, Stanley, Lyman, Hughes, Beadle, Marshall, Day and Roberts) while Children's Home Society operates the program

in partnership with the DOH in Sioux Falls and the surrounding communities. Bright Start uses Maternal Infant and Early Childhood Home Visiting (MIECHV) funds in 11 of the counties, and state Medicaid and TANF funds in Rapid City, Sioux Falls and Pine Ridge. The program uses the Nurse Family Partnership (NFP) model, as well as a home-grown curriculum in non-MIECHV funded counties. In FY 2016, 596 Bright Start families were served by the DOH.

The DOH operates the WIC program statewide. Since 2013 WIC has worked to update the SDWIC-IT system and in 2016 developed a committee of clinic representatives to assist us with prioritizing development and recommendations for improvements. WIC is currently in the process of implementing Electronic Benefit Transfer from a paper check process with statewide implementation to occur by mid-September 2017. WIC had approximately 193 full service grocery stores authorized to accept WIC benefits in FFY2016.

MCH WORKFORCE DEVELOPMENT AND CAPACITY UPDATES

Preventive and primary care services to the MCH population are provided through OCFS. These services focus on mothers, infants, children, family planning and case management. OCFS provides direction to state-employed nurses, nutrition educators, and dietitians for the provision of public health services in the state. This includes 89 field staff utilizing 18.0 FTE. This also includes 13 Central Office Staff which utilizes 7.06 FTE. Linda Ahrendt is the OCFS Administrator and Title V Administrator and has been with the DOH for 17 years. Scarlett Bierne is the OCFS Assistant Administrator and MCH Director and has been with the DOH for 10 years. Barb Hemmelman serves as the CYSHCN Director. Barb has been with the DOH since September 2004. Other MCH team members include the following:

- Sue Alverson, State Nutritionist
- Rhonda Buntrock, WIC Program Administrator
- Carolyn McGlade, State WIC Nutrition Coordinator
- Carrie Churchill, Home Visiting Program Manager
- Dee Dee Dugstad, Tobacco Control Program Coordinator
- Laura Streich, Tobacco Disparities Coordinator
- Lucy Fossen, Newborn Metabolic/Hearing Screening Coordinator
- Sara Gloe, SDFP Program Nurse Manager
- Emily Johnson, SDFP Nurse Consultant/Sexual Violence Prevention Coordinator
- Jill Munger, MCH Nurse Consultant/Infant Death Review Coordinator
- Connie Johnson, MCH Child/Adolescent Coordinator
- Tim Heath, Immunization Program
- Megan Hlavacek, Healthy Foods Coordinator
- Wade Huntington, Regional Manager
- Tammy Hybertson, Regional Manager
- Cherie Koch, Regional Manager
- Julie Miller, Regional Manager
- Vacant, Regional Manager
- Jennifer Fouberg, Regional Manager
- Jessica Scharfenberg, Regional Manager
- Peggy Seurer, OCFS Assistant Administrator – Public Health/Clinical Services Manager
- Bobbi Jo Peltier, Aberdeen Area IHS
- Susan Sporrer, Director of Policy and Special Projects
- Marty Link, Trauma Program Manager
- Mark Gildemaster, Manager, Data and Statistics
- Michelle Hoffman, Data and Statistics

- Ashley Miller, Chronic Disease Epidemiologist
- EA Martin, SDSU contract MCH and home visiting epidemiology

PARTNERSHIPS, COLLABORATION, AND COORDINATION UPDATES

Other Federal Investments –

HRSA Early Hearing Detection and Intervention (EHDI) funds were used to establish the SD EHDI Collaborative in partnership with the University of South Dakota to provide EHDI support and engagement activities with hospitals, physicians, audiologists, nurse midwives and parents. A newly developed SD EHDI Advisory board has begun quarterly meetings to provide feedback and guidance toward initiatives of the grant that will expand to ensure 25% family representation. Grant activities include parent support /deaf mentor program; DOH EHDI website enhancement; birthing facility toolkit/training; established EHDI communities of practice (COP) updated to Learning Community; medical home toolkit; and exploring IHS, WIC and home visiting partnerships.

Following the September 2015 Title X site review, the U.S. Department of Health and Human Services Region VIII Office of Family Planning recommended South Dakota "conduct a review of Community Health Sites (CHS) for efficiency and effectiveness of Title X Services and funding." South Dakota Family Planning Program (SDFPP) consolidated CHS offices and hope to establish partnerships with FQHC medical clinics located through South Dakota to increase full service delivery locations. The review was a thorough process that considered many factors including geographical location, client numbers, and infrastructure of the county/department. The SDFPP consolidated 41 service sites into 21. With fewer sites, SDFPP central staff can focus efforts on-ongoing training of family planning clinical staff and billing staff; providing frequent and effective onsite audits, contract oversight, and improve quality patient services. In calendar year 2016, the South Dakota Title X program provided services to 5,328 South Dakotans.

WIC serves participants through 78 clinic sites statewide (all but 3 counties in the state have a clinic). In addition the WIC program works cooperatively with three Indian Tribal Organizations (Cheyenne River, Rosebud Sioux, and Standing Rock) to ensure the entire state is covered for WIC services. In federal fiscal year 2016 WIC served on average 17,174 participants. WIC was able to serve 98% of the income eligible infants but only 44% of the income eligible children. Overall, WIC is serving 58% of all WIC income eligible participants. The WIC Program was awarded Breastfeeding Bonus funding as South Dakota was one of eight states nationally to have the largest increase in fully breastfed infants. This funding was used to provide Certified Lactation Counseling training for dietitians and nursing professionals within the Department of Health. The WIC program also received funding to launch a child retention media campaign that will include social media efforts, revision of the WIC Program logo, development of new marketing posters and Public Service Announcements. A new website, www.sdwic.org, has also been developed. To increase the ability of the WIC Program to provide nutrition education in remote areas of the state, South Dakota was awarded grant funding to pilot tele-nutrition education initiatives. This will allow participants to receive nutrition education via the use of technology. By September 2017, WIC will have Electronic Benefit Transfer system (eWic) for the provision of WIC benefits. This will eliminate the paper check system for purchasing foods at retailers. In addition, WIC is working to develop the infrastructure to support data analysis efforts for pregnancy and pediatric nutrition surveillance for the Mt. Plains Region; piloting a new Breastfeeding Peer Counseling tracking system; and providing Breastfeeding Peer Counseling statewide; and developed new Breastfeeding toolkits for pregnant and breastfeeding women to encourage breastfeeding and improve duration rates.

Other DOH Programs –

As of 2016, the SD QuitLine has assisted nearly 91,000 South Dakotans in their efforts to quit smoking. The SD

QuitLine has one of the most successful quit rates in the country at 42.9%.

The South Dakota Vaccines for Children program supplies vaccine to 250 facilities across the state. All Advisory Committee on Immunization Practices recommended vaccines are supplied. South Dakota has approximately 116,600 children 0 through 18 eligible for the program which is 53% of all persons in that age group.

Other Government Agencies –

DOH and DSS financially support the SD HelpLine Center to provide suicide prevention activities across the state.

The DOH has a MOU with Medicaid to share data and collaboratively work on key issues each agency would like to address through data analysis. This collaboration has been assisted in looking at oral health, chronic disease, and prenatal care. Medicaid data analysis will also assist with provider training to enhance quality of care.

Medicaid and MCH have worked together on a child well visit infographic to promote preventive visits and improve immunization rates among parents. Providers received guidance on Bright Futures Guidelines and reimbursement rates for preventive care as a part of the MCH work on increasing preventive medical visits of women, child, and adolescents.

In addition Community Health Services has agreements with DSS Medicaid for reimbursement of services.

Tribes/Tribal Organizations –

The Home Visiting program is implemented in three of the nine reservations in SD reservation areas so cultural competence is very important to working with native clients/community partners.

In Sisseton, the Nurse Home Visitor and Rural Team Site Coordinator are members of the First 1000 Days Interagency Committee formed to focus on educating service providers and community members on mitigating toxic stress in childhood, as well as including a roundtable discussion on community issues and program sharing. The site coordinator provided a presentation to the entire committee on the results of the 2014 statewide PRAMS, to share discussion on how the PRAMS data applies to maternal and infant health in the Sisseton community. In Pine Ridge, the Home Visiting Community Advisory Board, “Raising Healthy Families Together – Thiwahe Zani Okičhiya Ichaȟwičhayapi ” meets quarterly and is convened by the DOH Home Visiting team. The meetings usually involve a featured program presentation, followed by roundtable sharing which involves discussion of community needs and issues.

During the past year Home Visiting program staff provided support via two teleconferences to the Arizona MIECHV program to share tribal outreach strategies.

Delta Dental Mobile Program - The DOH promotes and refers individuals to Delta Dental of South Dakota’s mobile dental program which has provided preventive and restorative care to underserved children across South Dakota since 2004. Delta Dental manages, operates and staff the two mobile dental trucks, and works with local community site partners to identify children up to age 21 most in need of care who can least afford it. Dental services provided include teeth cleaning, fillings for cavities, tooth extractions, dental sealants, fluoride treatments, instructions on care of teeth/gums, and tobacco/smoking cessation counseling. The dental trucks typically spend a week in each community and each truck is on the road roughly 40 weeks a year. Since September 2004, the Delta Dental Mobile Program has visited 81 communities across the state (including 30 Native American communities) and has served

nearly 35,000 children. The retail dollar value of care provided is more than $17.4 million. After completing a three-year grant-funded program in 2015 that focused on reducing disparities by providing preventive oral care on South Dakota's nine Native American reservations, Delta Dental elected to combine that program into a new version of the Delta Dental Mobile Program. That aspect of the program includes seven dental hygienists and three community health workers who provide reservation-based services including teeth cleanings, dental sealants and fluoride applications as well as oral health education and care coordination. In 2016, the community-based staff served 4,720 children ages 0 through the 8th grade. In total, Delta Dental's clinical services program served 8,553 patients in 2016.

FY 2017 Application/FY 2015 Annual Report Update

PROCESS UPDATES

As noted above, the 2015-2020 Department of Health Strategic Plan was released in January 2016.

The DOH realigned its MCH team to include two separate workgroups led by four MCH team facilitators. One MCH workgroup focuses on strategies around Child/Adolescent Health and Children, Youth with Special Health Care Needs and the second workgroup focuses its efforts on Women and Maternal Health/Perinatal Infant Health strategies. These teams meet on a re-occurring basis and are tasked with monitoring and updating MCH data measures, expanding both internal/external MCH memberships as appropriate and revising and providing oversight for the MCH state plan objectives and strategies. In addition, both MCH teams meet as a larger group on a monthly basis to discuss and share MCH block grant data and evaluation needs. The data and evaluation meetings are designed to increase utilization and dissemination of data across the MCH programs. The revised MCH workgroup structure was developed in order to enhance internal and external partnerships to address MCH priorities, utilize DOH communications and social media platforms to enhance education and awareness, maintain DOH infrastructure/workforce in order to provide education and outreach to clients and providers, and maintain data and epidemiology support to assist with the collection and analysis of MCH data. In addition, this year the MCH team was pulled together to choose SPMs as well as ESMs for the MCH SAP. During this process, the MCH Team decided to include only NPMs, SPMs that reflect current MCH activities and ESMs that are meaningful as well as measurable. The ESMs and SPMs selected by the MCH Team include:

ESMs

- ESM 1.1: Number of partners who collaborate to promote well women visits
- ESM 5.1: Number of page engagements to the For Baby's Sake Facebook page
- ESM 5.2: Percent of infant deaths reviewed for which a SUIDI reporting form was received
- ESM 6.1: Number and type of partnerships to promote early childhood screening
- ESM 7.1: Number of partners convened specific to motor vehicle safety activities
- ESM 10.1: Number of providers offered resources and outreach regarding Bright Futures
- ESM 11.1: Number of trainings for providers on components of medical home model
- ESM 13.1: Number of media platforms (i.e., websites, Facebook, TV, radio, print) that promote oral health messaging
- ESM 14.1: Number of media platforms (i.e., websites, Facebook, TV, radio, print) that includes tobacco prevention/cessation messages

SPMs

- SPM 1: Percent of suicide attempts by adolescents ages 14 through 18
- SPM 2: Percentage of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85the percentile (overweight or obese)
- SPM 3: Percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent
- SPM 4: MCH data is analyzed and disseminated

TITLE V PROGRAM CAPACITY UPDATES

The name of the Office of Family and Community Health was changed to the Office of Child and Family Services.

As of September 2015 when SCID was implemented, South Dakota now screens for 29 disorders either pursuant to statute or administrative rule.

AGENCY CAPACITY UPDATES

The DOH operates the Bright Start program in 12 counties (Pennington, Butte, Lawrence, Oglala Lakota, Bennett, Stanley, Lyman, Hughes, Beadle, Marshall, Day and Roberts) while Children's Home Society operates the program in partnership with the DOH in Sioux Falls and the surrounding communities. Bright Start uses Maternal Infant and Early Childhood Home Visiting (MIECHV) funds in 11 of the counties, and state Medicaid and TANF funds in Rapid City, Sioux Falls and Pine Ridge. The program uses the Nurse Family Partnership (NFP) model, as well as a home-grown curriculum in non-MIECHV funded counties. In FY 2015, 636 Bright Start families were served by the DOH.

MCH WORKFORCE DEVELOPMENT AND CAPACITY UPDATES

Preventive and primary care services to the MCH population are provided through OCFS. These services focus on mothers, infants, children, family planning and case management. OCFS provides direction to state-employed nurses, nutrition educators, and dietitians for the provision of public health services in the state. This includes 85 field staff utilizing 12.79 FTE. This also includes 13 Central Office Staff which utilizes 7.06 FTE. In addition, Linda Ahrendt was named the OCFS Administrator and Title V Administrator in November 2015. Linda has been with the DOH for 16 years and prior to becoming OCFS Administrator was the OCDPHP Administrator. Scarlett Bierne is the OCFS Assistant Administrator & MCH Director. Scarlett has been with the DOH for 9 years and prior to moving to OCFS worked in OCDPHP and Office of Disease Prevention Services (ODPS). Barb Hemmelman serves as the CYSHCN Director. Barb has been with the DOH since September 2004. Other MCH team members include the following:

- Amanda Ainslie, SDFP Nurse Consultant & Sexual Violence Coordinator
- Sue Alverson, State Nutritionist
- Rhonda Buntrock, WIC Program Administrator
- Carrie Churchill, Home Visiting Program Manager
- Dee Dee Dugstad, TCP Coordinator
- Julie Ellingson, Oral Health Coordinator/School Health Coordinator
- Lucy Fossen, Newborn Metabolic/Hearing Screening Coordinator
- Jennifer Fouberg, Regional Manager
- Mark Gildemaster, Manager, Data and Statistics
- Sara Gloe, SDFP Program Nurse Manager
- Tim Heath, Immunization Program
- Megan Hlavacek, Healthy Foods Coordinator
- Beth Honerman, Breastfeeding Coordinator
- Wade Huntington, Regional Manager
- Tammy Hybertson, Regional Manager
- Cherie Koch, Regional Manager
- Marty Link, EMS/Trauma Program Manager
- Ashley Miller, Chronic Disease Epidemiologist
- Julie Miller, Regional Manager
- Bobbi Jo Peltier, Aberdeen Area IHS
- Chip Rombough, Regional Manager
- Jessica Scharfenberg, Regional Manager
- Peggy Seurer, OCFS Assistant Administrator – Public Health/Clinical Services Manager
- Susan Sporrer, Director of Policy and Special Projects
- Laura Streich, Tobacco Disparities Coordinator
- Jenny Williams, Infant Death Review Coordinator/CSHS Consultant
- EA Martin, SDSU contract MCH and home visiting epidemiology

PARTNERSHIPS, COLLABORATION, AND COORDINATION UPDATES

Other Federal Investments - CDC EHDI funds were used to establish the SD EHDI Collaborative in partnership with USD to provide EHDI support and engagement activities with hospitals, physicians, audiologists, nurse midwives and parents. A newly developed SD EHDI Advisory board has begun quarterly meetings to provide feedback and guidance toward initiatives of the grant.Grant activities include parent support /mentor program; DOH EHDI website enhancement; birthing facility toolkit/training; establishing EHDI communities of practice (COP); medical home toolkit; and exploring IHS, WIC and home visiting partnerships.

Other DOH Programs - As of 2015, the SD QuitLine has assisted nearly 88,000 South Dakotans in their efforts to quit. The SD QuitLine has one of the most successful quit rates in the country at 41.8%.

Other Government Agencies - DOH and DSS financially support the SD HelpLine Center to provide suicide prevention activities across the state.

Tribes/Tribal Organizations - During the past year Home Visiting program staff collaborated with the Maine MIECHV program to share tribal outreach strategies and tribal government systems in order to enhance the DOH's ability to provide tribal outreach in SD.
The Home Visiting program is implemented in three of the nine reservations in SD reservation areas so cultural competence is very important to working with native clients/community partners. The two home visitors on the Pine Ridge team are Lakota and members of the Oglala Sioux Tribe and the site coordinator has lived within 30 miles of the reservation for 20 years. The Pine Ridge Reservation site is currently a part of a Tribal Formative project that is guided by staff at the Prevention Resource Center (PRC) at the University of Colorado, which serves as the research arm of NFP. This formative work involves two innovations to the traditional NFP model: (1) admitting non-first time (multiparous) women who are less than 28 weeks gestation; (2) assessing and amending the Visit to Visit Guidelines and other service delivery methods to meet the needs of the local American Indian/Alaska Native population. South Dakota chose to have Pine Ridge

participate in this Formative Project due to the extremely high needs of the Oglala-Lakota people, and also to increase the potentially eligible caseload by including multiparous women as clients.
In Sisseton, the Home Visitation program has linked with GPTCHB on ECCS grant activities. The Nurse Home Visitor and Rural Team Site Coordinator are members of the First 1000 Days Interagency Committee formed to carry out the next steps from the Community GONA (Gathering of Native Americans) and the ECCS project on mitigating toxic stress in childhood. The First 1000 Days group supports the work plan of the ECCS project, and has completed a wide variety of activities including community presentations on ACES, planning for the first MCH Resiliency Conference, focus groups for the development of marketing materials, and a community resource directory.

Delta Dental Mobile Program - The DOH promotes and refers individuals to Delta Dental of South Dakota's mobile dental program which has provided preventive and restorative care to underserved children across South Dakota since 2004. Delta Dental manages, operates and staff the two mobile dental trucks, and works with local community site partners to identify children up to age 21 most in need of care who can least afford it. Dental services provided include teeth cleaning, fillings for cavities, tooth extractions, dental sealants, fluoride treatments, instructions on care of teeth/gums, and tobacco/smoking cessation counseling. The trucks typically spend a week in each community and each truck is on the road roughly 40 weeks a year. Since September 2004, the Delta Dental Mobile Program has visited 79 communities across the state (including 28 Native American communities) and has served nearly 30,000 children and more than 1,000 adults. The retail dollar value of care provided is more than $15 million. After completing a three-year grant-funded program in 2015 that focused on reducing disparities by providing preventive oral care on South Dakota's nine Native American reservations, Delta Dental elected to combine that program into a new version of the Delta Dental Mobile Program. That aspect of the program includes seven dental hygienists and three community health workers who provide reservation-based services including teeth cleanings, dental sealants and fluoride applications as well as oral health education and care coordination. In 2015, the community-based staff served nearly 4,400 children ages 0 through the 8th grade. In total, Delta Dental's clinical services program served nearly 7,300 patients in 2015.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

As noted above, the DOH 2020 Initiative provides a clear, concise blueprint for the activities of the DOH:

Improve Birth Outcomes and Health of Infants, Children, and Adolescents in South Dakota

- Increase awareness of the importance of healthy lifestyle choices among women of childbearing age
- Promote awareness and implementation of safe sleep practice
- Improve South Dakota's age-appropriate immunization rate
- Reduce risky behaviors among children and adolescents

Improve the Health Behaviors of South Dakotans to Reduce Chronic Disease

- Work with partners to implement statewide plans to reduce the burden of chronic disease
- Help South Dakotans across the lifespan be physically active, eat healthy, and be tobacco free
- Increase the number of people screened for chronic disease

Strengthen the Healthcare Delivery System in South Dakota

- Provide effective oversight and assistance to assure quality health facilities, professionals, and services
- Sustain essential healthcare services in rural and underserved areas
- Provide effective coordination of health information technology and health information exchange efforts among public and private stakeholders

Strengthen South Dakota's Response to Current and Emerging Public Health Threats

- Maintain and improve the identification, assessment and response to current and emerging public health threats
- Enhance the state's capacity to effectively coordinate the response to current and emerging public health threats
- Establish a dedicated environmental health program within the DOH to respond to environmental health threats

The South Dakota MCH program uses the DOH 2020 Initiative as its blueprint with primary focus on the goal of "improving birth outcomes and health of infants, children, and adolescents in South Dakota". However each goal impacts improved outcomes for MCH populations.

The framework guiding South Dakota's needs assessment process mirrors the national MCH needs assessment process of engaging stakeholders, assessing needs and identifying desired outcomes, examining strengths, weaknesses and capacity, reviewing resources, selecting priorities, and selecting NPMs.

The South Dakota MCH program utilized its MCH team as the needs assessment team. The MCH team includes program representatives from CYSHCN, Women, Infants, and Children (WIC), perinatal health, adolescent health, child health, sexual violence prevention, family planning, newborn metabolic and hearing screening, rural health, immunizations, oral health, tobacco prevention and control, nutrition, epidemiology, home visiting, and data. The MCH team was responsible for identifying priorities that will drive efforts for the next five years to improve the health of the MCH population.

Quantitative methods of data review included summarizing all MCH NPMs and NOM, along with previous measures that were not included. Available data from state and national databases were searched and data were summarized. In particular, emphasis was placed on South Dakota's national ranking and trends over time in each measure. When possible, data were presented by various demographic characteristics. The assessment included a summary table that lists South Dakota's ranking, the South Dakota 2013 rate, the US base rate (year), the US Healthy People 2020 target, 5-year trends, and trends by race for each NOM and NPM. The document was originally developed in September 2014 and has since undergone two revisions based on changes made by HRSA in the proposed measures. The final assessment document is attached. The document was distributed at various meetings held by the DOH to discuss MCH needs.

Once the data had been summarized and the MCH team identified priorities and possible NPMs, qualitative data was collected from local DOH community health offices across the state. These groups were asked to prioritize the possible NPMs before and after reviewing the data tables. In addition, staff shared additional priority needs specific to their communities.

Many data sources were utilized to inform the Needs Assessment process and are referenced in the attached 2015 MCH Needs Assessment document. State data sources included vital records data (up to 10 years of birth and death), hospital discharge data from the South Dakota Association of Healthcare Organizations (SDAHO), South Dakota Pediatric Nutrition Surveillance System (PedNSS) data prior to 2012, Department of Public Safety (DPS) Accident Records data, Oral Health Survey, Newborn Hearing Screening Program data, DOH infectious diseases data, and DSS Medicaid data. National data sources included HRSA MCH data website, Kids Count website, National Survey of Children's Health, National Survey of Children with Special Healthcare Needs, National Immunization survey, and national Behavioral Risk Factor Surveillance System (BRFSS) data.

II.B.2. Findings

II.B.2.a. MCH Population Needs

The following provides an overview of the findings per domain identified by the MCH team.

Women/Maternal Health

South Dakota's data shows:

- Low percent (19.7%) of cesarean deliveries among low-risk first births, have exceeded the Healthy People 2020 objective
- 70.6% of mothers initiated prenatal care in the first trimester. The 5 year trend shows an overall improvement in this area; however South Dakota is ranked near the bottom in comparison of other states (43rd of 51 states in 2012). In addition, 77.2% of White mothers sought prenatal care in the first trimester vs. 48.4% of Native American mothers. Only 53.9% of mothers less than 20 years of age and 61.9% of WIC moms accessed early prenatal care. While South Dakota has improved or maintained in this area, it has not attained the Healthy People 2020 objective.
- Highest infant mortality rate (60 per 1,000 live births) occurred when mothers did not have prenatal care. In comparison, when mothers received prenatal care in the first trimester the infant mortality rate was only 5.8.
- Based on South Dakota birth certificate data, there were a total of 10 maternal deaths (mother died during pregnancy or within one year of giving birth)between 2010 and 2013 for a rate of 20.8/100,000 live births which is almost twice the national rate.
- Birth rate for teenagers aged 15-17 years was 16.4 per 1,000. The 5 year trend shows a downward trend for both White and Native Americans.
- 68% of women had a past year preventive visit. Even with ACA, it is still a challenge for women to get an annual medical visit. This challenge is made worse by the fact that two-thirds of the state is considered a HPSA and the distance some women have to travel to receive care.

Conclusions:

Existing Programs/Strategies	Concerns:
- Medicaid eligibility to cover pregnancy - Bright Start Home Visiting Program - Baby Care Program - Early Head Start - WIC - South Dakota QuitLine - CoIIN - Family Planning - OFCH offices	- Cultural disparities and tribal collaboration - Access to care and prenatal visits - Shortages of primary care providers - Transportation issues to get to services - Domestic violence - Mental health - Oral health - Pregnant women on Medicaid accessing dental services due to lack of Medicaid providers - Substance abuse - Weight gain during pregnancy - Importance of preconception and inter-conception health - Funds/manpower/resources

Perinatal/Infant Health

South Dakota's data shows:

- During 2013, there were 80 South Dakota resident infant deaths reported for an infant mortality rate of 6.5 per 1,000 live births. The Native American infant mortality rate was significantly higher than whites (11.2 vs 5.2). The resident neonatal mortality rate per 1,000 live births was 3.5 for White vs. 4.6 for Native Americans.
- The leading causes of infant death in 2013 were: (1) certain conditions in perinatal period – 45.0%; (2) congenital malformations – 22.5%; (3) sudden infant death syndrome (SIDS) – 11.3%; and (4) accidents – 10.0%.
- There were 48 neonatal deaths (deaths occurring to infants from birth through 27 days old) for a rate of 3.9 deaths per 1,000 live births. There were 32 post-neonatal deaths (deaths occurring to infants 28 days to 1 year of age) for a rate of 2.6 deaths per 1,000 live births. In comparison, in 2012 neonatal and post-neonatal rates were 5.7 and 2.9 per 1,000 live births, respectively.
- The highest mortality rate was for babies born who weighed less than 1,000 grams.
- Mothers who reported they used tobacco while pregnant had an infant mortality rate of 10.6 vs. 6.2 for mothers who reported they did not use tobacco while pregnant.
- Ranked in the bottom five states in the US in perinatal, infant, neonatal, and post-neonatal mortality.
- Percentage of infants ever breastfed is higher than national rate.
- High percent of very low birthweight infants are born in a Level III/NICU hospital.
- Percent of preterm births and low birth weight deliveries are low compared to national data.
- Percent of early term birth is decreasing.
- Percent of infants exposed to alcohol in utero and percent born with neonatal abstinence syndrome are below the national rate.

Conclusions:

Existing Programs/Strategies	Concerns:
- Family Planning - Bright Start Home Visiting Program - Baby Care Program - March of Dimes public education/awareness - WIC - South Dakota QuitLine - *For Baby's Sake* campaign/education - Cribs for Kids - COIIN - Statewide Infant Death Review - State Early Intervention program - Breastfeeding peer counselors for WIC clients - Newborn Metabolic Screening Program - Will soon have PRAMS data	- Cultural disparities - Limited NICU providers - Access to care and prenatal visits - Shortage of primary care providers - Geography and distance to providers - Hearing screening and lost to documentation rates - Continuity of care - Limited data on oral health during pregnancy - Maternal alcohol and tobacco use - Maternal mental health - Cultural beliefs (Safe Sleep)

Child Health

South Dakota's data shows:

- Percent of children (1-17) who have decayed teeth or cavities (19.0% in 2007) is below US Healthy People 2020

target.

- Ranked 40th in children receiving a developmental screening (43.7% 2009-10).
- Ranked 48th nationally in child mortality (ages 1-9) with a rate of 25.2 per 100,000.
- Low percent of 19-35 month olds with complete vaccine series (74.5% in 2012).
- Type of insurance coverage seems to affect immunization rates.
- High percentage of 2-5 year olds with a high BMI (33.2% in 2012).
- Rate of injury-related hospitalizations (both fatal and non-fatal) is high among 9-19 year olds.

Conclusions:

Existing Programs/Strategies	Concerns:
- Vaccine program and public awareness efforts - Strong school-entry immunization law - Munch Code program - Harvest of the Month - GFP Fitness Passport Challenge - Safe Routes to School - FitCare program - Early Childhood Enrichment Programs - Department of Education (DOE) TEAM Nutrition funding - WIC program and food packages - OFCH offices - Bright Start Home Visiting Program - Dakota Smiles Mobile Dental van - Healthy Start - Office of Highway Safety and Buckle Up campaigns - Car seat program	- Farm/ranch accidents - Motor vehicle injury - Young driving age - Adult BMI – not a good role model - Percent of working mothers - Amount of screen time - Secondhand smoke exposure - Car seat program – not as far reaching as it was - Immunization rate for 4th DTap - Oral health and lack of Medicaid providers - Families don't understand the importance of EPSDT when child appears healthy

Adolescent Health

South Dakota's data shows:

- Although adolescent motor vehicle mortality (ages 15-19) is higher than the US rate, it has been decreasing over the last 10 years among the white population.
- High percentage of parents consider their children in excellent or very good health (ranked #1 nationally).
- Ranked #9 in the percentage of adolescents (ages 10-17) who are overweight or obese.
- Ranked #49 in adolescent mortality (ages 10-19).
- Ranked #47 in adolescent suicide rate (ages 15-19) 2009-2012 rate was 10.0 per 100,000.
- Ranked #48 in percentage of adolescents (ages 12-17) with a preventive medical visit in the past year.
- Ranked low in many of the percentages of adolescents (ages 13-17) who have received vaccines for HPV (rank #25 for females, rank #39 for males), Tdap (rank #49), and meningococcal conjugate (rank #47).
- Attempted suicide rates from 2009-2013 for age 15-19 was 16.2 per 100,000 with the majority of suicide attempts in both sexes are by poisoning.
- Teen pregnancy rate is 16.4 per 1,000.

Conclusions:

Existing Programs/Strategies	Concerns:
- Abstinence education program - Family Planning - OFCH offices - Rape Prevention Education program - Contract with HelpLine Center - Suicide Prevention Advisory Committee - Volunteers of America - Office of Highway Safety programs - Immunization program and awareness efforts - Office of Disease Prevention (ODP)	- Title V is not the lead agency in regards to many of the adolescent health initiates (i.e., suicide, mental health, traffic safety) - Young driving age in South Dakota - Lack of parent education on need for immunization at this age - Attempted suicide rates - Sexually transmitted infection (STI) rates - Electronic cigarettes - Substance abuse - Emancipated minors – adolescents living on their own - Tribal collaboration

Children and Youth with Special Health Care Needs

South Dakota's data shows:

- High percentage of CYSHCN received services to make transitions to adult health care.
- Ranked #5 in the percentage of children identified with special health care needs.
- Low percentage of CYSHCN have a medical home.
- High percentage of children have been diagnosed with autism spectrum disorder (rank #43) and ADD/ADHD (rank #36).
- In the 6-11 year olds the rates for access to community based services and satisfaction with services is lower.

Conclusions:

Existing Programs/Strategies	Concerns:
- Newborn metabolic screening program - Newborn hearing screening program - Health KiCC - Parent Connection - Genetics outreach clinic - Communities of Care – connecting providers in the full integration of care to support children and families with special health care needs - State early intervention program - Developmental Disabilities Council	- Data for this area are old - Who is health home when child sees a specialist for the chronic medical condition - Number of conditions that meet the federal criteria for CYSHCN is daunting - Shortage of specialty providers in certain locations of the state - Number underdiagnosed - DOH is not the lead on many of the federally coverable conditions (i.e., mental health, developmental delays) - Uninsured and underinsured - 19 to 21 year olds and insurance coverage - Family involvement/input for programmatic planning

Cross-cutting or Life Course

South Dakota's data shows:

- High percentage of infants and children (ages 1-17) with a preventive dental visit in past year.
- Low percentage of children live in households where someone smokes (half the national rate).
- High percentage of children (ages 9-17) are adequately insured (ranked #12).
- Percentage of overweight/obese in child and adolescents.
- In 2013, 22.5% of mothers stated they smoked three months prior to pregnancy and 15.1 percent smoked anytime during their pregnancy.

Conclusions:

Existing Programs/Strategies	Concerns:
- Success of QuitLine - OFCH office - Telemedicine - ACES (Adverse Childhood Experience Study) - Newborn Metabolic Screening program - Office of Rural Health (ORH) - ODP - WIC program - Family Planning program - Healthy SD	- Shortage of providers across the state - Don't have current data on a lot of these measures - South Dakota does not participate in Medicaid expansion - Number of underinsured - Social determinants - Issues getting an approved provider due to insurance carrier - Travel to services - Oral health and lack of Medicaid providers

As a result of the data review, a list of possible priorities was identified:

Infant mortality	Oral health for all populations
Native American infant mortality	Preconception/inter-conception health
Maternal weight prior to pregnancy	Percent of women with a past year preventive visit
Teen pregnancy	Access to care
Substance abuse – drugs, alcohol, tobacco	Immunization rates
High risk behaviors in adolescents	CYSHCN and medical home
Prevalence of obesity among children and youth/lack of physical activity	Mental/behavioral health including access to care, autism, mental health provider outreach
Prenatal care including health appointments earlier in pregnancy	6-11 year olds and access to care/medical home
Metabolic screening	Appropriate nutrition for infants/children
Hearing screening (1-3-6)	Adequate insurance
STIs	Bullying
Social determinants of health	Suicides and attempted suicides
Unintentional injuries in children	Adolescent motor vehicle deaths
Cross agency collaboration	Safe sleep
Breastfeeding	Maternal alcohol and substance abuse
EEDs	Data

The MCH team developed seven priorities from the 32 priority needs. In narrowing down the list of priorities, the team looked at alignment with DOH 2020 Initiative, legislative priorities, priorities of other partner programs and agencies, where MCH was the lead agency and had capacity to impact change, was progress measurable and whether there was a data source to measure, and did if it aligned with NPMs and NOMs.

With so many initial priority needs identified, the MCH team attempted to “group” multiple priorities under larger umbrella priority needs statements. This resulted in the identification of seven priority need areas that were broader or allowed for the merging of the need with the intended outcome. At the time the needs assessment process was being conducted, the DOH did not have the final MCH guidance and the MCH team felt these broader statements would also allow the state a little more flexibility in addressing any new requirements. While there has been improvement in some of the previous priority needs, it was felt that continued monitoring/efforts could be included with these broader needs statements. The final seven priorities are:

- Promote preconception/inter-conception health
- Reduce infant mortality
- Promote positive child and youth development to reduce morbidity and mortality (intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and drug utilization)
- Improve early identification and referral of developmental delays
- Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN
- Promote oral health for all populations
- Improve state and local surveillance, data collection, and evaluation capacity

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

The DOH is an executive-level department with the Secretary of Health appointed by, and reporting to, the Governor. The mission of the DOH is to promote, protect, and improve the health and well-being of all South Dakotans. The DOH is charged with the protection of the public health by appropriate measures set forth and authorized by state law. South Dakota Codified Law (SDCL) 34-1-21 designates the DOH as the sole state agency to receive, administer, and disburse

federal Title V monies and authorizes the DOH to adopt rules to administer the Title V program relating to MCH and CSHS services. Administrative Rules of South Dakota (ARSD) 44:06 provides guidance on the delivery of services to CYSHCN and outlines general operation of the program, eligibility requirements, providers, family financial participation, claims, and scope of benefits. SDCL 34-24-18 requires all infants born in South Dakota to be screened for phenylketonuria (PKU), hypothyroidism, and galactosemia and provides rulemaking authority for the DOH to require additional screening for other metabolic, inherited and genetic disorders. ARSD 44:19 contains the rules regulating metabolic screening including screening for biotinidase deficiency, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders fatty acid oxidation disorders, organic acid disorders, and cystic fibrosis. The DOH is currently updating ARSD 44:19 to include screening for Severe Combined Immunodeficiency (SCID) with an anticipated effective date of August 9, 2015.

The DOH is organized into three divisions – Health and Medical Services, Administration and Health Systems Development and Regulation. The State Epidemiologist reports directly to the Secretary of Health.

Copies of applicable DOH organizational charts are provided as an attachment.

II.B.2.b.ii. Agency Capacity

The Division of Health and Medical Services (HMS) is the health care service delivery arm of the DOH and administers MCH services. HMS consists of three offices. The MCH team has representation from each of these offices. They provide input and direction on the goals and activities. In addition, these offices provide direct service, education, and outreach to clients and community partners in order to address the MCH needs throughout the state.

OFFICE OF FAMILY AND COMMUNITY HEALTH (OFCH) – OFCH administers the MCH Block Grant for the DOH. OFCH provides leadership and technical assistance to assure systems that promote the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. OFCH staff provide training and ongoing technical assistance to DOH field staff as well as private health care providers who deliver MCH services. Staff are responsible for the development of policies and procedures relevant to the delivery of MCH services for pregnant and postpartum women, infants, children, adolescents, and CYSHCN. OFCH works closely with field staff on data collection needed for federal and state reports as well as for program evaluation.

The CSHS program Health KiCC (Better Health for Kids with Chronic Conditions) provides financial assistance for medical appointments, procedures, treatments, medications, and travel reimbursement for children with certain chronic health conditions. Service coordination is also available upon request. Health KiCC covers 100% of eligible covered expenses. If a person is eligible, Health KiCC covers the entire cost of the coverable services after other third party sources are billed. Assistance is limited to $20,000 per year.

The Perinatal program provides direction and technical assistance for primary and preventive care for women and infants including risk assessment and care coordination of pregnant women, perinatal education, prenatal/Bright Start home visits, and education on safe sleep.

The Newborn Screening program helps identify babies who may have a metabolic disorder and alerts the baby's physician to the need for further testing and special care. South Dakota currently screens for 28 disorders either pursuant to statute or administrative rule. As was noted above, the DOH is currently updating its administrative rules to begin screening for SCID. The Newborn Screening program also works with hospitals to encourage screening of newborns for hearing loss prior to hospital discharge or by one month of age. The program works to ensure health care providers and parents are informed about the benefits of early hearing screening and that follow-up is provided to infants referred for further hearing evaluation.

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

South Dakota Family Planning (SDFP) offers men and women of childbearing age reproductive health education, contraceptive counseling and methods, physical examinations, and STI counseling, testing and treatment. Payment for family planning services is based on a sliding fee schedule according to family size and income.

The Child/Adolescent Health program collaborates on a variety of activities 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.

Community health offices provide professional nursing and nutrition services and coordinate health-related services to individuals, families, and communities across the state. Services include education and referral, immunizations, developmental screenings, management of pregnant women, WIC, family planning, nutrition counseling/ education, and health screenings (i.e., blood pressure, blood sugar, vision, hearing, etc.). In most counties, these services are delivered at state DOH offices. In 11 Public Health Alliance (PHA) sites, the office coordinates the delivery of services through contracts with local county governments and private health care providers.

The Bright Start nurse home visiting program provides nurse home visiting services to high risk families during pregnancy, after delivery, and continuing until the child's third birthday. The program focuses on high-risk pregnant mothers and new parents with limited economic and/or social and health resources. Ideally, the visits begin during the pregnancy but can begin whenever the family is referred to the program. Interventions include: (1) prenatal, maternal, and infant/child health assessments and education; (2) infant/child developmental assessments; (3) parenting education; (4) health, safety, and nutrition education; and (5) linking families with other resources in the community to maximize their overall functioning. The DOH operates the Bright Start program in 12 counties (Pennington, Butte, Lawrence, Oglala Lakota, Bennett, Stanley, Lyman, Hughes, Beadle, Marshall, Day and Roberts) while the Children's Home Society operates the program in Sioux Falls and the surrounding communities. In FY 2014, 567 families were served by Bright Start.

OFFICE OF CHRONIC DESEASE PREVENTION AND HEALTH PROMOTION (OCDPHP) – OCDPHP coordinates a variety of programs designed to promote health and prevent disease.

The All Women Count! (AWC) Breast and Cervical Cancer Control program coordinates statewide activities to promote early detection of breast and cervical cancer. Mammograms, Pap smears and related exams are available at no cost to eligible women at many physician offices, mammography units, family planning clinics, and other clinics throughout the state. AWC serves women (30-64 years of age for pap smears, 50-64 for mammograms) who are without insurance to pay for screening exams or who have insurance but cannot pay the deductible or co-payment.

The South Dakota Cancer Registry is a statewide population-based cancer registry that collects and reports data on cancer incidence and mortality.

The Nutrition and Physical Activity program provides resources, technical assistance, and programs to a variety of target audiences such as parents and caregivers, schools/youth organizations, workplaces, communities, and health care providers to help prevent obesity and other chronic diseases. The Nutrition and Physical Activity program collaborates with many DOH programs to address poor nutrition and inadequate physical activity. The *South Dakota State Plan for Nutrition and Physical Activity to Prevent Obesity and Other Chronic Diseases* is designed to increase healthy eating and physical activity as ways to reduce overweight and obesity and their subsequent risk for chronic diseases such as cardiovascular disease, hypertension, and diabetes.

The School Health Program (SHP) works with schools on tobacco, healthy eating, and physical activity. Schools have opportunities for training on health and physical activity program resources and access to model policy and environment resources related to healthy vending (Munch Code), tobacco, and healthy eating (Harvest of the Month). The DOH collaborates with DOE in its work with schools and agencies that serve school-age children.

The Diabetes Prevention and Control program focuses on providing training and outreach to established diabetes prevention programs and increase the number of individuals who receive diabetes self-management education.

The Oral Health program coordinates activities to increase awareness of the importance of oral health and preventive care, foster community and statewide partnerships to promote oral health and improve access to dental care, and promote the use of innovative and cost effective approaches to oral health promotion and disease prevention. The program collaborates with numerous internal and external partners to address workforce issues, access to care, and reinforce disease prevention and dental education.

The Tobacco Control Program (TCP) coordinates state efforts to prevent young people from starting to use tobacco products, help current tobacco users quit, and reduce non-smokers' exposure to secondhand smoke. While smoking prevalence has decreased for many populations in South Dakota, Native Americans, Medicaid clients, pregnant women, spit tobacco users, and youth/young adults continue to use tobacco at much higher rates. The TCP assesses tobacco use patterns and identifies cessation needs and appropriate evidence-based strategies in order to develop more effective interventions for identified disparate populations.

The Heart Disease and Stroke Prevention Program works to improve cardiovascular health, reduce the burden, and eliminate disparities associated with heart disease and stroke. The program focuses on improving the quality measures related to the identification and treatment of hypertension.

OFFICE OF DISEASE PREVENTION (ODP) – ODP coordinates infectious disease prevention and control programs. Within ODP, the Immunization Program provides vaccines for VFC-eligible children in South Dakota to prevent such childhood diseases as measles, mumps, rubella, varicella, HiB, hepatitis B, and bacterial meningitis. The program also provides recommendations and education on adult immunizations such as influenza, pneumonia and tetanus. The Immunization program provides vaccine materials, training, and support to both public and private immunization providers in the state and works in partnership with local and statewide coalitions. The South Dakota Immunization Information System (SDIIS) is a computerized software system that allows healthcare providers to share immunization records.

ODP staff investigate sources of STI infections, provide treatment, and apply preventive measures to those exposed. Field offices provide confidential counseling and testing for HIV/AIDS as well as educational materials, training for the public, schools and health care providers, and assistance with health care costs for those with HIV disease. The office provides TB clinics and contracts with the private medical sector for evaluation, treatment and follow-up of TB cases. ODP also conducts disease outbreak investigations in the state.

The Division of Administration provides centralized support to DOH programs including financial management, computer systems, communications, health planning, legislative coordination, grant writing, health information technology, and research. The State Public Health Laboratory provides testing, consultation, and expert testimony in support of local, state and federal agencies and the general public. The division also provides oversight of the state's correctional health care system. The Office of Data, Statistics and Vital Records (DSVR) provides technical assistance for the development, implementation, and evaluation of data collection activities. DSVR maintains the vital records system for the state including births, deaths, marriages, divorces, and fetal deaths and issues certified copies of such records.

The Division of Health Systems Development and Regulation administers regulatory programs related to health protection and health care facilities including the traditional public health areas of sanitation and safety, inspection and licensure of public facilities and Medicaid/Medicare survey and certification of health care facilities and providers. ORH works to improve the delivery of health services to rural and medically underserved communities with an emphasis on access including recruitment of health professionals, technical assistance to health care facilities, development and use of telemedicine applications, emergency medical services, and oversight of the South Dakota Trauma System. The Office of Public Health Preparedness and Response directs the state's public health emergency response efforts. Past DOH preparedness funding has been used to strengthen the public health infrastructure in South Dakota including improvements in communication and computer systems for MCH field staff.

II.B.2.b.iii. MCH Workforce Development and Capacity

Preventive and primary care services to the MCH population are provided through OFCH. OFCH provides direction to state-employed nurses, nutrition educators, and dietitians for the provision of public health services in the state. Field staff providing primary preventive services for mothers, infants, and children include 6.97 FTE for mothers and infants and 6.37 FTE for children and adolescents. Another 3.55 FTE provide family planning services in the state. In addition, OFCH field staff spend 3.07 FTE on case management to pregnant women which is billed to DSS Medicaid. OFCH and OCDPHP central office program staff dedicated to providing program direction to specific MCH program areas include: 1.89 for child and adolescent health, 0.77 for perinatal health, 2.14 for family planning services; and 2.55 for CSHS.

The OFCH Administrator position is currently vacant following the retirement of Darlene Bergeleen on June 8, 2015. The position is currently posted on the state Bureau of Human Resources website and applications are being accepted until the position is filled. Barb Hemmelman serves as the CYSHCN Director. Barb has been with the DOH since September 2004. Other MCH team members include the following:

- Linda Ahrendt, OCDPHP Administrator
- Sue Alverson, State Nutritionist
- Rhonda Buntrock, WIC Program Administrator
- Shelly Cowen, Sexual Violence Prevention Coordinator
- Amanda Ainslie, SDFP Program Administrator
- Julie Ellingson, Oral Health Coordinator/School Health Coordinator
- Lucy Fossen, Newborn Metabolic/Hearing Screening Coordinator
- Mark Gildemaster, Manager, Data and Statistics
- Dee Dee Dugstad, TCP Coordinator
- Laura Streich, Tobacco Disparities Coordinator
- Josie Petersen, Workforce Development
- Tim Heath, Immunization Program
- Scarlett Bierne, ODP Assistant Administrator
- Peggy Seurer, Perinatal Nursing Consultant
- Susan Sporrer, Director of Policy and Special Projects
- Vacant, Breastfeeding Coordinator
- Jenny Williams, Infant Death Review Coordinator/CSHS Consultant
- Ashley Miller, Chronic Disease Epidemiologist
- Carrie Churchill, Home Visiting Program Manager
- EA Martin Group, SDSU, contract MCH and Home Visiting epidemiology

The MCH project works closely with SDPC to identify and recruit parents of CYSHCN to provide mentoring and peer support to other families with CYSHCN. SDPC provides a family perspective to CSHS program staff regarding programs, policies and procedures, maintain a statewide database of support parents and groups, provide parent-to-parent training, and link parents throughout the state with trained supporting parents in a community-based manner. The MCH Program Coordinator serves on the advisory panel to assist in ongoing collaboration opportunities.

II.B.2.c. Partnerships, Collaboration, and Coordination

A detailed description of DOH programs is provided above. All DOH programs work collaboratively to coordinate efforts and maximize resources in serving citizens of South Dakota.

Other MCH Investments

Title V and SDPC applied for and were awarded a Rural Health Outreach for CYSHCN Project (RHOP) to implement strategies tailored to South Dakota's needs and strengths to achieve integrated, community-based systems of care for CYSHCN and their families. This includes providing statewide leadership in facilitating partnerships among the multiple agencies and organizations serving CYSHCN critical to creating an infrastructure to achieve the six core components for CYSHCN and their families; creating a shared vision and strategic plan with all key stakeholders to implement and integrate the core outcomes for CYSHCN at the state and local levels using evidence-based and best practice models; and

supporting and enhancing ongoing efforts in the state to address needs specific to all of the six core components, with a focus on early and continuous screening and transition to adult life.

State Systems Development Initiative (SSDI) funds are used to develop and/or collect data, data management, and epidemiology support specific to the MCH populations for evaluation and program planning purposes.

The Maternal, Infant and Early Childhood Home Visiting (MIECHV)-funded Home Visiting program in South Dakota, Bright Start, is a partner in serving the MCH population of the state. The Nurse Family Partnership model has a strong emphasis on prenatal care, breastfeeding, immunizations, smoking cessation, infant safe sleep, developmental screening, oral health and nutrition. Trained nurse home visitors address these and other issues with pregnant women, infants and children until age two in identified high risk counties. In addition to the direct service work, Bright Start is committed to building a system of strong data collection and an Early Childhood Comprehensive System (ECCS) in the counties served.

Other Federal Investments

South Dakota was a universal provider of most childhood vaccines until January 2015. Because of significant changes in how states could use federal vaccine funding, the DOH is implementing a system for local DOH offices to bill third party payors for all non-Vaccines for Children (VFC) children seeking immunizations from local offices. The DOH will continue to provide influenza vaccine to all immunization providers for children 6 months to 18 years of age.

Since September 2010, OFCH has received federal abstinence-only education funding to provide abstinence education to South Dakota youth. The DOH worked with stakeholders to develop a state Abstinence Education Plan as well as review data to identify the target population for abstinence programming as 9-11 year olds, at least 50% of whom are Native American. Through an annual request for proposal (RFP) process, the DOH contracts for the implementation of an evidence-based, medically accurate program designed to promote abstinence from sexual activity.

Since October 2010, OFCH has received federal PREP funds to deliver evidence-based programs emphasizing abstinence and contraception targeting at risk youth 15-19 years of age within the juvenile correctional system and in foster care with the goal of preventing pregnancy and STIs. Programming is designed to give youth the skills and knowledge they need to reduce risky behaviors and identify the qualities of healthy relationships between individuals and within families. PREP in South Dakota is a collaborative effort of the DOH, DSS, DOE, Department of Human Services (DHS), and Department of Corrections (DOC). South Dakota's PREP Program uses *Reducing the Risk*, an approved, evidence-based curriculum which is one of the first rigorously-evaluated sex education curricula shown to have a measureable impact upon behavior. The program also addresses adult preparation subjects include healthy relationships, adolescent development, financial literacy, parent-child communication, educational/career success, and health life skills.

Since 1999, OFCH has received federal CDC Early Hearing Detection and Intervention (EHDI) funds for the development, maintenance and enhancement of Early Hearing Detection and Intervention Information System Surveillance Program

Other HRSA Programs

Representatives from the DOH and the Community HealthCare Association of the Dakotas (CHAD) continually explore ways to increase collaboration and coordination of health services such as MCH, family planning, community health, and infectious disease control. In some areas, DOH staff are co-located with community health centers (CHC). Where feasible, local DOH staff meet regularly with CHC staff to address identified needs and facilitate the development of a seamless system of care.

In April 2015, OFCH was awarded HRSA funds for Reducing Loss to Follow-up after Failure to Pass Newborn Hearing Screening.

Other DOH Programs

The DOH receives $5 million annually from the cigarette tax for tobacco prevention and control efforts. Funds are used to support cessation and statewide programming, community and school programming, and counter marketing, surveillance/evaluation, and administration. South Dakota offers QuitLine services including coaching, free tobacco cessation products, and three lifetime opportunities for tobacco users to use the QuitLine. South Dakota provides either Chantix or Zyban or patches or gum for QuitLine participants regardless of income. Since January 2002, the SD QuitLine has assisted over 81,351 South Dakotans in their efforts to quit. The SD QuitLine has the most successful quit rate in the country at 43% (next closest is 28.7%).

Other Government Agencies

DSS provides the following programs for MCH populations in South Dakota. The DOH works to refer clients it serves to appropriate programs.

- *Children's Health Insurance Program (CHIP)* – South Dakota CHIP provides quality health care (including regular check-ups, well-child care exams, dental and vision care) for children and youth. To be eligible for CHIP, children must be under the age of 19 and current residents of South Dakota. Children who are uninsured or already have health insurance may be eligible for CHIP based on income and eligibility guidelines.

- *Pregnant Women* – DSS provides Medicaid to pregnant women who meet income and resource limits and general eligibility guidelines. Pregnant women may qualify for limited coverage or full coverage.

- *South Dakota Medicaid for Certain Newborns* – Children born to women eligible for Medicaid are also eligible for Medicaid. There is no resource or income limit. Coverage continues from the month of birth until the end of the month in which the child turns one year of age as long as the child continues to live in South Dakota.

- *Disabled Children's Program* – The Disabled Children's Program provides Medicaid for children with disabilities who have medically fragile conditions requiring skilled nursing care in a medical facility if they were not being cared for at home.

- *Family Support Services* – Family Support Services provide Medicaid for South Dakotans with a developmental disability such as Down's Syndrome, autism or cerebral palsy. In addition to the standard Medicaid covered services, other services include services coordination, respite care, specialized medical/adaptive equipment/supplies, nutritional supplements, personal care, companion care, and environmental accessibility adaptations.

- *Temporary Assistance for Needy Families (TANF)* – TANF is a needs-based program for families with children under the age of 18 (or under the age of 19 if the child is in high school) who need financial support due to: (1) death of a parent(s); (2) parent(s) absence from the home; or (3) physical/mental incapacity or unemployment of parent(s). The primary focus of the state TANF program is to help families help themselves by promoting family responsibility and accountability and encouraging self-sufficiency through work.

- *Health Homes* – Health homes is a federally defined initiative in the ACA designed for Medicaid recipients with multiple chronic conditions. South Dakota has two types of Health Homes – those led by Primary Care Providers and those led by Community Mental Health Centers – to serve Medicaid recipients with complex health care needs resulting in high costs to Medicaid. Each Health Home is led by one or more designated providers who lead an individualized team of health care professionals and support staff to meet the needs of each recipient.

- *Supplemental Nutrition Assistance Program (SNAP)* – SNAP helps low-income South Dakotans buy food they need to stay healthy while they work to regain financial independence.

The DOH and DSS have an interagency agreement to establish and assure referral mechanisms between agencies. The intent of the agreement is to maximize utilization of services and assure that services provided under Title V and Title XIX are consistent with the needs of recipients and that the objectives and requirements of the two programs are met. The agreement establishes procedures for early identification and referral of individuals under age 21 in need of services such as EPSDT, family planning, case management, and WIC. Representatives from both agencies meet regularly to discuss various issues including care coordination of high-risk pregnant women, referral mechanisms, outreach for Medicaid, and CHIP.

The DOH collaborates with DSS to address issues affecting children and adolescents and their families such as suicide, tobacco use, FASD, and HIV prevention. DOH staff provide assistance and representation on the Division of Alcohol and Drug Abuse Advisory Council for Safe and Drug-Free Schools application reviews, Developmental Disabilities Council, and FASD Task Force. DOH collaborates with DSS on the Child Safety Seat Distribution Program which focuses on keeping children safe by providing child safety seats at no cost to families meeting income eligibility requirements to ensure the child is in the best child seat for their height and weight. Several OFCH offices are car seat distribution sites. In addition, CYSHCN provides funding for the purchase of child safety seats for children with special needs.

DHS administers the state's Respite Care Program. The program is jointly funded with state general funds, MCH block grant funds, and some DHS federal grant funds. MCH block grant funds are used to provide services for children on the program

diagnosed with chronic medical conditions. CSHS program staff assist families with referral to the Respite Care Program. The program has an advisory group with representation from various state programs serving families who have children with special needs including special education, child protection, developmental disabilities, mental health, and CYSHCN. Parents are also represented on this group.

DOH is involved in an interagency agreement with DOE, DHS, and DSS to ensure collaboration in the maintenance and implementation of a statewide, comprehensive, coordinated, multidisciplinary, and interagency service delivery system for children eligible under Part C of the Individuals with Disabilities Education Act (IDEA). This system is designed to ensure the availability and accessibility of early intervention services for all eligible infants and toddlers and their families. This agreement outlines the roles and responsibilities of the participating agencies related to the specific services required and provides guidance for their implementation.

The DOH has a number of information and referral mechanisms to assist in the identification and enrollment of eligible children for Medicaid services such as WIC, CSHS, CHNs, and PHA. WIC facilitates referrals and links applicants with services so that families can access Medicaid as well as other health and social programs. In addition to the State program, there are three tribally-operated WIC programs on the Cheyenne River, Rosebud and Standing Rock Indian reservations. Coordination between the WIC and Medicaid program occurs as all Medicaid eligibility approvals of pregnant women are automatically reported to the WIC program on a weekly basis. CHN/PHA staff serve as an information and referral source to inform families of Medicaid availability and facilitate enrollment in Medicaid by referral. CSHS financial assistance process requires the family to also apply to Medicaid to ensure they are accessing all services that can be of assistance.

In 2003, the South Dakota Legislature passed a concurrent resolution supporting the creation of a South Dakota plan for suicide prevention. The overarching goals of the suicide plan include: (1) implementation of effective, research-based suicide prevention programs to reach the public and at-risk populations (i.e., elderly, Native Americans, youth/young adults, and rural communities); (2) provision of guidelines to schools for the development of effective suicide prevention programs; (3) development of public information campaigns designed to increase public knowledge of suicide prevention; (4) work with postsecondary institutions to develop effective clinical and professional education on suicide; (5) assurance that schools have effective linkages with mental health and substance abuse services; and (6) implementation of effective, comprehensive support programs for survivors of suicide. DOH and DSS have a joint contract with SD Helpline Center to provide suicide prevention activities across the state. Activities supported by this joint contract include support of a 24 hour, 7 days a week crisis line, crisis line texting in 30 high schools, maintenance of a suicide prevention website, and mental health first aid training.

Tribes/Tribal Organizations

Meetings are held between MCH, IHS, GPTCHB, and coordinators from the Healthy Start programs in South Dakota. Due to the high staff turnover rate within IHS, tribal programs and Healthy Start programs, it is difficult to build sustained relationships and continuity to coordinate partnerships/efforts. The DOH remains committed to these meetings to discuss program services on South Dakota Indian reservations as well as the coordination and referral of services for the home visiting program and other MCH services.

The DOH TCP administrator sits on the steering committee of the Sacred Life Coalition, a part of GPTCHB Northern Plains Tribal Tobacco Technical Assistance Center. This coalition is committed to enhancing and increasing awareness of tobacco control and prevention for Native Americans in the Northern Plains by providing a forum for input, advocacy, education, collaboration, planning, and action along the commercial tobacco prevention continuum. This group of tribal and community stakeholders works to achieve all of their goals in a manner that values the importance of traditional tobacco use, and above all else, respect individual, tribal, and cultural differences.

Health Professional Education Programs/Universities

The DOH has a long-standing collaborative relationship with the Center for Disabilities within the USD SOM Department of Pediatrics. The South Dakota Leadership Education Excellence in Caring for Children with Neurodevelopmental and Related Disorders (LEND) is a program of the Center for Disabilities that works to improve the health status of infants, children, and adolescents with neurodevelopmental and related disabilities. The LEND program provides one year of specialized training

focusing on the interdisciplinary training of professionals for leadership roles in the provision of health and related services to infants, children and adolescents with neurodevelopmental and related disabilities and their families. The program augments graduate studies in the disciplines of audiology, health administration, medicine, nursing, nutrition, speech-language pathology, occupational/physical therapy, pediatric dentistry, psychology, and public health social work. In addition to LEND, MCH and the Center for Disabilities collaborate on a number of training and other interagency projects. The Center for Disabilities Autism Spectrum Disorders Program provided “Autism Spectrum Disorders in Public Health Settings” training to all OFCH staff including how to talk to parents when there are concerns.

Family/Community Partnerships
The DOH partners with SDPC who provides training and information statewide to meet the needs of parents and families caring for individuals with disabilities. SDPC has served continuously as the state's only Parent Training and Information Center (PTI) since 1985. SDPC provides assistance through these programs:

- The Parent Training and Information Center (PTI) helps parents receive appropriate education and services for their children with disabilities, works to improve education results for all children, trains and informs parents and professionals and connects children with disabilities to resources that address their needs.
- The *Family to Family Health Information Center (F2F HIC)* provides information and guidance to families, and the professionals who serve them, to access services and resources for children and youth with special health care needs.
- The *Navigator Program* provides individualized guidance and direction to parents and schools regarding special education and related services.
- The *Rural Health Outreach Project* draws upon SDPCs strategic partnerships, outreach and individual assistance to promote early and continuous identification of special health care needs, improved access to community-based systems of care and improved transition tools and options for youth in transition in the rural areas.

In addition to the activities referenced above, MCH staff also serve on a variety of workgroups and advisory boards including Highway Safety Workgroup, Oral Health Advisory Board, Healthy SD Workgroup, State Diabetes Coalition, Parent Connection Family to Family Advisory Council, Early Intervention Coordinating Council, and Developmental Disabilities Council, and South Dakota Youth Suicide Prevention Project Advisory Committee.

Delta Dental of South Dakota established the Dakota Smiles Mobile Dental Program in 2004 to treat children without access to dental care, which includes those children ages 0-21 who have not seen a dentist within the past two years and/or those that live more than 85 miles from a dentist. Dental services provided include teeth cleaning, fillings for cavities, tooth extractions, dental sealants, fluoride treatments, instructions on care of teeth/gums, and tobacco/smoking cessation counseling. The Dakota Smiles program works with local site partners/sponsors who pay a site partner fee of $2,500 per week and who have the ability to identify and recruit patients who would otherwise have difficulty accessing dental services. The care mobile typically spends a week in each community. Since September 2004, the Dakota Smiles Mobile Dental Program has visited 76 communities across the state (including 27 Native American communities) and served 26,473 children and 1,030 adults. Of those children, 50% were Medicaid/SCHIP enrolled and 43% were uninsured. To date, 163,800 diagnostic and preventive procedures and 57,854 restorative procedures have been completed. The retail dollar value of care provided is nearly $13 million. One of the dental care mobiles was recently lost in a fire and Delta Dental is exploring options for replacement of the vehicle and equipment.

The Circle of Smiles Programs focuses on reducing oral health disparities by expanding the preventive oral health workforce in two areas – dental hygienists and community health workers. Delta Dental of South Dakota has hired seven dental hygienists to work in reservation communities. In partnership, Indian Tribes hired 15 community health workers called oral health coordinators. Both workforces are deployed in community health settings on and near reservations to improve access to dental prevention services, oral health education, and care coordination. Since January 2013, the Circle of Smiles Program has visited 63 Native American communities and served 6,664 children and 717 adults. Of those patients, 73% were Medicaid/SCHIP enrolled and 25% were uninsured. To date, over 40,260 preventive procedures have been completed with a retail value of the care provided of nearly $1.7 million.

II.C. State Selected Priorities

No.	Priority Need
1	Promote preconception/inter-conception health
2	Reduce infant mortality
3	Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)
4	Improve early identification and referral of developmental delays
5	Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN
6	Promote oral health for all populations
7	Improve state and local surveillance, data collection, and evaluation capacity

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/ Outcome Measure
1	Promote preconception/inter-conception health	New	
2	Reduce infant mortality	New	
3	Promote positive child and youth development to reduce morbidity and mortality (intentional/ unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)	New	
4	Improve early identification and referral of developmental delays	New	
5	Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN	New	
6	Promote oral health for all populations	New	
7	Improve state and local surveillance, data collection, and evaluation capacity	New	Impacts all NPMs across all domains

As a result of the data review, a list of possible priorities was identified:

Infant mortality	Oral health for all populations
Native American infant mortality	Preconception/inter-conception health
Maternal weight prior to pregnancy	Percent of women with a past year preventive visit
Teen pregnancy	Access to care
Substance abuse – drugs, alcohol, tobacco	Immunization rates
High risk behaviors in adolescents	CYSHCN and medical home
Prevalence of obesity among children and youth/lack of physical activity	Mental/behavioral health including access to care, autism, mental health provider outreach
Prenatal care including health appointments earlier in pregnancy	6-11 year olds and access to care/medical home
Metabolic screening	Appropriate nutrition for infants/children
Hearing screening (1-3-6)	Adequate insurance
STIs	Bullying
Social determinants of health	Suicides and attempted suicides
Unintentional injuries in children	Adolescent motor vehicle deaths
Cross agency collaboration	Safe sleep
Breastfeeding	Maternal alcohol and substance abuse
EEDs	Data

The MCH team developed seven priorities from the 32 priority needs. In narrowing down the list of priorities, the team looked at alignment with DOH 2020 Initiative, legislative priorities, priorities of other partner programs and agencies, where MCH was the lead agency and had capacity to impact change, was progress measurable and did we have a data source to measure, and did they align with NPMs and NOMs. The final seven priorities are:

- Promote preconception/inter-conception health
- Reduce infant mortality
- Promote positive child and youth development to reduce morbidity and mortality (intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and drug utilization)
- Improve early identification and referral of developmental delays
- Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN
- Promote oral health for all populations
- Improve state and local surveillance, data collection, and evaluation capacity

There were no changes made to these state selected priorities during the FFY 2016 grant year.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

The MCH team developed seven priorities from the 32 priority needs. There was significant alignment between the findings from the 2011-2015 and the 2016-2020 needs assessment processes. A majority of South Dakota's current priority efforts will continue for the next five years. The following table captures South Dakota's current priorities and newly selected priority efforts and the NPMs chosen.

Priority and Population Domain	2011-2015 MCH Priorities	2016-2020 MCH Priorities
Maternal/Women Health – NPM 1 Percent of women with a past year preventive medical visit		
Reduce unintended pregnancies	X	
Improve pregnancy outcomes	X	
Promote preconception/inter-conception health		X
Perinatal Health – NPM 5 Percent of infants placed to sleep on their backs		
Reduce infant mortality	X	X
Child's Health – NPM 6 Percent of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool		
Promote positive child and youth development to reduce morbidity and mortality (intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization)		X
Improve early identification and referral of developmental delays		X
Reduce morbidity and mortality among children and adolescents	X	
Reduce childhood obesity	X	
Adolescent Health – NPM 7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 and NPM 10 Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year		
Promote positive child and youth development to reduce morbidity and mortality (intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization)		X
Reduce morbidity and mortality among children and adolescents	X	
Improve adolescent health and reduce risk-taking behaviors	X	
CYSHCN – NPM 11 Percent of children with and without special health care needs having a medical home		
Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN		X

Improve the health of, and services for, CYSHCN through comprehensive services and support	X	
Cross-cutting/Life Course – NPM 13 A) Percent of women who have a dental visit during pregnancy and B) percent of infants and children, 1 to 17, who had a preventive dental visit in the past year and NPM 14 A) Percent of women who smoke during pregnancy and B) percent of children who live in a household where someone smokes		
Improve state and local surveillance, data collection, and evaluation capacity	X	X
Promote oral health for all populations		X
Improve and assure appropriate access to services that are focused on families, women, infants, children, adolescents and CYSHCN	X	

While looking at needs and NPMs, the team also started a "parking lot" for potential SPMs to be included in the next annual application. Topics for state measures included: (1) maternal alcohol and substance abuse; (2) Native American infant mortality; (3) safe sleep; (4) breastfeeding; (5) adolescent suicide/attempted suicide rates; (6) adolescent motor vehicle; (7) CYSHCN (to include metabolic); (8) EEDs; and (9) immunizations.

During FFY 2016, the MCH team did not identify a need to change any of the selected priority needs or National Performance Measures. It was identified that some of the State Objectives under our chosen NPMs needed tweaked in order to best capture progress toward the intended measure. In addition, some of the ESMs were also reworded to better capture the intent and focus of the activities.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

The newly realigned MCH team was pulled together to choose SPMs as well as ESMs for the MCH State Action Plan. During this process, the MCH Team reviewed data compiled for the 5 year needs assessment. The review identified the following three areas of concern that were not previously addressed with the selection of NPMs:

- 2012 National ranking shows that South Dakota is 49th out of 51 states at 33.2% of children ages 2-5 years receiving WIC Services with a BMI at or above the 85th percentile.
- In 2013, South Dakota had the 14th highest suicide rate in the U.S. In 2013, South Dakota ranked #51 nationally in suicide deaths among youth aged 15-19 years and the rate of attempted suicides has increased significantly between 2009 and 2013.
- Infant mortality rates among women attending <50% of their prenatal visits for White and Native American mothers in 2006-2012 were 10.4 and 11.8 per 1,000 live births compared to 3.2 and 9.2 per 1,000 if the attended 50-109% of their prenatal visits. Among White and Native American mothers, 19.5% and 42.8% attended less than 80% of their prenatal visits (3.6% and 15.9% attended less than 50%, respectively).

As a result, the MCH team selected four SPMs.

- SPM 1: Percent of suicide attempts by adolescents ages 14 through 18.
- SPM 2: Percentage of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)
- SPM 3: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent.
- SPM 4: MCH data is analyzed and disseminated.

During FFY 2016 the MCH team moved forward with efforts to address the chosen State Performance Measures. The MCH team did not identify a need to change any of the State Performance Measures and will continue to implement strategies to move toward improvement in each of these areas.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Percent of suicide attempts by adolescents 14 through 18 years of age
- SPM 2 - Percentage of children, ages 2-5, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)
- SPM 3 - Percent of women (15-44 years of age) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80%
- SPM 4 - MCH data is analyzed and disseminated

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/ Outcome Measure
1	Promote preconception/inter-conception health	New	
2	Reduce infant mortality	New	
3	Promote positive child and youth development to reduce morbidity and mortality (intentional/ unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)	New	
4	Improve early identification and referral of developmental delays	New	
5	Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN	New	
6	Promote oral health for all populations	New	
7	Improve state and local surveillance, data collection, and evaluation capacity	New	Impacts all NPMs across all domains

As a result of the data review, a list of possible priorities was identified:

Infant mortality	Oral health for all populations
Native American infant mortality	Preconception/inter-conception health
Maternal weight prior to pregnancy	Percent of women with a past year preventive visit
Teen pregnancy	Access to care
Substance abuse – drugs, alcohol, tobacco	Immunization rates
High risk behaviors in adolescents	CYSHCN and medical home
Prevalence of obesity among children and youth/lack of physical activity	Mental/behavioral health including access to care, autism, mental health provider outreach
Prenatal care including health appointments earlier in pregnancy	6-11 year olds and access to care/medical home
Metabolic screening	Appropriate nutrition for infants/children
Hearing screening (1-3-6)	Adequate insurance
STIs	Bullying
Social determinants of health	Suicides and attempted suicides
Unintentional injuries in children	Adolescent motor vehicle deaths
Cross agency collaboration	Safe sleep
Breastfeeding	Maternal alcohol and substance abuse
EEDs	Data

The MCH team developed seven priorities from the 32 priority needs. In narrowing down the list of priorities, the team looked at alignment with DOH 2020 Initiative, legislative priorities, priorities of other partner programs and agencies, where MCH was the lead agency and had capacity to impact change, was progress measurable and did we have a data source to measure, and did they align with NPMs and NOMs. The final seven priorities are:

- Promote preconception/inter-conception health
- Reduce infant mortality
- Promote positive child and youth development to reduce morbidity and mortality (intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and drug utilization)
- Improve early identification and referral of developmental delays
- Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN
- Promote oral health for all populations
- Improve state and local surveillance, data collection, and evaluation capacity

There were no changes made to these state selected priorities during the FFY 2016 grant year.

II.F. Five Year State Action Plan

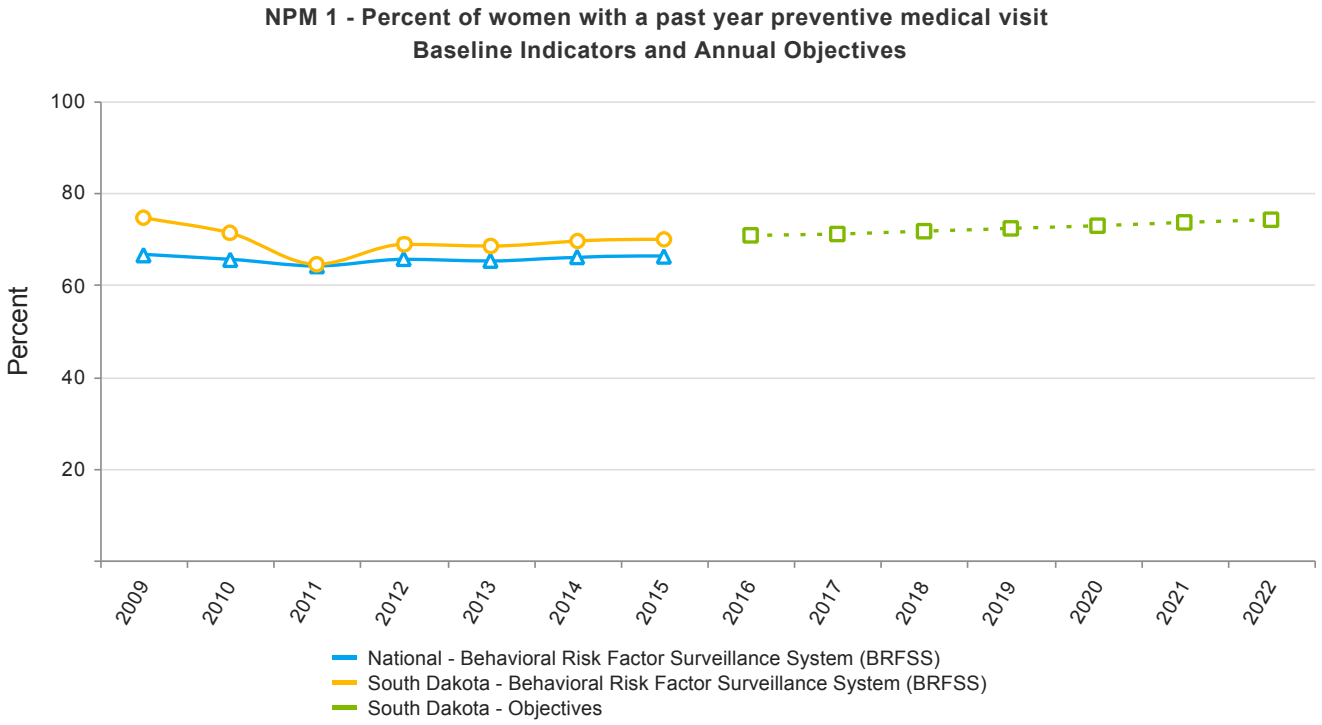
II.F.1 State Action Plan and Strategies by MCH Population Domain

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-2014	125.3	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	28.0	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	6.1 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.0 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	5.1 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	8.5 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.0 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.5 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	23.7 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.3	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.7	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.3	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.4	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	138.4	NPM 1

National Performance Measures



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	70.7
Annual Indicator	69.8
Numerator	98,560
Denominator	141,180
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	71.0	71.6	72.2	72.8	73.5	74.1

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Number of partners who collaborate to promote well women visits

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	9
Numerator	
Denominator	
Data Source	meeting notes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	9.0	9.0	9.0	9.0	9.0	10.0

State Performance Measures

SPM 3 - Percent of women (15-44 years of age) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80%

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	78.1
Numerator	9,457
Denominator	12,102
Data Source	SD Vital Records
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	79.3	79.9	80.5	81.1	81.6	82.2

State Action Plan Table

State Action Plan Table (South Dakota) - Women/Maternal Health - Entry 1

Priority Need
Promote preconception/inter-conception health

NPM
Percent of women with a past year preventive medical visit

Objectives
By June 30, 2020, increase the percent of 18-24 year old women who had a preventive medical visit in the past year from 66.4% (2014) to 67.8%. (BRFSS)

Strategies
Schedule quarterly DOH-wide team meetings to address preventive screening and women's health
Collaborate with Medicaid and BHR to promote well visits and reminder strategies.
Make resources available to promote and educate women on preventive medical visits.
Include well-care visit messages in DOH-wide social media and other communications
Explore the option to document women's well visits under the referral section in the WIC, Bright Start, and Family Planning programs.
Maintain DOH infrastructure/workforce in order to provide education and outreach to clients and providers

ESMs	Status
ESM 1.1 - Number of partners who collaborate to promote well women visits	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 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 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

State Action Plan Table (South Dakota) - Women/Maternal Health - Entry 2

Priority Need

Promote preconception/inter-conception health

SPM

Percent of women (15-44 years of age) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80%

Objectives

By June 30, 2020, increase the percent of women (15 through 44 years) who talked to a healthcare worker about preparing for a healthy pregnancy before they got pregnant from 32.8% (2014) to 34.5% (PRAMS).

Strategies

Schedule quarterly DOH-wide team meetings to address Preconception Health

Implement strategies to increase awareness on importance of preconception/inter-conception and postpartum health in social media and other communications

Outreach to insurance groups to promote early and adequate access to prenatal care for all women

Make resources available to women and providers

Maintain DOH infrastructure/workforce in order to provide education and outreach to clients and providers

Women/Maternal Health - Plan for the Application Year

South Dakota Women/Maternal Health Domain Plan for FFY18

Within the Women/Maternal Health Domain, one National Performance Measure and one State Performance Measure have been identified.

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

National Performance Measure 1: Percent of women ages 18-44 with a past year preventive medical visit

Objectives:

1. 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 66.4% (2014) to 67.8%. (BRFSS)

Strategies:

1.1. (New strategy) Schedule quarterly DOH-wide team meetings to address preventive screening and women's health.

(Previous Strategy) Convene a DOH-wide team to address preventive screening and women's health

Justification for change – A DOH-wide team has already been convened. This strategy was progressed to meeting quarterly.

- Continue to meet on a quarterly basis to discuss ways to promote women's health in South Dakota

1.2. (New strategy) Collaborate with Medicaid and BHR to promote well visits and reminder strategies.

(Previous strategy) Link with insurance groups to promote well women visits and reminder strategies

Justification for Change – This strategy was changed to make it more specific. The DOH has named the partners it will be collaborating with in efforts to promote well women visits.

- Title V staff will continue to enhance the existing partnership with Medicaid and BHR (State employee health insurance) to promote well women visits.

1.3. (New strategy) Make resources available to promote and educate women on preventive medical visits.

(Previous strategy) Make resources available to women including what to expect at a well visit

Justification for change – This strategy was changed to give it more definition/direction.

- Continue to disseminate existing resources from ACOG; CDC; Before, Between and Beyond Pregnancy; and March of Dimes on the importance of Well Women visits
- Investigate the source to update the Get Covered SD pamphlet to utilize for the 2018 Marketplace enrollment

- Create new resource that addresses well women visits for the Bright Start baby boxes (current pamphlet only addresses folic acid use)

1.4. Include well-care visit messages in DOH-wide social media and other communications

- Maintain Preconception Health section on *For Baby's Sake* website
- Promote 'Scheduling Annual Well Woman Check-ups' section on *For Baby's Sake* website
- Continue to disseminate information via Facebook on Well Woman's visits for Women's Health Month in May
- Create print ads to promote well woman visits in the 'hood and Rapid City Parent magazines

1.5. (Added strategy) Explore the option to document women's well visits under the referral section in the WIC, Bright Start, and Family Planning programs.

- Meet with each program to determine if their data system would allow this information to be documented.

1.6. Maintain DOH infrastructure/workforce in order to provide education and outreach to clients and providers.

- Maintain current FTE for MCH programs
- Provide training for field staff on Preconception and Inter-conception health

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

State Performance Measure 3: The percent of women (15-44 years of age) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80%

Objectives:

1. By June 30, 2020, increase the percent of women (15 through 44 years) who talked to a health care worker about preparing for a healthy pregnancy before they got pregnant from 32.8% (2014 PRAMS-like Survey) to 34.5%

Strategies:

3.1. (New strategy) Schedule quarterly DOH-wide team meetings to address Preconception Health

(Previous Strategy) Convene a DOH-wide team to address early and adequate prenatal care

Justification for change – This workgroup has already convened and would like to focus on the objective which relates mainly to preconception health.

- Continue to meet quarterly to discuss ways to promote preconception health in SD

3.2. Implement strategies to increase awareness of importance of preconception/ inter-conception and postpartum health in social media and other communications

- Promote *For Baby's Sake website* additions 'Preconception Health and Planning' and 'Scheduling

Prenatal Check-ups'

- Continue to promote Text4Baby in DOH offices, website and Facebook posts.
- Create Facebook posts with messaging related to preconception health
- Enhance 'Preconception Health' content on *For Baby's Sake* website to include information for men.

3.3. Outreach to insurance groups to promote early and adequate access to prenatal care for all women

- Identify private insurance companies/groups to target in promoting messaging to their clients regarding the importance of preconception health and early and adequate prenatal care
- Work with the State's BHR to promote preconception health and early and regular prenatal care for its employees

3.4. Make resources available to women and providers

- Develop a timetable for posting preconception and inter-conception messaging on Facebook
- Continue to promote the use of Text4Baby to all pregnant moms on the website, in Facebook posts, and through print materials in all Community Health offices across the state.
- Disseminate data from 2014 PRAMS-like survey to providers related to early and adequate prenatal care through ads in the SD Medicine Journal

3.5. Maintain DOH infrastructure/workforce in order to provide education and outreach to clients and providers.

- Title V staff will educate field staff working with pregnant and postpartum moms on the resources available to promote preconception health and early and regular prenatal care

South Dakota Women/Maternal Health Domain Annual Report FFY2016

Many of the MCH Team efforts during FFY2016 were focused on previous goals and targets as the MCH continues to work on finalizing the state action plan. The DOH was also focused on team building as there was no FTE assigned to oversee the work in this domain before.

Within the Women/Maternal Health Domain, one National Performance Measure and one State Performance Measure have been identified.

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

National Performance Measure 1: Percent of women ages 18-44 with a past year preventive medical visit

Data Statement:
Although South Dakota did not reach its 2015 target of 70.1% there is a significant increase over the last five years in the percent of women with a past year preventive visit with a 2015 rate of 69.8%. In 2014, South Dakota was ranked 17th in the nation for the highest percent of women with a preventive visit.

Objectives:

- 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 66.4% (2014) to 67.8%. (BRFSS)

Data Statement:
Although the total percent of women with a past year preventive visit has increased over the last five years, the percent of 18 through 25 year old women having a preventive visit has decreased significantly between 2013 and 2015 from 68.5% to 63.5%. The South Dakota 2015 rate of 63.5% is below the 2015 Objective of 70.1%.

Strategies:

1.1. Convene a DOH-wide team to address preventive screening and women's health

- This team did not convene before September 30, 2016.

Challenges:
Staff vacancies in the Office of Child and Family Services (which MCH is a part of) made it difficult to form a team. FFY 2016 was a team building year for Maternal Child Health within the Department of Health.

1.2. Link with insurance groups to promote well women visits and reminder strategies

- Staff from the Office of Child and Family Services met with DSS-Medicaid to discuss ways to promote well women visits for those covered by Medicaid. Reminder strategies were also discussed. This discussion centered around utilizing annual check-up reminders similar to those that are already being used with children on Medicaid in the State. DSS mails an annual check-up reminder several months before the child's birthday with information about the importance of preventive care.

Challenges:

It was decided to start to develop a relationship with Medicaid first in regards to the well women visit before moving forward with contacting other insurance groups. The DOH was already working with Medicaid on other programs so this seemed like a good place to start.

1.3. Make resources available to women including what to expect at a well visit

- Field staff from Bright Start, Family Planning and Community Health shared ACA resources with clients around the state. If a client did not have health insurance upon admission to any of the programs, they were referred to Medicaid, HealthCare.gov or a local Navigator to get signed up.
- SD Family Planning continued to partner with Get Covered South Dakota to promote enrollment in ACA for women's health screens.
- Information about what to expect at a well visit was disseminated by Bright Start staff across the state as this is a part of their postpartum curriculum.

Challenges:

Unable to track the number of referrals that were made to ACA or how many were enrolled as a result of these referrals.

1.4. Include well-care visit messages in DOH-wide social media and other communications

- Community Health field staff utilized the pamphlet *Before You Know You're Pregnant* with postpartum moms to communicate the message 'preventive visits are important for overall health'.
- The DOH's *For Baby's Sake* website had a section titled 'It Starts With You' which discussed the importance of regular annual visits for all women in child bearing years.
- Text4Baby information was included in the Bright Start baby box that was mailed to every new mother in South Dakota who hadn't had a newborn in the last 4 years.

Challenges:

The DOH has focused its past efforts on Inter-conception and Postpartum messaging. With the lack of FTE in this Domain it has been difficult to broaden the scope.

1.5. Maintain DOH infrastructure

- DOH received approval for a full time MCH Coordinator to work in the area of Women/Maternal Health and Perinatal Infant Health

Challenges:

Several positions within the Office of Child and Family Services were vacant during this grant period which made it difficult to carry out the strategies for this NPM.

ESMs

1.1. Number of partners who collaborate to promote well women visits

- The following is a list of partners who collaborated over this grant period to promote well women visits in South Dakota:

- SD Medicaid
- SD Bright Start
- SD Family Planning
- All Women Count
- Get Covered SD
- PREP
- SD Office of Disease Prevention
- 211 HELP line
- Teddy Bear Den – Sioux Falls

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

State Performance Measure 3: The percent of women (15-44 years of age) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent

Data Statement:
The 2015 rate of 78.1% is close to the 2015 Objective of 78.2% and there has been a significant increase between 2011 (75.9%) and 2015 (78.1%).

Objectives:

1. (New objective) By June 30, 2020, increase the percent of women (15 through 44 years) who talked to a health care worker about preparing for a healthy pregnancy before they got pregnant from 32.8% (2014 PRAMS-like Survey) to 34.5%

   (Previous objective) By June 30, 2020, decrease the percent of unmarried women (15 through 44) who did not talk to a healthcare worker about preparing for a healthy pregnancy before they got pregnant from 75.3% to 71.5%.

   Justification for change – This objective was modified to incorporate a broader look at preconception planning for all women of child bearing age not just unmarried women. The MCH team felt that the goal should include all women ages 15-44 instead of just a sub-category of women.

   Data Statement:
   In 2014, 32.8% of women talked to a health care worker about preparing for a healthy pregnancy before they got pregnant.

Strategies:

S3.1. Convene a Department of Health-wide team to address early and adequate prenatal care

- This team did not convene before September 30, 2016.

Challenges:
In FFY 2016 the Office of Child and Family Services was in the process of filling vacancies within the department and building its MCH team. It wasn't until the end of 2016 that the first MCH Coordinator position was approved and advertised.

S3.2. Implement strategies to increase awareness of importance of preconception/ inter-conception and postpartum health in social media and other communications

- Title V funds were used to promote a Preconception Health section on the *For Baby's Sake* website.
- Field staff from across the state promoted the use of Text4Baby with their pregnant and postpartum clients. South Dakota has consistently ranked third in the nation for the percentage of eligible women enrolled.

Challenges:
In South Dakota half of pregnancies are unplanned. The preconception planning message may not seem relevant to these women because they were not intending on becoming pregnant. Another challenge with this strategy is lack of funding to expand messaging to a new target audience.

S3.3. Outreach to insurance groups to promote early and adequate access to prenatal care for all women.

- Staff from the Office of Child and Family Services met with DSS-Medicaid to discuss ways to promote well women visits for those covered by Medicaid. This discussion centered around utilizing annual check-up reminders similar to those that are already being used with children on Medicaid in the State. The rationale for focusing on the well women visit is if women are receiving a yearly well women visit with their doctor then pregnancy planning should be a part of the discussion.

Challenges:
Movement on this strategy has been slow because Title V staff first needed to build a rapport with DSS staff before any work in this area could be accomplished.

S3.4. Make resources available to women and providers.

- Shared data from the 2014 PRAMS-like survey on early and regular prenatal care to members of the South Dakota Perinatal Association.
- Disseminated data from 2014 Prams-like survey identifying barriers to early and regular prenatal care on the DOH website.
- Through partnership with DSS Medicaid, all pregnant women entering Office of Child and Family Services programs were risk assessed and referred to a provider if they had not already started prenatal care. A total of 3,352 pregnant women had a risk assessment completed during this grant period.
- All pregnant WIC clients across the state were seen monthly to receive benefits, educational resources and to assure compliance with their regular prenatal care. A total of 4,035 modified case management visits and 6,439 prenatal health reviews were completed during this grant period.

Challenges:
The challenge with this strategy was identifying resources that providers are receptive to.

S3.5. Maintain DOH infrastructure/workforce in order to provide education and outreach to clients and providers.

- Approval received for a 1.0 FTE MCH Coordinator who will be responsible to coordinate efforts under the Women/Maternal Health Domain

Challenges:

In previous years there has been no FTE directly assigned to this domain.

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-2014	5.7	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.4	NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	114.0	NPM 5

National Performance Measures

NPM 5 - Percent of infants placed to sleep on their backs
Baseline Indicators and Annual Objectives

FAD for this measure is not available for the State.

State Provided Data	
	2016
Annual Objective	88.2
Annual Indicator	86.7
Numerator	9,607
Denominator	11,078
Data Source	SD PRAMS LIke Survey
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	88.9	89.6	90.3	91.1	91.8	92.5

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Number of page engagements to the For Baby's Sake Facebook page

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	52,849
Numerator	
Denominator	
Data Source	For Babys Sake Facebook Page Count
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	53,729.0	54,609.0	55,489.0	56,369.0	57,249.0	58,129.0

ESM 5.2 - Percent of Sudden Unexpected Infant Deaths reviewed for which a SUIDI reporting form was received and reviewed as part of the Infant Death Review Team meeting.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	70
Numerator	70
Denominator	100
Data Source	SUIDI reporting system
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	70.0	70.0	70.0	80.0	80.0	90.0

State Action Plan Table

State Action Plan Table (South Dakota) - Perinatal/Infant Health - Entry 1

Priority Need
Reduce infant mortality

NPM
Percent of infants placed to sleep on their backs

Objectives
By June 30, 2020, increase the percent of infants from other races (not White or Native American) placed to sleep on their backs from 79.9% (2014) to 84% (PRAMS)
By June 30, 2020, decrease the percent of infants who share a bed with their mother or anyone else as determined in the 2016 PRAMS-like survey. Target for 2020 will be based on achieving a 10% reduction in this rate by 2026.

Strategies
Maintain DOH infrastructure/workforce in order to provide education and outreach to clients and community partners
Engage and support collaboration among state agencies to promote education on the importance of safe sleep practices
Implement strategies to increase awareness of the importance of safe sleep practices targeted to Native Americans, dads, and grandparents
Collaborate with community partners to facilitate infant death review
Train law enforcement on use of Sudden Unexplained Infant Death Investigation (SUIDI) reporting forms

ESMs	Status
ESM 5.1 - Number of page engagements to the For Baby's Sake Facebook page	Active
ESM 5.2 - Percent of Sudden Unexpected Infant Deaths reviewed for which a SUIDI reporting form was received and reviewed as part of the Infant Death Review Team meeting.	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 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

South Dakota Perinatal/Infant Health Domain Plan for FFY18

Within the Perinatal/Infant Health Domain, one National Performance Measure has been identified.

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

NPM 5 Percent of infants placed to sleep on their backs

Objectives:

1. By June 30, 2020, increase the percent of infants from other races (not White or AI) placed to sleep on their backs from 79.9% (2014) to 84% (PRAMS)

2. By June 30, 2020, decrease the percent of infants who share a bed with their mother or anyone else as determined in the 2016 PRAMS-like survey. Target for 2020 will be based on achieving 10% reduction in this rate by 2026.

Strategies:

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

- Present Infant Death Review report to Child and Family Services MCH Interagency Workgroup to educate and solicit partnerships
- Disseminate PRAM safe sleep data to state agencies that work with families with infants.
- Add safe sleep question to SD WIC-IT infant assessment
- Collaborate with DSS Division of Childcare Services to develop resources for Licensed and Registered Daycare providers
- Complete trainings for all Community Health and Bright Start staff on safe sleep assessment algorithm

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

- Add culturally appropriate educational materials to safe sleep kits for distribution to native families.
- Distribute Grandparent safe sleep posters to Native communities
- Continue to collaborate with AARP in posting safe sleep messages on their social media sites
- Actively market Text4Baby to dads
- Continue to support media messaging to American Indians and grandparent audiences
- Create media messaging targeting dads
- Continue to support the First Lady's social media campaign to decrease infant mortality in the state.

5.3. Collaborate with community partners to provide infant death review

- Disseminate state infant death review report
- Facilitate training for East and West River Child Death Review Teams by the National Center for Fatality

Review and Prevention staff

5.4. Train law enforcement on use of Sudden Unexplained Infant Death Investigation reporting (SUIDI) forms.

- Continue to support contracted Pathologist's efforts to line up law enforcement trainings across the state

5.5. Maintain Department of Health infrastructure/workforce in order to provide education and outreach to clients and community partners.

- Maintain MCH FTE to carry out strategies and meet objectives
- Provide training to field staff on Infant Death Review process and resulting preventive strategies for safe sleep
- Require completion of NICHD Safe Sleep Curriculum for Nurses and Safe Sleep orientation modules within 90 days of employment for Office of Child and Family Services health professionals

South Dakota Perinatal/Infant Health Domain Annual Report FFY2016

Many of the MCH Team efforts during FFY2016 were focused on previous goals and targets as the MCH continues to work on finalizing the state action plan. 2016 was a MCH team building year; however, there were many accomplishments in the area of perinatal/infant health.

Within the Perinatal/Infant Health Domain one National Performance Measure has been identified.

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

NPM 5 Percent of infants placed to sleep on their backs

Data Statement:
The South Dakota 2014 rate of 86.7% is greater than the HP 2020 target of 75.9%.

Objectives:

1. By June 30, 2020, increase the percent of infants from other races (not White or AI) placed to sleep on their backs from 79.9% (2014) to 84% (PRAMS)

   Data Statement:
   The South Dakota 2014 rate of 79.9% is greater than the HP 2020 target of 75.9%, but significantly less than what is observed in White mothers and American Indian mothers.

2. (New objective) By June 30, 2020, decrease the percent of infants who share a bed with their mother or anyone else as determined in the 2016 SD PRAMS-like survey. (Target for 2020 will be based on achieving 10% reduction in this rate by 2026)

   (Previous objective) By June 30, 2020, decrease the percent of adults who co-sleep with their child as determined in the 2016 SD PRAMS-like survey.

   Justification for change – The definition of co-sleep varies depending on what source is being used. The term co-sleep has been replaced by the phrase share a bed to clarify the meaning of the objective.

   Data Statement:
   Data not available as of May 2017.

Strategies:

5.1. Provide training to interpreters to promote education on the importance of safe sleep practices to participants who are non-English speaking.

- It was determined from the 2014 PRAMS-like survey that the foreign families served were the most likely to place their babies prone or on their side to sleep. In FY2016 the DOH changed their interpreter policy. In the new policy, reimbursement for interpreter services was limited to contract agencies that employed certified interpreters. This change provided more assurance that the safe sleep education field staff was

providing was accurately interpreted to clients. As a result this strategy has been met and removed for future years.

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

- In FY 2016 a Child and Family Services MCH Interagency Work Group was convened comprised of DOH, DSS Child Care Services and Medicaid, Birth to Three, Head Start, and DHS Family Support to facilitate partnerships and leverage resources.
- Worked with USD school of nursing to develop day care education program targeting providers registered by the city of Sioux Falls (largest city in South Dakota) but not licensed through DSS.

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

- Supported radio, print, and social media campaigns promoting safe infant sleep.
- Expanded media campaign by Spokesperson, First Lady Linda Daugaard, targeting grandparents and promoting new safe sleep traditions in families.
- Shared data and promoted infant safe sleep and other DOH Infant mortality prevention strategies to members of the SD Perinatal Association.
- Finalized and disseminated data from 2014 PRAMS-like survey identifying use of infant sleep practices and differences by race/ethnicity.
- Funded Cribs for Kids program through Department of Health offices statewide. Expanded program to reservation areas served by Rosebud IHS and Tribal MCH, and Cheyenne River Sioux Tribal MCH. Maintained partnerships with Teddy Bear Den incentive program and Children's Inn both in Sioux Falls.
- Bright Start Home Visiting addressed safe sleep with 3 different questions on sleep positions added to their assessment tool.
- Expanded PRAMS assessment questions related to infant sleep environment.

5.4. Collaborate with community partners to provide infant death review

- Finalized review of 35 post hospital discharge infant deaths in 2015.
- Compiled trend data for the 97 infant deaths reviewed from 2013-2015.
- Contracted with Dr. Ann Wilson and Deborah Kuehn, CNP to coordinate infant death review across the state. Death review team members consisted of law enforcement, Child Protection Services, Forensic Pathologists, hospital staff, fire department staff, and EMS. The East River team met 3 times during this grant period and the West River Team met twice during this time frame.

Challenges:
Both teams are comprised of volunteers from their communities and are led by volunteers so it is difficult to have consistency in membership. The West River team has tribal officials on it but there is no consistency as far as who shows up for the meetings which makes it difficult to conduct thorough reviews.

5.5. Train law enforcement on use of Sudden Unexplained Infant Death Investigation (SUIDI) reporting forms

- Contracted with a Forensic Pathologist to provide infant death scene investigation training to law enforcement personnel across the state in an effort to increase use of SUIDI report forms. Dr. Randall trained 60 law enforcement personnel/ University students over this grant period.

Challenges:
It has been difficult to arrange trainings with law enforcement due to their rigorous schedules. Several law enforcement agencies in rural communities didn't feel the need to receive training as they see so few infant deaths.

5.6. Maintain Department of Health infrastructure/workforce in order to provide education and outreach to clients and community partners.

- DOH received approval for a full time MCH coordinator to work in the area of Women/Maternal Health and Perinatal/Infant Health.

Challenges:
Several positions within the Office of Child and Family Services were vacant during this grant period which made it difficult to carry out strategies for this NPM.

ESM:

Number of Page Engagements to the "for Baby's Sake" Facebook Page

- 52,849 page engagements occurred on the "for Baby's Sake" Facebook Page

Percent of Sudden Unexpected Infant Deaths reviewed for which a SUIDI reporting form was received and reviewed as a part of the Infant Death Review Team meeting.

- From January 1, 2016 through December 31, 2016, 70% of SUIDs reviewed had a SUIDI reporting form completed and reviewed by the Infant Death Review Team.

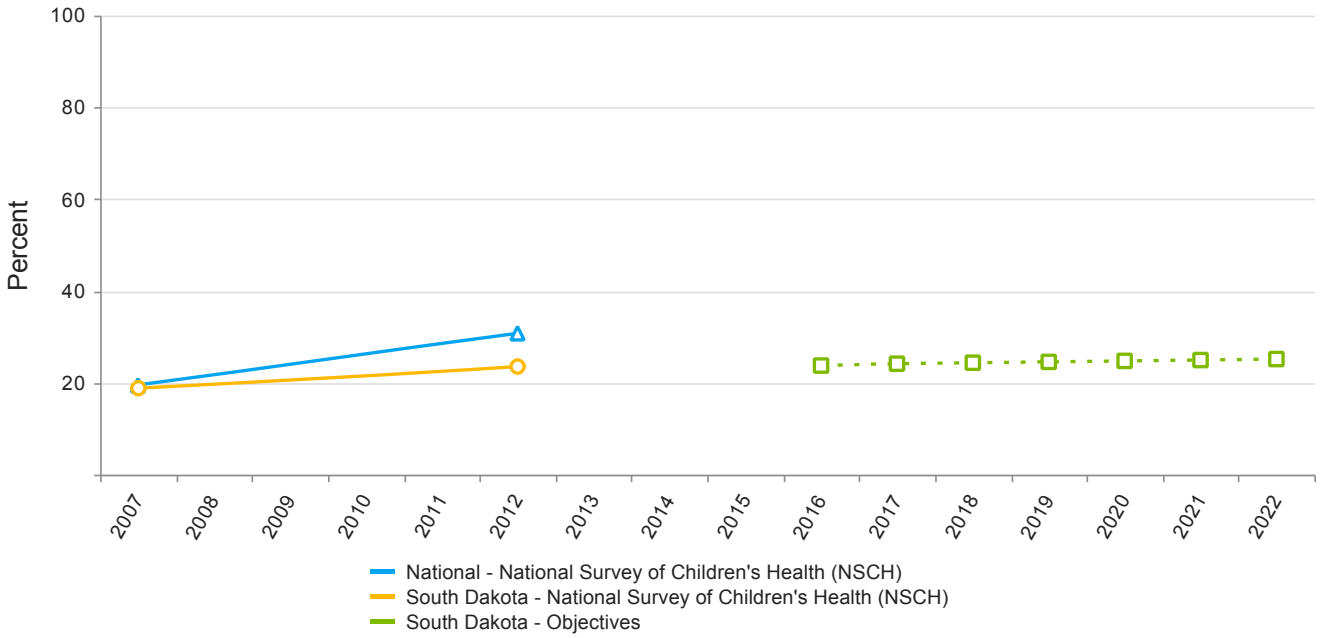
Child Health

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	NPM 6
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	91.7 %	NPM 6

National Performance Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	23.8
Annual Indicator	23.5
Numerator	12,793
Denominator	54,515
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	24.2	24.4	24.6	24.8	25.0	25.2

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Number of partners who collaborate to promote early childhood screening

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	6
Numerator	
Denominator	
Data Source	meeting notes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	6.0	6.0	7.0	7.0	7.0	7.0

State Performance Measures

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
Annual Objective	
Annual Indicator	36.1
Numerator	1,868
Denominator	5,179
Data Source	FAD NOM 20 WIC data
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.4	27.2	25.0	22.8	20.5	18.3

State Action Plan Table

State Action Plan Table (South Dakota) - Child Health - Entry 1

Priority Need

Improve early identification and referral of developmental delays

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

By June 30, 2020, increase the percent of children from non-metropolitan areas who have a developmental screening completed from 19.4% (2011-2012) to 20.5%. (NSCH)

Strategies

Convene a partner team to look at developmental screening and referral

Maintain DOH infrastructure/workforce to facilitate the completion of developmental screenings and anticipatory guidance for clients served

ESMs	Status
ESM 6.1 - Number of partners who collaborate to promote early childhood screening	Active

NOMs

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

NOM 19 - Percent of children in excellent or very good health

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

Priority Need

Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)

SPM

Percentage of children, ages 2-5, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)

Objectives

By June 30, 2020, decrease the percentage of students 5-6 years old with a BMI at or above the 85th percentile from 26.6% (2015) to 21.6% (School height/weight data)

Strategies

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

Maintain DOH infrastructure/workforce in order to provide education and outreach to clients and community partners

Integrate nutrition and physical education into broader health promotion efforts

Promote childcare training to improve public awareness on physical activity and nutrition policy

Include nutrition and physical activity messages in social media and other communications

South Dakota Child Health Domain Plan for FFY18

Within the Child Health Domain one National Performance Measure and one State Performance Measure have been identified.

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

National Performance Measure 6: Percent of children, ages 10-71 months receiving a developmental screening using a parent-completed screening tool

Objectives:

1. By June 30, 2020, increase the percent of children from non-metropolitan areas who have a developmental screening completed from 19.4% (2011-2012) to 20.5% (NSCH)

Strategies:

6.1. Convene a partner team to look at developmental screening and referral.

- Work with Medicaid to identify numbers receiving developmental screening and referral.
- Identify pocket areas of low screening numbers and direct efforts there

6.2. Maintain Department of Health infrastructure/workforce to facilitate the completion of developmental screenings and anticipatory guidance for clients served.

- Identify how to capture developmental screenings completed.
- Identify how to best utilize OCFS staff time to capture developmental screenings completed (example WIC vs. Home Visiting vs vaccination appts.)
- Document the need for a data system that will provide an unduplicated count of children screened
- Provide training on ASQ and ASQ SE screening and referral to DOH field staff

DOH 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)

Objectives:

1. By June 30, 2020, decrease the percentage of students 5-6 years old with a BMI at or above the 85th percentile from 26.6% (2015) to 21.6% (school height/weight data)

Strategies:

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

- Investigate Head Start policies around overweight and obese curriculum
- Continue to meet with Dept. of Education Head Start and Dept. of Social Services Child Care Services partners to address nutrition and physical activity efforts and possibilities for future collaboration.

S2.2. Integrate nutrition and physical activity education into broader health promotion efforts.

- Continue to support DSS Child Care Services efforts to provide FitCare training around target population
- Pursue Y programs offered to 2 to 5 year olds and possible linkages

S2.3. Include nutrition and physical activity messages in social media and other communications.

- Promote increase of fruits and vegetables consumption via social media campaign
- Promote Harvest of the Month customized lesson plans to introduce consumption of fruits and vegetables to toddler aged children.

S2.4. Promote child care training to improve public awareness on physical activity and nutrition policy.

- Promote FitCare and their nutrition component

S2.5. Maintain DOH infrastructure/workforce in order to provide education and outreach to clients and community partners.

- WIC program will continue to provide training via the Nutrition educator

South Dakota Child Health Domain Annual Report FFY2016

Many of the MCH Team efforts during FFY2016 were focused on previous goals and targets as the DOH continued our work on finalizing what the state action plan would look like. Therefore implementation of the new measures/strategies did not progress as much as anticipated during this reporting year.

Within the Child Health Domain one National Performance Measure and one State Performance Measure have been identified.

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

National Performance Measure 6: Percent of children, ages 10-71 months receiving a developmental screening using a parent-completed screening tool

Data Statement:
The most recent percent of children (10-71 months of age) receiving a developmental screening tool was 23.5% in 2011-2012. This rate was significantly lower than the US rate in similar years and is below the HP 2020 target of 24.9%. There has been no significant trend between 2007 and 2012.

Objectives:

1. By June 30, 2020, increase the percent of children from non-metropolitan areas who have a developmental screening completed from 19.4% (2011-2012) to 20.5%. (NSCH)

   Data Statement:
   The most recent percent of children (10-71 months of age) receiving a development screening tool and residing in non-metropolitan areas was 19.4% in 2011-2012. This is significantly lower than the rate in all SD children (23.5%).

Strategies:

6.1. Convene a partner team to look at developmental screening and referral.

- Participate on the State's Early Intervention Coordinating Council to ensure input on the early identification and referral process and the role DOH can play in this effort.
- A Child and Family Services Interagency workgroup consisting of membership from the DOH, DSS, DOE, and DHS has been established and meets on a quarterly basis – the group is focusing on ages 0-5 to improve service, promote collaborative programming, reduce duplication and support department/ program strategic plans.

6.2. Maintain Department of Health infrastructure/workforce to facilitate the completion of developmental screenings and anticipatory guidance for clients served.

- Appropriate screening offered during WIC certification
- Appropriate screening offered during Bright Start visits
- Appropriate screening offered when apparent delays are recognized by staff (non-contract sites)

- Appropriate screening offered during immunization appointments
- Send screening tools home for completion and return
- Having parents/guardians complete screening tools “in house” to ensure completion and return
- Providing reminders to bring completed screening tools to appointments
- 8,944 developmental screens completed in FY 2015-2016 by Community Health Office staff.

ESMs

6.1. Number of partners who collaborate to promote early childhood screening.

- Six partners – Home Visiting; Medicaid; Community Health; Head Start; Birth to 3; and Child Care Services

DOH 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:
The 2014 rate of 36.1% is greater than the HP 2020 target of 9.4%. There has been no significant trend between 2008 (36.0%) and 2014 (36.1%). In 2012, SD was ranked 38th in the nation for the lowest percent of children with a BMI at or above the 85th percentile.

Objectives:

1. By June 30, 2020, decrease the percentage of students 5-6 years old with a BMI at or above the 85th percentile from 26.6% (2015) to 21.6% (School height/weight data)

Data Statement:
The 2016 rate of 27.2% is greater than the HP 2020 target of 15.7% for 6 to 11 year olds. There has been no change in the rate between 2015 (26.6%) and 2016.

Strategies:

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

- A Child and Family Services Interagency workgroup consisting of membership from the DOH, DSS, DOE, and DHS has been established and meets on a quarterly basis – the group is focusing on ages 0-5 to improve service, promote collaborative programming, reduce duplication and support department/program strategic plans.

Challenges:
Difficult to coordinate a meeting time that works for multiple state agency leaders to discuss current work that aligns with the effort to decrease the percentage of students 5-6 years old with a BMI at or above the 85th percentile. Also lack of funding in promoting Nutrition and Physical Activity (NPA) education and child care staff turnover are an ongoing challenge.

S2.2 Integrate nutrition and physical activity education into broader health promotion efforts.

- Utilized the Harvest of the Month curriculum to provide creative ways to increase vegetable and fruit consumption for all ages. The tracking on the website showed that 19 childcare providers have utilized the program.
- Promoted National Nutrition Month and National Fruit and Vegetable Month in WIC offices to promote healthy habits.
- Partnered with SDSU Extension to provide WIC participants with monthly newsletters featuring healthy eating tips and recipes.

Challenges:
Lack of funding in promoting NPA education and child care staff turnover.

S2.3 Include nutrition and physical activity messages in social media and other communications.

- Included several activities and objectives to address overweight and other chronic diseases in the 2015 Nutrition and Physical Activity State Plan.
- Made educational brochures available on the DOH website to provide updated consumer and provider resources for overweight and obese children.
- Website and Facebook engagements specific to nutrition and physical activity:
  - HealthySD.gov – 13,526 engagements;
  - sdharvestofthemonth.org – 19,401 engagements;
  - www.Munchcode.org – 2,025 engagements;
  - Healthy SD Trails Facebook engagements – 42, 179;
  - YUM! Facebook page – 26,282.

S2.4 Promote child care training to improve public awareness and nutrition policy.

- Offered the fitCare program through a face-to-face meeting format and online format to increase the availability of the program. As of this reporting period there are 502 childcare providers trained in the fitCare program.
- Initiated Physical Activity Technical Assistance (PATA). Four childcare centers have adopted physical activity policies and 32 are working toward adoption of policies.

S2.5 Maintain DOH infrastructure/workforce in order to provide education and outreach to clients and community partners.

- Office of Child and Family Services recently restructured and involved the field staff and regional managers in the MCH process to align goals and objectives internally, which has improved the ability of staff to provide education and outreach to clients and community partners.

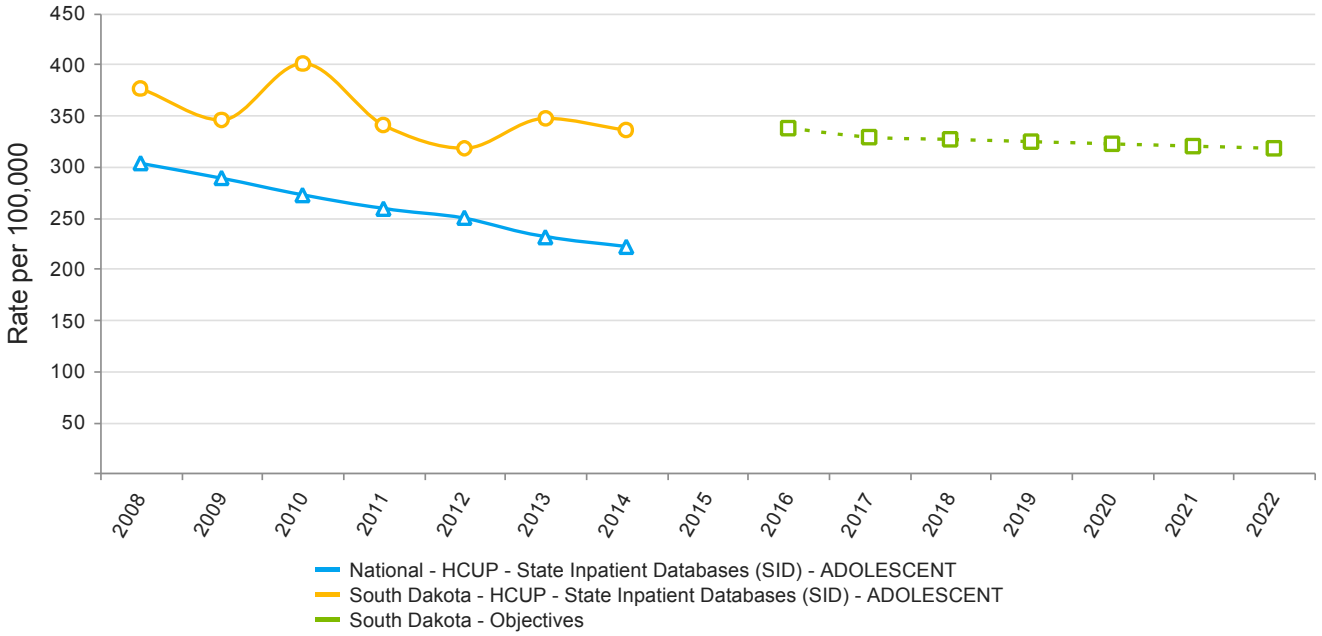
Adolescent Health

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-2015	24.8	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	56.6	NPM 7 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	14.6	NPM 7 NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	29.1	NPM 7 NPM 10
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling	NSCH-2011_2012	63.6 %	NPM 10
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	91.7 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	26.5 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	36.1 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	29.2 %	NPM 10
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	70.8 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	53.2 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	39.2 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	72.4 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	55.5 %	NPM 10

National Performance Measures

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
Baseline Indicators and Annual Objectives



NPM 7 - Adolescent Health

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - ADOLESCENT	
	2016
Annual Objective	337.2
Annual Indicator	335.0
Numerator	379
Denominator	113,144
Data Source	SID-ADOLESCENT
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	328.4	326.2	324.0	321.8	319.6	317.4

Evidence-Based or –Informed Strategy Measures

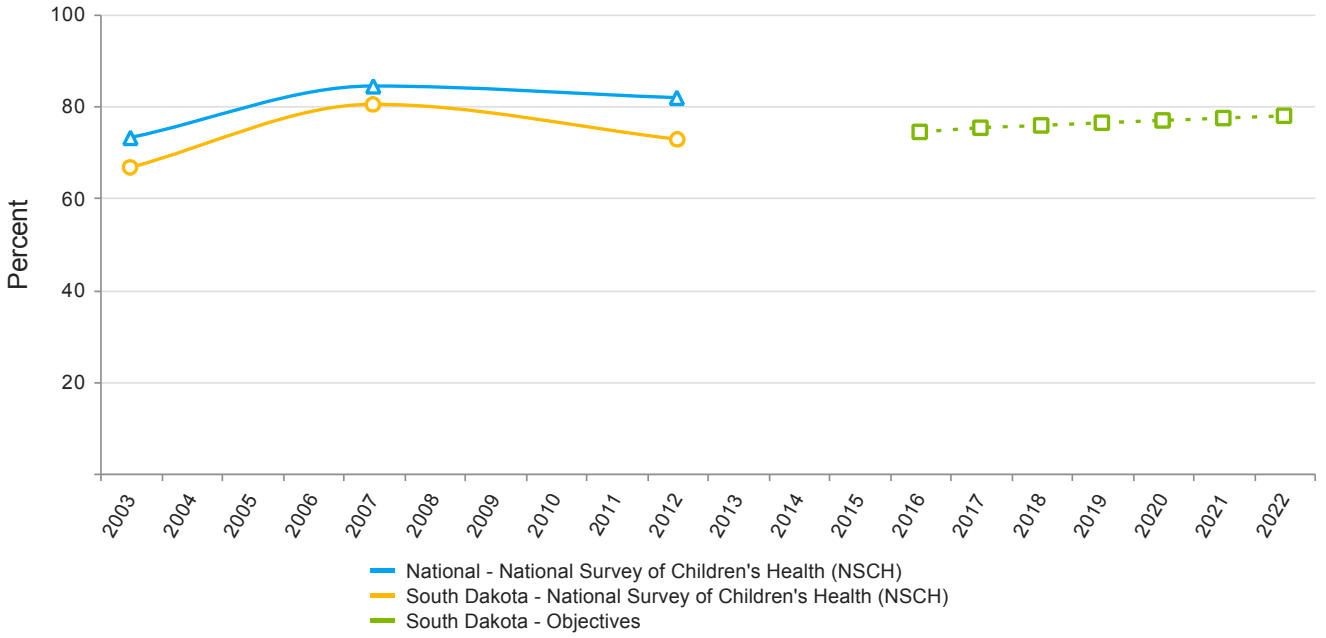
ESM 7.1 - Number of partners who collaborate to promote motor vehicle safety activities

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	meeting minutes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	2.0	3.0	3.0	4.0	4.0

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	74.3
Annual Indicator	72.6
Numerator	45,469
Denominator	62,654
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	75.2	75.7	76.3	76.8	77.3	77.8

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Number of publications/mailings promoting outreach regarding Bright Futures

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	number of mailings
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	2.0	2.0	2.0	2.0	2.0

State Performance Measures

SPM 1 - Percent of suicide attempts by adolescents 14 through 18 years of age

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	8.4
Numerator	98
Denominator	1,166
Data Source	YRBS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.2	6.6	6.0	5.4	4.7	4.1

State Action Plan Table

State Action Plan Table (South Dakota) - Adolescent Health - Entry 1

Priority Need

Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

By June 30, 2020, decrease the percentage of students who report they drove when drinking alcohol in the past 30 days from 7.9% (2015) to 7.5%. (YRBS)

By June 30, 2020, decrease the percentage of students who report in the past 30 days they rode with a driver who had been drinking alcohol from 20.1% (2015) to 19.2%. (YRBS)

By June 30, 2020, decrease the percentage of students who report they texted or e-mailed while driving a car or other vehicle in the past 30 days from 61.3% (2015) to 58.6%. (YRBS)

Strategies

Convene a team of internal/external partners for which motor vehicle safety is already part of their mission

Integrate injury prevention education, motor vehicle safety, and prevention of drug/alcohol use into broader DOH child health promotion efforts

Include motor vehicle injury prevention messages in social media and other communications

Explore the development of a collaborative website for adolescent health information

ESMs	Status
ESM 7.1 - Number of partners who collaborate to promote motor vehicle safety activities	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

Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN

NPM

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By June 30, 2020, increase the immunization rate for the >1 dose of meningococcal vaccine for adolescents 13-17 years of age from 57% (2014) to 66.6% (NIS).

Strategies

Schedule quarterly DOH-wide team meetings to address adolescent health

Partner with Bureau of Human Resources and SD Medicaid to promote adolescent well visits

Promote Bright Futures guidelines and provider one-on-one time with adolescents

Include well-care visit messages in social media and other communications

Target messaging regarding tobacco cessation coaching for adolescents

Promote 6th grade vaccination requirements

ESMs	Status
ESM 10.1 - Number of publications/mailings promoting outreach regarding Bright Futures	Active

NOMs

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

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table (South Dakota) - Adolescent Health - Entry 3

Priority Need

Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)

NPM

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By June 30, 2020, increase the percent of adolescents (14-18 years of age) who smoke and enroll in the SD QuitLine from 0.80% (2015) to 0.89% (QuitLine & YRBS)

Strategies

Schedule quarterly DOH-wide team meetings to address adolescent health

Partner with Bureau of Human Resources and SD Medicaid to promote adolescent well visits

Promote Bright Futures guidelines and provider one-on-one time with adolescents

Include well-care visit messages in social media and other communications

Target messaging regarding tobacco cessation coaching for adolescents

ESMs	Status
ESM 10.1 - Number of publications/mailings promoting outreach regarding Bright Futures	Active

NOMs

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

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table (South Dakota) - Adolescent Health - Entry 4

Priority Need

Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)

SPM

Percent of suicide attempts by adolescents 14 through 18 years of age

Objectives

By June 30, 2020, decrease the percent of high school students who made a suicide plan during the 12 months before the survey from 11.8% to 11.3%.

By June 30, 2020, increase by 10% the number of SD HelpLine calls/texts for support from the baseline of 2,289 to 2,518.

Strategies

Identify and partner with organizations for which suicide prevention is already a mission and highlight their efforts as examples others could follow

Integrate suicide prevention education into broader adolescent health promotion efforts within DOH

Adolescent Health - Plan for the Application Year

South Dakota Adolescent Health Domain Plan for FFY18

Within the Adolescent Health Domain two National Performance Measures and one State Performance Measure were identified.

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

National Performance Measure 7: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives:

1. By June 30, 2020, decrease the percentage of students who report they drove when drinking alcohol in the past 30 days from 7.9% (2015) to 7.5% (YRBS)

2. By June 30, 2020, decrease the percentage of students who report in the past 30 days they rode with a driver who had been drinking alcohol from 20.1% (2015) to 19.2% (YRBS)

3. By June 30, 2020, decrease the percentage of students who report they texted or e-mailed while driving a car or other vehicle in the past 30 days from 61.3% (2015) to 58.6%. (YRBS)

Strategies:

7.1 Convene a team of internal/external partners for which motor vehicle safety is already part of their mission.

- Implement collaborative action plan with external partners.
- DOH will develop a web-based toolkit for community based prevention.

7.2 Integrate injury prevention education and motor vehicle safety, and prevention of drug and alcohol use into broader child health promotion efforts by Department of Health.

- Utilize OCFS staff and resources to integrate injury prevention education and motor vehicle safety into broader child health promotion efforts.

7.3 Include motor vehicle injury prevention messages in social media and other communications.

- Utilize DOH website and appropriate social media platforms for prevention messaging.

7.4 Explore the development of a collaborative web site for adolescent health information.

- Meet with DOH partners to discuss a collaborative website.
- Develop a plan for adolescent messaging with OCFS media contractor.

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

National Performance Measure10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in

the past year.

Objectives:

1. By June 30, 2020, increase the immunization rate for the >1 dose of meningococcal vaccine for adolescents 13-17 years of age from 57% (2014) to 66.6%. (NIS)

2. By June 30, 2020, increase the percent of adolescents (14-18 years of age) who smoke and enroll in the SD QuitLine from .80% (2015) to .89% (QuitLine and YRBS)

Strategies:

10.1 (New strategy) Schedule quarterly DOH-wide team meetings to address adolescent health

(Previous strategy) Convene a Department of Health-wide team to address adolescent health.

Justification for change – Quantified number of meetings

- Continue to meet on a quarterly basis to discuss preventive well visits and other adolescent health issues

10.2 (New strategy) Partner with the Bureau of Human Resource and South Dakota Medicaid to promote adolescent well visits.

(Previous strategy) Implement outreach to insurance groups to promote adolescent well visits.

Justification for change – Quantified how many partners and which ones.

- Continue to work with two partner agencies to develop a plan to promote adolescent well visits.

10.3 (New strategy) Promote Bright Futures guidelines and provider one-on-one time with adolescents.

(Previous strategy) Make resources available for providers on Bright Futures guidelines and provider one-on-one time with adolescents.

Justification for change – Clarified our role in promoting versus providing resources

- Develop three publications/journal ads/articles promoting use of Bright Futures guidelines.
- Identify ways to use telehealth in schools to promote importance of medical well visits.
- Explore the development of a consultant contract with a Pediatrician to assist with outreach and training for medical providers.

10.4 Include well-care visit messages in social media and other communications.

- Contract for the development of adolescent health messaging focused on prevention

10.5 Target messaging regarding tobacco cessation coaching for adolescents

- Continue to integrate messaging throughout DOH and other partner agencies addressing adolescent

health issues

10.6 (New strategy) Promote 6th grade vaccination requirements.

(Previous strategy) Implementation of 6th grade vaccination requirements.

Justification for change – Implementation phase is completed.

- Will collect immunization data and report it to CDC
- Influenza media and flu preparedness

ESM:

(New ESM) Number of publications/mailings promoting Bright Futures guidelines

(Previous ESM) Number of providers offered resources and outreach regarding Bright Futures

Justification for change – More clearly defines DOH role.

DOH Goal 4: Develop and strengthen strategic partnerships to improve public health

SPM 1: Percent of suicide attempts by adolescents ages 14 through 18

Objectives:

- By June 30, 2020, decrease the percent of high school students who made a suicide plan during the 12 months before the survey from 11.8% (2015) to 11.3% (YRBS)

Strategies:

S1.1 Identify and partner with organizations for which suicide prevention is already a mission and highlight their efforts as examples others could follow.

- Contract with HelpLine center to provide suicide prevention education and training including high school texting program, primary care provider training, teacher trainings

S1.2 Integrate suicide prevention education into broader adolescent health promotion efforts with the Department of Health.

- Promote adolescent well visits which include mental health screening and one-on-one time with provider.
- Collaborate with DSS to develop a web based community toolkit for suicide prevention activities.

S1.3 Maintain Department of Health infrastructure/workforce in order to provide education and outreach to communities related to suicide prevention.

- Maintain MCH FTE to carry out strategies and meet objectives
- Provide training to field staff as appropriate

South Dakota Adolescent Health Domain Annual Report FFY2016

MCH Team efforts during FFY2016 were concentrated on previous goals and objectives with continued work on development and finalization of the state action plan. Progress toward the new measures/strategies for Adolescent Health was limited due to the state action plan focus and no designated Department of Health (DOH) Adolescent Health Coordinator during this timeframe. However with continued collaboration efforts, progress was still made in serving the adolescent population.

Within the Adolescent Health Domain, National Performance Measure 7 and National Performance Measure 10 were identified as areas of concentrated efforts and included State Performance Measure of lowering percent of suicide attempts by adolescents ages 14 through 18 as the state's elected measure.

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

National Performance Measure 7: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Data Statement:
For children ages 0 through 9 years, the South Dakota 2014 rate of 210.6/100,000 is above the 2014 objective of 180.6/100,000. There has been no significant trend between 2007 and 2014. In 2013, South Dakota was ranked 36th (out of 43) in the nation in rate of hospitalization for non-fatal injury for children ages 0 through 9 years.

For children ages 10 through 19 years, the South Dakota 2014 rate of 335.0/100,000 met the 2014 Objective of 335.0/100,000 and there has been a significant decrease in this rate between 2010 and 2014 (399.6 to 335.0/100,000). In 2013, South Dakota was ranked 42nd (out of 43) in the nation in rate of hospitalization for non-fatal injury for children ages 10 through 19 years.

Objectives:

1. By June 30, 2020, decrease the percentage of students who report they drove when drinking alcohol in the past 30 days from 7.9% (2015) to 7.5%. (YRBS)

   Data Statement:
   In 2015, 7.9% of students reported driving when drinking alcohol, which is slightly higher than the 2015 objective of 7.8%. The percent has decreased significantly from 13.0% in 2007 to 7.9% in 2015.

2. By June 30, 2020, decrease the percentage of students who report in the past 30 days they rode with a driver who had been drinking alcohol from 20.1% (2015) to 19.2%. (YRBS)

   Data Statement:
   The 2015 rate of 20.1% is slightly above the 2015 objective of 19.8% but below the HP 2020 target of 25.5%. The percent of students reporting they rode with a driver who had been drinking alcohol has decreased significantly from 24.3% in 2007 to 20.2% in 2015.

3. By June 30, 2020, decrease the percentage of students who report they texted or e-mailed while driving a car

or other vehicle in the past 30 days from 61.3% (2015) to 58.6%. (YRBS)

Data Statement:
In 2015, 61.3% of students reported texting while driving, which is less than the 2015 objective of 68.9%. The percent has decreased significantly from 63.2% in 2013.

Strategies:

7.1. Convene a team of internal/external partners for which motor vehicle safety is already part of their mission.

- DOH/DPS Motor Vehicle Injury Taskforce - The MCH team and Department of Public Safety partnered on this effort. There were challenges with gathering data from multiple agencies and then figuring out how to best utilize the data for program planning and goal setting to best support the combined efforts. There was good support for this project from agency leadership that helped in moving the project forward with anticipation of continued progression for additional partnerships.
- DOH/DPS Motor Vehicle Injury Taskforce develop an action plan specifically for seat belt safety that broadly focuses on public awareness and promotion.

Challenge:
DOH working with DPS was a relatively new relationship so it took more time than anticipated to create a streamlined work group.

7.2. Integrate injury prevention education and motor vehicle safety, and prevention of drug and alcohol use into broader child health promotion efforts by Department of Health.

- Seat belt promotion
- Car seat promotion and distribution
- Bicycle helmet promotion
- Farm safety and 4-H and Extension
- Choking hazards and prevention
- Health Occupation for Today and Tomorrow (HOTT) presentations – HOTT works to expose SD students to the variety of career opportunities available in the healthcare industry. This program was implemented to address the critical need for healthcare workers across the state.
- Missouri Breaks, a non-profit entity on the Cheyenne River Sioux Reservation, educated the Eagle Butte community on the danger of second hand smoke and promoted resources to educate on the health benefits of smoke free vehicles.
- As a part of the motor vehicle safety efforts, a toolkit is in the early process of being developed by the DOH. This toolkit can serve as a model for future work to support statewide efforts around injury prevention and other risk behaviors.

7.3. Include motor vehicle injury prevention messages in social media and other communications.

- This effort is in early formation stage, no specific places/platforms are being used as development of the social media is still underway.
- Establishing an effective work group practice with a new collaborative partner has taken some time and deciding how to make good use of our shared resources.

Challenge:

This strategy proved to be difficult to begin until the taskforce put a specific action plan into place, now this effort is progressing.

7.4. Explore the development of a collaborative web site for adolescent health information.

- Steps toward the beginning of this development are underway. Due to its magnitude, the DOH did not expect to get this done during this funding cycle.

ESMs

7.1. Number of partners who collaborate to promote motor vehicle safety activities

- Two partner agencies have convened – DOH and DPS

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

National Performance Measure10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Data Statement:
Although the 2011/12 rate of 72.6% is below the 2014 objective of 73.0% and the HP 2020 target of 75.6%, the percent is significantly lower than the US rate in 2011/12. There has been a significant increase in the percent of adolescents with a preventive medical visit from 66.7% in 2003 to 72.6% in 2011/12.

Objectives:

1. By June 30, 2020, increase the immunization rate for the >1 dose of meningococcal vaccine for adolescents 13-17 years of age from 57% (2014) to 66.6%. (NIS)

Data Statement:
While below the 80% HP 2020 target of 80%, there has been a significant increase in meningococcal vaccine rates for adolescents from 37.4% in 2011 to 55.5% in 2015.

2. (New Objective) By June 30, 2020, increase the percent of adolescents (14-18 years of age) who smoke that enroll in the Quit Line from 0.80% (2015) to 0.89% (Quit Line and YRBS)

(Previous Objective) By June 30, 2020, increase the number of adolescents (13-18 years old) that enroll in the SD Quit Line from 45 (observed in 2015) to 50.

Justification for Change – DOH was unable to identify a denominator to allow for effective, accurate tracking of progress.

Data Statement:
An estimated 0.8% of adolescents who smoke enrolled in the SD Quit Line. There has been no change in this trend between 2011 and 2015.

Strategies:

10.1. Convene a DOH-wide team to address adolescent health.

- The first focus of partners was on child preventive medical visits. MCH will utilize the lessons learned from that group to organize partners around adolescent preventive medical visits. The child workgroup was interested in getting quality baseline data. This information is not readily available from insurance plans. As a result, alternative data sources are currently being discussed in planning for addressing adolescent preventive medical visits.

10.2. Implement outreach to insurance groups to promote adolescent well visits.

- The original thinking was to go broad and invite multiple insurance partners to discuss this effort however, the DOH decided to start with an interagency partner, Medicaid, to first identify what outreach methods are the most effective. Once this is accomplished, the group's reach will be expanded to other insurance groups/partners.

10.3. Make resources available for providers on Bright Futures guidelines and provider one-on-one time with adolescents.

- Medicaid collaborated with the DOH to look at how to promote Bright Futures guidelines to their providers.
- American Academy of Pediatrics partnered to work on an article for the South Dakota Medicine Journal. The article is still being developed at the time of this reporting.

10.4. Include well-care visit messages in social media and other communications.

- Updated the Associated School Boards of South Dakota (ASBSD) K-12 Model Policy and promoted it on the DOH website and in the Good and Healthy Schools Newsletter
- Promoted and educated wellness counselors on the availability of the Quit Line through the Good and Healthy Schools Newsletter

10.5. Target messaging regarding tobacco cessation coaching for adolescents

- DOH field staff screen household contacts with an infant in home to address tobacco exposure
- Messaging includes Tobacco Rethink It Facebook & Instagram pages, SD Quit Line Facebook and Twitter accounts, RethinkTobacco.com and SDQuitLine.com, occasional TV & radio, print ads in the Lakota Nation Invitational and Stock Show programs, newspaper ads/articles coalitions put in local newspapers, and promotional materials (posters, brochures, palm cards, etc.).

10.6. Implementation of 6th grade vaccination requirements.

- Recall reminders for immunizations
- DOH Point of Dispensing exercise – staff conducted an emergency preparedness exercise specific to 6th grade immunizations
- School immunization record auditing
- Tap and MCV4 are now required for 6th grade entry in SD for the first time beginning in the 2016-2017 school year.
- Mass vaccination clinics were conducted to vaccinate for MCV4 and Tap

- Schools and providers have been notified of the new immunization requirements for 6th grade
- Weekly monitoring of Tap and MCV4 rates

Challenges:
It was challenging getting meningococcal added to the law for vaccines required for schools. The administrative rules process, notification of providers and schools with the new requirements went well. The collection and analyzing of school data is ongoing and rates look very good and should be published shortly.

ESMs

10.1. Number of publications/mailings promoting Bright Futures guidelines.

- One mailing occurred – Medicaid Providers were given updated information on Bright Futures.

DOH Goal 4: Develop and strengthen strategic partnerships to improve public health

State Performance Measure 1: Percent of suicide attempts by adolescents ages 14 through 18

Data Statement:
The 2015 South Dakota rate of 8.4% is less than the 2015 objective of 8.7% but greater than the HP 2020 target of 1.7%. There has been no significant trend in the percent of suicide attempts by adolescents aged 14 through 18 years between 2007 (8.7%) and 2015.

Objectives:

1. By June 30, 2020, decrease the percent of high school students who made a suicide plan during the 12 months before the survey from 11.8% (2015) to 11.3%. (YRBS)

Data Statement:
In 2015, 11.8% of high school students made suicide plan during the previous year. There is no significant trend between 2007 and 2015.

2. (Objective Removed) By June 30, 2020, increase by 10% the number of South Dakota Helpline calls/texts for support from baseline of 2289 (10/2013-9/2014) to 2518 (10% increase).

Justification for Change – Removed this objective as DOH did not have access to data specific to caller's age.

Strategies:

S1.1 Identify and partner with organizations for which suicide prevention is already a mission and highlight their efforts as examples others could follow.

- Contracted to support 24/7 statewide suicide crisis line
- Contracted to support follow-up to suicide crisis calls
- Contracted to support Youth Mental Health First Aid training
- Contracted to provide Suicide Prevention Training to Primary Care Providers

- Contracted to provide Teen Crisis texting support to 41 high schools. They have about 400 text conversations a year and the most common topics of conversation are suicide, relationship conflicts, and depression and family problems.
- 2016 legislation requires anyone applying for an initial or renewal certificate as a teacher, administrator or other education professional to participate in a minimum of one clock hour of suicide prevention training. This requirement begins July 1, 2017.
- Youth Suicide Prevention Advisory Committee consists of 17 state and local partners including a DOH MCH staff member who meet quarterly to implement/support suicide prevention efforts across the state.

S1.2 Integrate suicide prevention education into broader adolescent health promotion efforts within the DOH Health.

- Bright Start Home Visiting uses PHQ9 screening tool
- OCFS staff screen for post-partum depression

S1.3 Maintain DOH infrastructure/workforce in order to provide education and outreach to communities related to suicide prevention.

- Maintain contracts to support suicide prevention efforts in the state
- Participate on the South Dakota Youth Suicide Prevention Committee

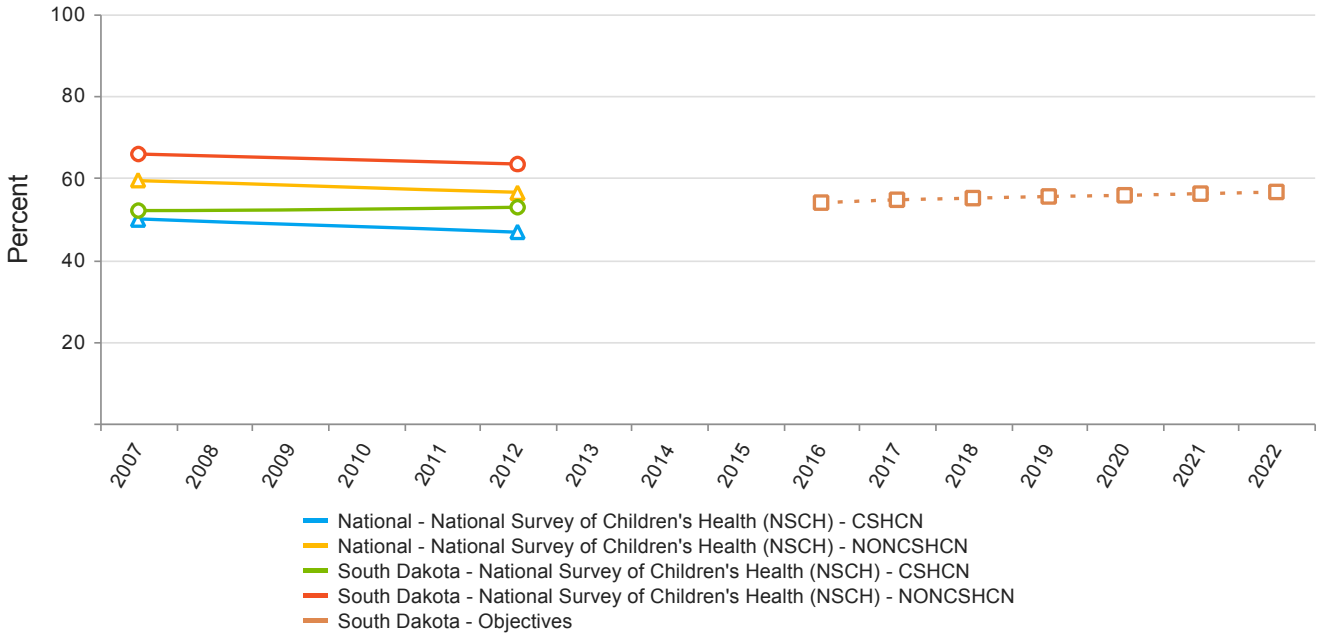
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	17.6 %	NPM 11
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	91.7 %	NPM 11
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)	NIS-2015	75.6 %	NPM 11
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	70.8 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	53.2 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	39.2 %	NPM 11
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	72.4 %	NPM 11
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	55.5 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs having a medical home
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	53.9
Annual Indicator	52.7
Numerator	15,450
Denominator	29,333
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	54.6	55.0	55.4	55.7	56.1	56.5

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of trainings for providers on components of medical home model

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	training list
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

State Action Plan Table

State Action Plan Table (South Dakota) - Children with Special Health Care Needs - Entry 1

Priority Need

Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN

NPM

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

Objectives

By June 30, 2020, increase the percentage of CYSHCN who report receiving care in a well-functioning system from 17.6% (NS-CSHCN 2009-11) to 18.7%. (NSCH)

By June 30, 2020, 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.

Strategies

Reach out for technical assistance to develop and implement a survey of partners/providers on medical home components within their program/practice

Provide information and education to primary care providers, pediatric specialists, and community providers on medical home model

Facilitate access to necessary services through partnerships with South Dakota's parent training center, other state agencies, and service providers

Assist families of CYSHCN with costs incurred as a result of their child's chronic health condition that are not covered by other sources

Maintain DOH infrastructure /workforce to facilitate specialized care in order to make connections to medical home

Coordinate the newborn screening infrastructure including: (a) contract laboratory for newborn screening of all South Dakota 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

ESMs	Status
ESM 11.1 - Number of trainings for providers on components of medical home model	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Children and Youth with Special Health Care Needs Plan for FFY 2018

As the MCH Impact team moved forward with efforts to implement the strategies it was quickly identified that this would be a much longer process in order to ensure that families and providers are actively engaged in the changes the would be implemented. This in turn will impact the plans for FFY2018.

DOH 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

Objectives:

1. By June 30, 2020, increase the percentage of CYSHCN who report receiving care in a well-functioning system from 17.6% to 18.7%. (NSCH)

2. By June 30, 2020, 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)

Strategies:

11.1. Reach out for Technical Assistance to develop and implement a survey of partners/providers on medical home components with their program/practice

- Using the results of family surveys and facility interviews, identify how best to meet the needs of families of children and youth with special health care needs within a medical home.
- Meeting with case managers under Medicaid Health Home to address gaps in services, resources, and training.

11.2. Provide information and education to primary care providers, pediatric specialists, and community providers on medical home model

- Using the results of family surveys and facility interviews identify what information and education to provide to primary care providers, pediatric specialists, and community providers.
- Explore the development of a consultant contract with a Pediatrician to assist with outreach and training for medical providers.

11.3. Facilitate access to necessary services through partnerships with South Dakota's parent training center, other state agencies, and service providers.

- Contract with parent training center to assist with training, resource, and referral of parents of children with special health care needs.
- Maintain interagency agreement to assist with the cost of providing Respite Care Services to families.
- Participate on State Interagency Coordinating Council to assist with the early identification and service provision for children under the age of three determined to have a developmental delay
- Participate on the Developmental Disabilities Council, which supports activities that assist individuals with

developmental disabilities

- Participate on the Child and Family Services Interagency Workgroup to identify areas for collaboration within other state agencies serving children ages 0 to 5 years.
- Identify ways to enhance the DOH website to improve family access to resources.
- Pursue development of infographic(s) specific to children and youth with special health care needs.

11.4. Assist families of children and youth with special health care needs with costs incurred as a result of their child's chronic health condition that are not covered by other sources.

- Using the results of family surveys and facility interviews, identify how best to meet the needs of families of children and youth with special health care needs within a medical home.
- Identify if there is a need to continue to provide direct financial assistance under the Health KiCC Program
- Contract with geneticist to provide outreach clinic in western part of the state to improve access to care
- Contract with SD Parent Connection, South Dakota's Family to Family Health Information Center, to assist with resource, referral, training specific to medical home and transitioning of medical care based on age.

11.5. Maintain Department of Health infrastructure/workforce to facilitate specialized care in order to make connections to medical home.

- Maintain contract with South Dakota's Family to Family Health Information Center
- Continue evaluating key partnerships around serving Children and youth with special health care needs.
- Maintain contract with contract laboratory for newborn screening.
- Maintain contract with Sanford Children's Specialty Clinic for newborn screening program medical consultants, genetic counseling and program recommendations.

Objective 2 By June 30, 2020, 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.

Strategies:

2.1. Coordinate the newborn screening infrastructure to address: (a) contract laboratory for newborn screening of all South Dakota 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.

- Monitor newborn screening program quality indicators such as poor quality specimen percentage rates, incomplete specimen card information, and specimen timeliness.
- Within the newborn screening program, prepare for implementation of HL7 standards which provide a framework for the exchange, integration, sharing, and retrieval of electronic health information.
- Strengthen partnership with Sanford Children's Specialty Clinic for newborn screening program medical consultants, genetic counseling and program recommendations.
- Upgrade newborn screening program user manual.

Children and Youth with Special Health Care Needs Annual Report Update

Many of the MCH Team efforts during FFY2016 were focused on previous goals and targets as the MCH continues to work on finalizing the state action plan. Therefore the amount of progress made on the new measures/strategies was not as significant as originally targeted.

DOH 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* a special health care need - The SD 2011/12 rate of 52.7% was higher, but not significantly higher, than the US rate during the same time period. There has been no significant trend between 2007 and 2011/12.

Percent of children *without* a special health care need - The SD 2011/12 rate of 63.2% was significantly higher than the US 2011/12 rate and close to the HP 2020 target of 63.3%. However, there has been a significant decrease in the percent of children without special health care needs who have a medical home between 2007 and 2011/12.

Objectives:

1. By June 30, 2020, increase the percentage of CYSHCN who report receiving care in a well-functioning system from 17.6% to 18.7%. (NSCH)

   Data Statement:
   The 2009/11 rate of 17.6% was lower, but not significantly, than the US rate in 2011/12.

2. By June 30, 2020, 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)

   Data Statement:
   In 2015, 100% of newborn infants who are outside of the normal limits for a newborn screening disorder received prompt and appropriate follow-up testing. This has remained the same since 2014.

Strategies:

11.1. Reach out for technical assistance to develop and implement a survey of partners/providers on medical home components with their program/practice

- Began to review medical home literature, trainings, other state experiences, and potential South Dakota partners to move forward with medical home components.
- Began discussions with other programs that are implementing a health home model to identify possible partnerships/collaborations

Challenge:
Did not get as far as developing surveys during this federal fiscal year as it was difficult to identify who, how, and what to ask on a survey.

11.2. Provide information and education to primary care providers, pediatric specialists, and community providers on medical home model

- Through a contract with the Parent Training Center from October 1, 2015 through September 30, 2016, provided individual assistance/training contacts with 864 professionals in 123 communities to assist them in their work serving families of CYSHCN.

Challenge:
No training provided specific to medical home as survey not completed to address family and provider needs

11.3. Facilitate access to necessary services through partnerships with South Dakota's parent training center, other state agencies, and service providers.

- Contracted with parent training center to assist with training, resource, and referral of parents of children with special health care needs. From October 1, 2015 through September 30, 2016, provided individual assistance/training contacts to 735 families in 130 communities. 50% of these contacts were related to children ages 12 and over; 41% related to children ages 6-11; 9% related to children ages 0-5. Family member race (when known) was 90% Caucasian, 8% American Indian and less than 1% each African American, Pacific Islander, Asian American and Hispanic.
- Interagency agreement implemented to assist with the cost of providing Respite Care Services to families. From June 1, 2015 through May 31, 2016, the Respite program served 936 children and adults in 703 families.
- Participated on State Interagency Coordinating Council to assist with the early identification and service provision for children under the age of three determined to have a developmental delay
- Participated on the Developmental Disabilities Council, which supports activities that assist individuals with developmental disabilities
- Participated on the Child and Family Services Interagency Workgroup to identify areas for collaboration within other state agencies serving children ages 0 to 5 years.

Challenge:
Identifying a way to get the information directly to the families and providers in regards to what assistance/resources are available.

11.4. Assist families of children and youth with special health care needs with costs incurred as a result of their child's chronic health condition that are not covered by other sources.

- Provided care coordination and financial assistance to eligible families of children with eligible chronic medical conditions
- Provided mileage reimbursement to eligible families to reduce financial burden of traveling to provider and improve access to care
- Contracted with geneticist to provide outreach clinic in western part of the state to improve access to care
- Contracted with SD Parent Connection, South Dakota's Family to Family Health Information Center, to assist with resource, referral, training specific to medical home and transitioning of medical care based on age.

- Required all families that apply for financial assistance under the DOH program, Health KiCC, also apply for SD Medicaid.
- Encouraged all families to contact a Navigator to review possible health insurance coverage.

Challenge:

Numbers served via direct services are decreasing and therefore has been discussion around discontinuing this financial assistance program. Issue is how to best assist/direct the families that are presently being served to ensure they have the supports they need to address on-going care.

11.5. Maintain Department of Health infrastructure/workforce to facilitate specialized care in order to make connections to medical home.

- Maintained FTE working with CYSHCN
- Maintained contract with South Dakota's Family to Family Health Information Center
- Began process of evaluating key partnerships around serving Children and youth with special health care needs.
- Maintained contract with contract laboratory for newborn screening.
- Maintained contract with Sanford Children's Specialty Clinic for newborn screening program medical consultants, genetic counseling and program recommendations.

Objective 2 Strategy 2.1 Coordinate the newborn screening infrastructure to address: (a) contract laboratory for newborn screening of all South Dakota 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.

- Contract Laboratory, the State Hygienic Laboratory at the University of Iowa, reports 96.4% of newborn screening results for CY2015 were provided to South Dakota healthcare providers <= 7 days of age.
- Presumptive positive and borderline newborn screening result follow-up protocols were updated and approved by the program medical consultants
- Advanced changes to the dried blood spot collection cards to include both the ordering healthcare provider and the primary care provider to ensure the correct provider/facility is notified of the recommended follow-up testing in a timely manner.
- Partnered with Sanford Children's Specialty Clinic for newborn screening program medical consultants, genetic counseling and program recommendations.
- Collaborated with SHL and South Dakota healthcare providers to locate and follow-up on all infants with out-of-normal range test results.
- Utilized EVRSS (Electronic Vital Records Screening System) to match metabolic newborn screening records to the birth certificate ensuring follow-up and identification of "Never Tested" infants.
- Monitored program quality indicators such as poor quality specimen percentage rates, incomplete specimen card information, and specimen timeliness.

ESM:

Number of trainings for providers on components of the medical home model

- No trainings provided during this reporting period

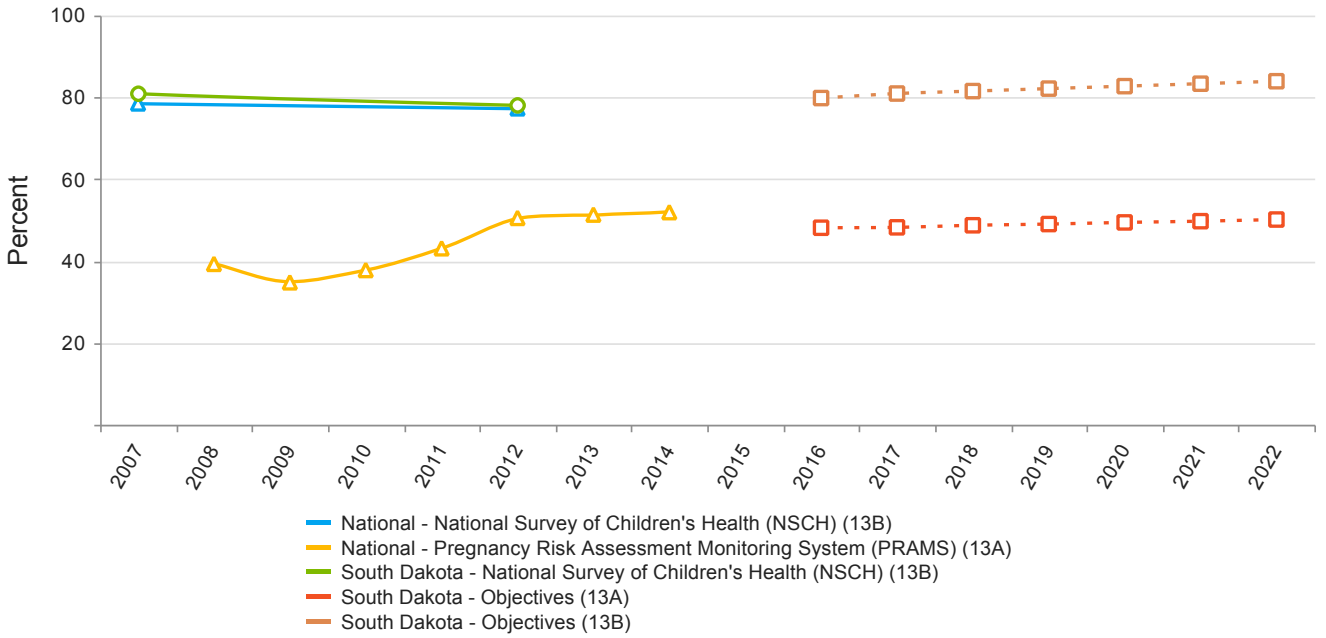
Cross-Cutting/Life Course

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-2014	125.3	NPM 14
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	28.0	NPM 14
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	6.1 %	NPM 14
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.0 %	NPM 14
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	5.1 %	NPM 14
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	8.5 %	NPM 14
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.0 %	NPM 14
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.5 %	NPM 14
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	23.7 %	NPM 14
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.3	NPM 14
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.7	NPM 14
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.3	NPM 14
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.4	NPM 14
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	138.4	NPM 14
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	114.0	NPM 14
NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months	NSCH-2011_2012	17.3 %	NPM 13
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	91.7 %	NPM 13 NPM 14

National Performance Measures

NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year
Baseline Indicators and Annual Objectives



NPM 13 - A) Percent of women who had a dental visit during pregnancy

FAD for this measure is not available for the State.

State Provided Data	
	2016
Annual Objective	48.1
Annual Indicator	47.8
Numerator	5,472
Denominator	11,447
Data Source	SD PRAMS-like survey
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	48.2	48.7	49.0	49.4	49.7	50.1

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	79.7
Annual Indicator	77.8
Numerator	147,938
Denominator	190,201
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	80.8	81.4	82.0	82.6	83.2	83.8

Evidence-Based or –Informed Strategy Measures

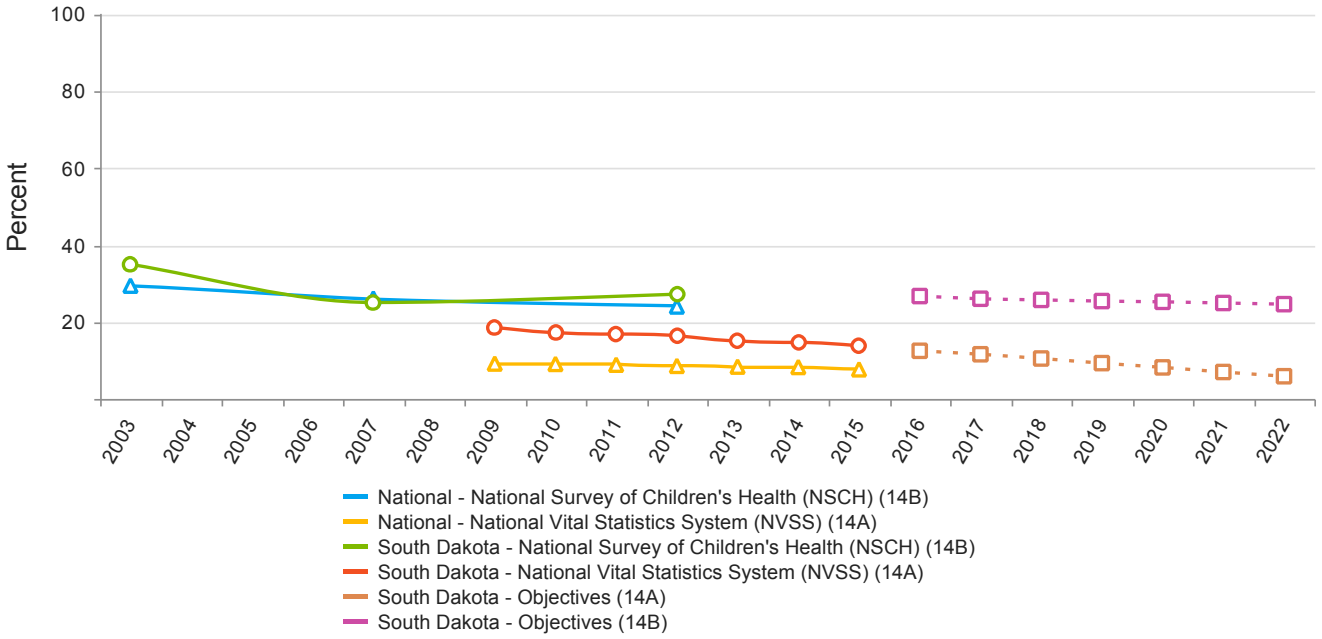
ESM 13.1 - Number of media platforms (i.e., websites, Facebook, TV, radio, print) that promote oral health messaging

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	3
Numerator	
Denominator	
Data Source	media platform count
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	3.0	4.0	4.0	4.0	4.0	4.0

NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
Baseline Indicators and Annual Objectives



NPM 14 - A) Percent of women who smoke during pregnancy

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	12.6
Annual Indicator	14.0
Numerator	1,714
Denominator	12,279
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	11.7	10.6	9.4	8.3	7.1	6.0

NPM 14 - B) Percent of children who live in households where someone smokes

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	26.8
Annual Indicator	27.5
Numerator	55,055
Denominator	200,548
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	26.1	25.8	25.5	25.3	25.0	24.7

Evidence-Based or –Informed Strategy Measures

ESM 14.1 - Number of media platforms (i.e., websites, Facebook, TV, radio, print) that include tobacco prevention/cessation messages

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	10
Numerator	
Denominator	
Data Source	media platform count
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	10.0	10.0	10.0	10.0	10.0

State Performance Measures

SPM 4 - MCH data is analyzed and disseminated

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	NA
Data Source Year	NA
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

State Action Plan Table

State Action Plan Table (South Dakota) - Cross-Cutting/Life Course - Entry 1

Priority Need
Promote oral health for all populations

NPM
A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Objectives
By June 30, 2020, increase the percent of pregnant women who are talked to by their healthcare worker about the importance of good oral health during pregnancy and infancy from 58.4% (2014) to 61.3%. (PRAMS)
By June 30, 2020, increase the percentage of children, ages 6-9, enrolled in Medicaid for at least 90 days, who received a dental sealant on a permanent molar from 11.5% (2012-2014) to 18.8% (CMS/EPSDT)

Strategies
Provide oral health information to new mothers through the DSS Bright Start Welcome Box
Maintain DOH infrastructure/workforce in order to provide education and outreach to clients
Identify a target population and oral health messaging to enhance public awareness efforts including messaging on DOH media platforms
Facilitate access to oral health services through partnerships with South Dakota's parent training center, other state agencies, and service providers

ESMs	Status
ESM 13.1 - Number of media platforms (i.e., websites, Facebook, TV, radio, print) that promote oral health messaging	Active

NOMs

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (South Dakota) - Cross-Cutting/Life Course - Entry 2

Priority Need

Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)

NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objectives

By June 30, 2020, increase the percent of adults who report smoking is not allowed anywhere in their home from 86% (2014) to 91%. (BRFSS)

By June 30, 2020, reduce the percentage of pregnant females receiving WIC services who smoke during pregnancy from 26.7% (2014) to 15% (SD Vital Records)

Strategies

Maintain DOH infrastructure/workforce in order to provide education and outreach to clients and make SD QuitLine referrals as appropriate

Include smoking cessation and promote tobacco free environment messages in social media and other communications across the DOH

ESMs	Status
ESM 14.1 - Number of media platforms (i.e., websites, Facebook, TV, radio, print) that include tobacco prevention/cessation messages	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 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 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 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (South Dakota) - Cross-Cutting/Life Course - Entry 3

Priority Need

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

SPM

MCH data is analyzed and disseminated

Objectives

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

Strategies

Review all data sets available and identify any gaps

Identify data collection methods to address gaps

Implement new data collection efforts as needed

Develop and disseminate fact sheets on findings

Analyze the data to identify future program efforts

South Dakota Cross-Cutting/Life Course Domain Plan for FFY18

Within the Cross-Cutting/Life Course Domain two National Performance Measures and one State Performance Measure have been identified.

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

National Performance Measure 13: A) Percent of women who had a dental visit during pregnancy, and B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Objectives:

1. By June 30, 2020, increase the percentage of children, age 6-9, enrolled in Medicaid for at least 90 days who received a dental sealant on a permanent molar from 11.5% (2012-2014) to 18.8% (CMS/EPSDT)

2. By June 30, 2020, increase the percent of pregnant women who are talked to by their health care worker about the importance of good oral health during pregnancy and infancy from 58.4%(2014) to 61.3% (PRAMS)

Strategies:

13.1. Provide oral health information to new mothers through the DSS Bright Start Welcome Box.

- Provide the Bright Start Welcome boxes with two oral health brochures promoting good oral health for infants and pregnant women.

13.2. Identify a target population and oral health messaging to enhance public awareness efforts including messaging on Department of Health media platforms.

- Continue efforts to develop oral health messaging to include on social media platforms

13.3. Facilitate access to oral health services through partnerships with South Dakota's parent training center, other state agencies, and service providers.

- Promote the Delta Dental Mobile Program
- Provide resources to the public on the hazards of spit tobacco on Oral Health
- Conduct oral health screenings at WIC visit/referral
- Update the Oral Health website as needed to include information about tobacco cessation, diabetes, cancer, fluoridation, and nutrition.
- Participate on the Nutrition/Physical Activity State Plan Workgroup.
- Promote distribution of sugar sweetened beverage (SSB) information and provide brochures that promote drinking water to reduce SSB consumption and promote healthy lifestyles.

13.4. Maintain Department of Health infrastructure/workforce in order to provide education and outreach to clients.

- Maintain MCH FTE to carry out strategies and meet objectives.
- Provide training to field staff as appropriate.

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

National Performance Measure 14: A) Percent of women who smoke during pregnancy; and B) Percent of children who live in households where someone smokes

Objectives:

1. By June 30, 2020, reduce the percent of pregnant females receiving WIC services who smoke during pregnancy from 26.7% (2014) to 15% (SD Vital Records)

2. By June 30, 2020, increase the percent of adults who report smoking is not allowed anywhere in their home from 86% (2014) to 91% (BRFSS)

Strategies:

14.1. Include smoking cessation and tobacco free environment messages in social media and other communications across the Department of Health.

- Provide advertising focused on pregnant women on TV, radio, Facebook, and other media sources to promote the QuitLine to pregnant women.
- Continue to provide the Postpartum Program developed and launched in June 2016 for the South Dakota QuitLine to assist postpartum women with relapse prevention. Continue to provide training on warm referrals to QuitLine.
- Review evaluation data from Prenatal 5As Intervention Record for tobacco use pilot. This record provided a guideline for discussions about tobacco use, and a reminder for QuitLine referrals.
- Utilize www.befreesd.com website to provide QuitLine Priority Population Guidelines
- Continue to work with the Teddy Bear Den to provide QuitLine referrals and tobacco education to at-risk pregnant women and young mothers.
- Continue to work with Coteau Des Prairies Health Care System on creating systems change to incorporate tobacco education and QuitLine referrals in their work with pregnant women.
- The Priority Population Workgroup will continue to meet to discuss issues directly relating to the six SD TCP priority populations.
- The SD TCP will continue to provide bibs and QuitLine information for Bright Start Boxes.
- Continue to provide QuitLine trainings as needed at WIC offices, including tribal WIC offices on reservations
- Continue discussion on development of a healthy pregnancy resource that would include tobacco information
- Continue to support Teens Against Tobacco Use (TATU) program
- Develop reports that capture WIC Pregnant woman assessment answers on tobacco use before and during pregnancy to be used in program planning.
- Develop reports that capture WIC Child Assessment answers on smoking in household to be used in program planning.
- Incorporate tobacco free messaging targeted to these populations in OCFS media RFP

14.2. Maintain Department of Health infrastructure/workforce in order to provide education and outreach to clients and make SD Quit Line referrals as appropriate.

- Continue offering QuitLine services and Community Based and Disparities grants
- Educate WIC Staff and Bright Start home visitors as needed on the resources available for Tobacco cessation and the QuitLine services with a focus on pregnant women

DOH Goal 5: Maximize the effectiveness and strengthen infrastructure of the Dept. of Health

State Performance Measure 4: MCH data is analyzed and disseminated.

Objectives:

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

Strategies:

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

- The DOH will continue to contract with an outside entity to assist the DOH in the review of all data sets and to identify any gaps.

S4.2. Identify data collection methods to address gaps

- The DOH will continue to contract with an outside entity to assist in the identification of additional or different data sources to ensure data collected meets the needs of the MCH Block Grant and Impact Team.

S4.3. Implement new data collection efforts as needed.

- The DOH will continue to review and consider any new data opportunities that would assist in obtaining raw data and monitoring quality and completeness of data.

S4.4. Develop and disseminate fact sheets on findings

- The DOH will contract with an outside entity to assist in the development of fact sheets and infographic data briefs.

S4.5. Analyze the data to identify future program efforts.

- The MCH Impact Team will continue to use data to drive program planning efforts.

South Dakota Cross-Cutting/Life Course Domain Annual Report FFY2016

Many of the MCH Team efforts during FFY2016 were focused on previous goals and targets as the MCH continues to work on finalizing the state action plan. This meant there was less time to address the new measures/strategies and therefore did not progress as much as anticipated.

Within the Cross-Cutting/Life Course Domain two National Performance Measures and one State Performance Measure were identified.

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

National Performance Measure 13: A) Percent of women who had a dental visit during pregnancy, and B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Data Statement:
13 A) In 2014, it is estimated that 47.0% of women had a dental visit during pregnancy. This is slightly less than the HP 2020 target of 49.0%.

13 B) In 2011/12, 77.8% of infants and children received a preventive dental visit. This is less than the HP 2020 target of 86.2%. There has been a significant decrease in the percent between 2007 (80.7%) and 2011/12. In 2007, South Dakota ranked 16th in the nation for the highest percent of infants and children receiving a dental visit in the past year.

Objectives:

1. (New Objective) By June 30, 2020, increase the percentage of children, age 6-9, enrolled in Medicaid for at least 90 days who received a dental sealant on a permanent molar from 11.5% (2012-2014) to 18.8% (CMS/EPSDT)

   (Previous objective) By June 30, 2020, increase the percentage of 6-9 year old children who received a dental sealant on at least one permanent molar from 57% to 62.7% (Oral Health 3rd Grade Basic Screening Survey).

   Justification for Change – The Oral Health Screening Survey is only conducted every other year and with a limited number surveyed.

   Data Statement:
   The South Dakota 2015 rate of 11.0% is close to the 2015 Objective of 11.1% but less than the HP 2020 target of 28.1%. In addition, there has been a significant decrease in the percent of children who received a dental sealant between 2011 (15.2%) and 2015.

2. By June 30, 2020, increase the percent of pregnant women who are talked to by their health care worker about the importance of good oral health during pregnancy and infancy from 58.4% (2014) to 61.3% (PRAMS)

   Data Statement:

In 2014, 58.4% of South Dakota mothers delivering a live infant were talked to about the importance of good oral health.

Strategies:

13.1. Provide oral health information to new mothers through the DSS Bright Start Welcome Box.

- Provide the Bright Start Welcome boxes with two oral health brochures for distribution each month to approximately 1,000 new mothers promoting good oral health for their infants and themselves.

13.2. Develop oral health messaging to enhance public awareness efforts including messaging on Department of Health media platforms.

- There were 1,562 views of the Oral Health website from October. 1, 2015 thru September 30 2016.

Challenges:
Identifying oral health promotion messaging and appropriate site placement for that messaging.

13.3. Facilitate access to oral health services through partnerships with South Dakota's parent training center, other state agencies, and service providers.

- Participated in Delta Dental Mobile Program
- Provided resources to the public on the harms of spit tobacco on Oral Health
- Conducted oral health screenings at WIC visit and made referrals as appropriate
- Updated the Oral Health website to include information about tobacco cessation, diabetes, cancer, fluoridation, and nutrition. There were 1,562 views of the Oral Health website from Oct. 1, 2015 thru Sept. 30 2016.
- Provided National Children's Health Month information for school nurses, health teachers, and school personnel in the February issue of the electronic School Newsletter. This newsletter is developed and distributed monthly.
- Participated on the Nutrition/Physical Activity State Plan workgroup.
- Provided and promoted distribution of Sugar Sweetened Beverage (SSB) information and brochures that promote drinking tap water to reduce SSB consumption and promote healthy lifestyles.
- The WIC program asks "Oral health conditions affecting eating: Yes/No (text field)" for every eligible woman and child. There is a referral letter that is printed for the family to take to the provider. In addition a follow-up date is entered to see what has occurred as a result of the referral letter.
- Provided 26,643 educational oral health brochures (1,600 Spanish)
- Provided Regional Managers and their 90 Community Health Nursing staff with 42,394 dental hygiene resources for distribution to the families they serve.

Challenges: Outreach to new partners.

13.4. Conduct Oral Health Basic Screening Survey of 3rd Graders.

- This is only conducted every three to five years so this was not completed during this reporting period. This strategy will be removed as the screening survey will not be conducted again during this 5 year grant cycle.

13.5. Maintain Department of Health infrastructure/workforce in order to provide education and outreach to clients.

Challenges: Staff changes

ESMs

13.1. Number of media platforms (i.e., websites, Facebook, TV, radio, print) that promote oral health messaging

- Three media platforms were used: Oral Health Website, DOH Facebook, printed brochures.

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

National Performance Measure 14: A) Percent of women who smoke during pregnancy; and B) Percent of children who live in households where someone smokes

Data Statement:
14 A) The South Dakota 2015 rate of 14.0% is slightly higher than the 2015 Objective of 13.7% and is higher than the HP 2020 target of 1.4%. There has been a significant downward trend over the last five years with 16.9% of pregnant women smoking in 2011. In 2014, South Dakota ranked 35th (out of 46) in the nation in the lowest percent of women who smoke during pregnancy.

14 B) The South Dakota 2011/12 rate of 27.5% is higher than the HP 2020 target of 23.6%. There has been a significant downward trend since 2003 when 34.9% of children lived in a household where someone smoked. In 2007, South Dakota ranked 16th in the nation in the lowest percent of children who live in households where someone smokes.

Objectives:

1. (New Objective) By June 30, 2020, reduce the percent of pregnant females receiving WIC services who smoke during pregnancy from 26.7% (2014) to 15% (SD Vital Records)

   (Previous Objective) By June 30, 2020, reduce the percentage of pregnant females that smoke from 14.8% to 8.1% (FAD NVSS, 2014) (to achieve HP 2020 target by 2026)

   Justification for Change – Objective was the same as the Performance Measure.

   Data Statement:
   In 2016, 24.5% of pregnant women receiving WIC smoked. This is greater than the HP 2020 target of 1.4% but there has been a significant downward trend since 2012 when 28.5% of pregnant women receiving WIC smoked.

2. By June 30, 2020, increase the percent of adults who report smoking is not allowed anywhere in their home from 86% (2014) to 91% (BRFSS)

   Data Statement:
   The South Dakota 2015 rate of 88% is greater than the 2015 Objective of 87.4% and there has been an increase in the percent of adults who report smoking is not allowed anywhere in their home since 2011 (82%).

Strategies:

14.1. Include smoking cessation and promote tobacco free environment messages in social media and other communications across the Department of Health.

- Provided advertising focusing on pregnant women on TV, radio, Facebook, and other media sources to promote the QuitLine to pregnant women.
- Provided training on “Tobacco Free what’s this?” and promoted a model policy to multiple dwelling unit owners and managers in Sioux Falls in June 2016.
- Provided resources on the dangers of second hand smoke to the public through the online ordering system.
- A Postpartum Program was developed and launched in June 2016 for the South Dakota QuitLine to assist postpartum women with relapse prevention. Pregnant women who enroll in the standard QuitLine coaching are eligible to opt-in to the program (timing based on their due date) which includes four additional relapse prevention calls and gift card incentives. If a woman relapses while enrolled in the Postpartum Program, they are eligible to automatically re-enroll in standard QuitLine services.
- As one of the SD TCP priority populations, pregnant or nursing women are able to re-enroll in QuitLine services every three months.
- Training on warm referrals to QuitLine has been focused on providers and organizations that serve pregnant women. Starting in February 2016, the QuitLine started tracking warm referrals for future evaluation.
- The Rapid City Bright Start program piloted a Prenatal 5As Intervention Record for tobacco use from January to September 2016. This record provided a guideline for discussions about tobacco use and a reminder for QuitLine referrals. Evaluation of the pilot is continuing into the next grant year.
- Priority Population QuitLine Data Briefs were finalized in January 2016. Each of these data briefs, including one for pregnant women, includes QuitLine enrollment and Outcome data, and were used as talking points with partners and healthcare providers.
- QuitLine Priority Population Guidelines developed during the previous grant year have been updated with recent data and are posted on the www.befreesd.com website.
- A SD Tobacco Disparities Grantee, the Teddy Bear Den, provides QuitLine referrals and tobacco education to at-risk pregnant women and young mothers. They are also a partner in increasing warm referrals to the QuitLine.
- A SD Tobacco Disparities Grantee, Coteau Des Prairies Health Care System, is working on creating systems change to incorporate tobacco education and QuitLine referrals in their work with pregnant women.
- A Priority Population Workgroup was formed in October 2015 to discuss issues directly relating to the six SD TCP priority populations.
- The SD TCP continues to provide baby/infant bibs and QuitLine information for Bright Start Welcome Boxes.
- Representatives from the SD TCP have presented information to the Regional Managers on the Priority Population Guidelines, the QuitLine Postpartum Program, and the PROF (an online QuitLine training module)
- QuitLine trainings have been held at WIC offices, including tribal WIC offices on the Cheyenne River and Rosebud reservations
- Discussion continues to occur about the development of a healthy pregnancy resource that would include tobacco information
- A Healthcare Tobacco Policy Assessment was finalized in April 2016 and included a variety of healthcare

facilities, including WIC and Family Planning sites. The report included facility scores and QuitLine referrals, as well as next steps for policy improvement.

- Teens Against Tobacco Use (TATU) program trained 47 schools and 367 students during the 2015-16 school year.
- Boys & Girls Club of Watertown and Brookings were recipients of Tobacco Disparities Grants (the Brookings grant also includes funding for Yankton and Moody County facilities). A large part of their activities include implementing the Clubs Against Tobacco curriculum, which includes a focus on eliminating nonsmokers' exposure to secondhand smoke.
- The SD TCP currently has collected 50 smoke-free multi-unit housing policies
- QuitLine training was held with Sanford pediatric residents in April 2016
- WIC program surveys ask seven questions during their Pregnant woman assessment specific to tobacco and drug use prior to and during pregnancy.
- WIC program surveys ask two questions in their child assessment specific to exposure to smoke

14.2. Maintain Department of Health infrastructure/workforce in order to provide education and outreach to clients and make SD QuitLine referrals as appropriate.

- Educated WIC Staff and Bright Start home visitors on the Tobacco Cessation and QuitLine Service resources available for pregnant women

ESMs

14.1. Number of media platforms (i.e., websites, Facebook, TV, radio, print) that include tobacco prevention/cessation messages

- Ten media platforms:
  - 2 Facebook pages (SD QuitLine & ForBabySakeSD),
  - SD QuitLine Twitter account,
  - 3 websites (sdquitline.com, befreesd.com & forbabysakesd.com),
  - Occasional TV & radio (FBS and QuitLine),
  - Newspaper ads/articles coalitions put in local newspapers, and
  - Promotional print materials (FBS posters, secondhand/thirdhand smoke brochures)

DOH Goal 5: Maximize the effectiveness and strengthen infrastructure of the Dept. of Health

State Performance Measure 4: MCH data is analyzed and disseminated.

Objectives:

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

Strategies:

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

- Completed review of 2015 infant deaths. DOH now has three years of trend data. Planning to develop

infographics and articles or reports to disseminate the data to stakeholders/public.

- Through infant death review process, the DOH has identified the complete death scene investigation is not consistently being documented. DOH has contracted to provide infant death scene investigation training to law enforcement personnel across the state in an effort to increase use and sharing of SUIDI report form for infant death review.
- Although MCHBG federally available data (FAD) (https://www.hrsa.gov/about/organization/bureaus/mchb/fad-resource-document.pdf) have been useful in the past, the addition of all states' data will provide South Dakota with easily accessible data for ranking South Dakota on a national basis. The DOH will use these data to continue to summarize the National Performance Measures and National Outcome Measures, including South Dakota and US rates, South Dakota rankings, trends over time and HP2020 and SD2020 goals in the 'MCH Annual Report on Rankings and Trends' document (see Appendix).
- Other data sets used in the past year include Medicare data on elective deliveries and the South Dakota Association of Healthcare Organizations (SDAHO) Inpatient Data Collection System for analyses related to racial disparities in South Dakota pediatric injury hospitalization rates. In addition to MCHBG National Performance and Outcome Measures, South Dakota Vital Records have been used for: 1.) a report on trends in spontaneous and indicated preterm deliveries among singleton gestations (2006-2013); 2.) an investigation of trends in teen births in South Dakota; 3.) calculation of age specific and overall fertility rates for South Dakota by race; and 4.) an analysis on the interaction between pre-pregnancy BMI and gestational weight gain on pregnancy and birth outcomes.

S4.2. Identify data collection methods to address gaps

- SDFP continues to utilize Ahlers computer program as a practice management system for data and billing. SDFP applied for additional grant dollars to assist with procuring an EMR but was not awarded funding. SDFP program staff continue to work with Ahlers and field staff to improve data entry to make sure all data is collected accurately.
- Contract with Health Management Associates to assist with billing and sustainability assessment of the SDFP program.
- Some of the data needed for the MCHBG was not available, in particular, data on safe sleep. However, the DOH conducted a 2014 PRAMS-like survey so data on sleep position is now available. A 2016 PRAMS-like survey is ongoing and includes additional information on safe sleep practices along with information on dental visits and illicit drug use during pregnancy. Both of these South Dakota PRAMS-like surveys followed the CDC PRAMS protocol, oversampled American Indian and Other Race groups, and incorporated both sampling and non-response weights into the analysis.
- In 2016 the DOH and the Great Plains Tribal Chairman Health Board were awarded funding to participate in the CDC PRAMS. These organizations have been working together, along with the North Dakota DOH to coordinate efforts to insure high response rates and adequate representation of the American Indian population in the PRAMS.

S4.3. Implement new data collection efforts as needed.

S4.4. Develop and disseminate fact sheets on findings

- Comprehensive analyses and presentation of the 2014 PRAMS-like survey has recently been completed and a full report is available online (http://doh.sd.gov/documents/statistics/2014-SD-PRAMS.pdf), as is an Executive Summary (http://doh.sd.gov/documents/statistics/2014-PRAMS-Exec-Summary.pdf). One-page fact sheets are being developed and will be posted in the South Dakota Health and Disease Update and

in the South Dakota Public Health Bulletin, both of which are widely distributed throughout the state. In addition, these fact sheets will be available online on the DOH PRAMS survey website.

- The DOH published several articles in the South Dakota Public Health Bulletin in 2015 on topics of suicide and suicide attempts in adolescents and adults, incidence and pattern of lethal congenital anomalies, and trends in teen births. Other publications have recently been published or submitted (see below).

S4.5. Analyze the data to identify future program efforts.

- 2015 YRBS, 2015 YTS and 2015 BRFSS reports are complete.
- Data from the MCH Annual Report on Rankings and Trends (see Appendix) identified several areas of concern that have been followed up. The high rate of infant mortality lead to this being a South Dakota MCH priority, while the high rate of unintentional injuries that were noted lead to a further analysis of unintentional injuries and the decision to include NPM-7 and NOM-16.3. Safe sleep was identified as a priority based on the MCH Annual Report and a statewide Infant Death Review, and lead to the inclusion of additional safe sleep questions in the South Dakota 2016 PRAMS (co-sleeping in particular).
- The South Dakota 2014 PRAMS-like data analysis identified several at-risk populations that have been targeted in the State Action Plan. For example, it was noted in the 2014 PRAMS-like survey that a higher percent of unmarried women did not talk to a healthcare worker about preparing for a healthy pregnancy compared to married women. This lead to one of the State Action Plans – decrease the percent of unmarried women who did not talk to a healthcare worker about preparing for a healthy pregnancy before they got married. Another example is the lower percent of mothers of Other Races who placed their infant to sleep on their backs; leading to one of the State Action Plans being to increase the percent of infants from Other Races placed on their back to sleep. The FAD data also were used to identify that a lower percent of non-metro MSA children reported having a developmental screening. This population is now being targeted to increase the percent with developmental screening.
- As a result of recent analyses of the interaction between pre-pregnancy BMI and gestational weight gain on adverse pregnancy and birth outcomes, along with the observed high rate of overweight and obese mothers and excessive weight gain in the state, the DOH feels it is important to disseminate these findings to South Dakota healthcare providers in a timely manner. This will be done in the near future.

Dissemination of Data:

Presentations:

- Invited speaker (B Specker), “Making a Difference with Tribal PRAMS Data: A Collaboration between Tribes, a Tribal Epidemiology Center & South Dakota Department of Health”, CityMatCH and MCH Leadership Conference, Philadelphia, September, 2016
- Bai W, Specker B, Kightlinger, L. Racial disparities in pediatric injury hospitalization rates in a rural state. APHA 143rd Annual Meeting, Chicago, October, 2015 (oral presentation)

Publications:

- Binkley T, Beare T, Minett M, Koepp K, Wey H, Specker B. Response to an online version of a PRAMS-like survey in South Dakota. Maternal and Child Health Journal, 2016, DOI: 10.1007/s10995-016-2118-6
- Bai W, Specker B, Kightlinger L. Teen births in South Dakota, 2006-2014. South Dakota Public Health Bulletin, November, 2015.
- Specker B, Bai W, Binkley T, Beare T, Koepp K, Minett M, Peterson L, Weidauer L, Wey H. South Dakota Pregnancy Risk Assessment Monitoring System (PRAMS)-Like 2014 Data Report.

http://doh.sd.gov/documents/statistics/2014-SD-PRAMS.pdf

- Specker B, Bai W, Binkley T, Beare T, Koepp K, Minett M, Peterson L, Weidauer L, Wey H. South Dakota Pregnancy Risk Assessment Monitoring System (PRAMS)-Like 2014 Executive Summary. http://doh.sd.gov/documents/statistics/2014-PRAMS-Exec-Summary.pdf

Publications – submitted (abstracts included below):

- Bai W, Kightlinger L, Specker B. Racial Disparities in South Dakota Pediatric Injury Hospitalization Rates, submitted.

  Objectives: We investigated racial disparities in pediatric injury hospitalization rates.
  Methods: Hospital discharge data for South Dakota residents aged 0-19 years between 2009 and 2013 were used to calculate annual injury hospitalization rates. Children and adolescents were divided into five age groups (<1, 1-4, 5-9, 10-14, 15-19 years) and two racial groups (American Indian [AI] and White).
  Results: Between 2009-2013 there were 2,826 pediatric hospitalizations due to injuries at a rate of 247/100,000. Injury hospitalization rates among AI children were higher than White children (485 vs. 196/100,000 respectively) and have increased over time (both races, $p<0.01$). AI children had higher unintentional and suicide-related hospitalization rates in all age groups compared to White children. Suicide-related injuries were apparent in 10-14 year age group and were the major manner of injury among 15-19 year old AI adolescents at a rate three times higher than Whites (514 vs. 154/100,000, $p<0.001$). Mechanisms and nature of hospitalized injuries were consistent with the high rate of suicide-related admissions.
  Conclusion: South Dakota American Indian children have disproportionately higher hospitalization rates due to unintentional, suicide- and homicide-related injuries.
- Bai W, Wey H, Specker B. Pre-pregnancy BMI and Gestational Weight Gain on Pregnancy Outcomes, submitted.

  Background: Maternal obesity and excessive gestational weight gain (GWG) adversely affects maternal and birth outcomes. However, there are few reports on how these two factors may interact in determining pregnancy outcomes.
  Objective: We investigated the combined and independent influence of gestational weight gain (GWG) and pre-pregnancy body mass index (BMI) on pregnancy and birth outcomes.
  Design: Birth certificate data on 99,334 singleton births to South Dakota residents in 2006-2014 were used in logistic regression models to estimate main effects and relative excess risks due to interactions after controlling for confounders.
  Results: Overweight and obese mothers had increased odds for prolonged labor (OR=1.2 [95% CI 1.1, 1.3] and 1.3 [1.2, 1.4], respectively), infant mortality (1.5 [1.2, 1.8] and 1.4 [1.1, 1.7]), low Apgar score (1.2 [1.1, 1.3] and 1.3 [1.2, 1.4]), and NICU admission (1.1 [1.0, 1.2] and 1.3 [1.2, 1.4]). Inadequate GWG was associated with decreased odds of prolonged labor (0.8 [0.7, 1.0]) and increased odds of infant mortality (1.5 [1.2, 1.8]), and excessive GWG was associated with increased odds of prolonged labor (1.1 [1.0, 1.2]) and NICU admission (1.1 [1.1, 1.2]). There were significant overall additive interactions between pre-pregnancy BMI and GWG on risk of gestational diabetes, cesarean section, small- and large-for-gestational age, and preterm birth.
  Conclusion: Overweight and obese mothers would benefit from lower GWG on many pregnancy outcomes, and underweight mothers should be encouraged to gain weight during pregnancy to minimize the risk of a SGA birth.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

As was mentioned earlier, Division of Family and Community Health is the health care service delivery arm of the DOH and administers MCH services and consists of three offices.

OCFS administers the MCH Block Grant for the DOH. OCFS provides leadership and technical assistance to assure systems 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 staff provide training and ongoing technical assistance to DOH field staff as well as private health care providers who deliver MCH services. Staff are responsible for the development of policies and procedures relevant to the delivery of MCH services for pregnant and postpartum women, infants, children, adolescents, and CYSHCN. OCFS works closely with field staff on data collection needed for federal and state reports as well as for program evaluation.

Community health offices and PHA sites provide professional nursing and nutrition services and coordinate health-related services to individuals, families, and communities across the state. Services include immunizations, developmental screenings, management of pregnant women, WIC, family planning, nutrition counseling/education, health screenings (i.e., blood pressure, blood sugar, vision, hearing, etc.), and education/referral. In most counties, these services are delivered at state DOH offices. In 11 PHA sites, services are delivered through contracts with local county governments and private health care providers.

OCDPHP coordinates programs designed to promote health and prevent disease. The office coordinates statewide activities to promote early detection and education of breast and cervical cancer, colorectal cancer, cardiovascular disease, stroke, diabetes, overweight and obesity, and tobacco control. In addition, the DOH has a chronic disease epidemiologist who provides epidemiological support for the chronic disease and health promotion programs as well as for MCH programs.

ODPS provides vaccines for South Dakota's children. These vaccines include MMR, Hepatitis A & B, Diphtheria, Tetanus & Pertussis, Polio, Varicella, Hib, Pneumococcal, Rotavirus, Meningococcal, Human Papillomavirs and Influenza and provides recommendations and education on adult immunizations such as influenza, pneumonia, and tetanus. Staff investigate sources of STI infections, provide treatment and apply preventive measures to those exposed. Field offices provide confidential counseling and testing for HIV/ AIDS as well as educational materials, training for the public/schools/health care providers, and assistance with health care costs for those with HIV disease. The office provides follow-up of TB cases and also conducts disease outbreak investigations in the state.

South Dakota’s healthcare industry has experienced substantial and steady growth since 1972 when record keeping began. Growth of the healthcare industry is projected to continue for the foreseeable future and is projected to be one of South Dakota’s largest growth industries over the next decade. The industry’s demand for workers is driven in part by an aging patient population; an expanding general population; technological advances in the workplace requiring additional staff; a growing emphasis on disease management; and an aging healthcare workforce who must be replaced as they retire. In order to begin to address these needs, the South Dakota Healthcare Workforce Initiative, a collaborative effort between DOH, DOE, and the Department of Labor, and the Board of Regents, was implemented. The overall goal of this initiative is to address healthcare workforce issues in South Dakota and to work toward ensuring a competent and qualified healthcare workforce that meets the needs of all South Dakota citizens. The South Dakota Healthcare Workforce Center was established within ORH to function 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. Specific program examples include recruitment of health professionals, assistance to facilities such as hospitals and rural health clinics, helping interested organizations develop and use technology applications and general information and referral.

In addition, 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 the OCFS staff. The Office of Child and Family Services will be hosting a conference July 2017 that will bring together staff from across the state to provide professional development and networking opportunities based on the needs identified within the assessment. In addition, as a part of our performance appraisal system there is a section entitled: Development. Staff are to identify at least one behavior or one performance expectation to develop over the coming year and what means will be used to evaluate progress made during follow up coaching and evaluation sessions. This is one way of addressing individual workforce development needs.

II.F. 3. Family Consumer Partnership

The MCH program works closely with SDPC to identify and recruit parents of CYSHCN to provide mentoring and peer support to other families with CYSHCN. They provide a family perspective to CSHS program staff regarding programs, policies and procedures, maintain a statewide database of support parents and groups, provide parent-to-parent training, and link parents throughout the state with trained supporting parents in a community-based manner.

MCH staff serve on multiple advisory panels, councils, and workgroups that bring together family/consumer partners. This includes the advisory group for the HRSA Hearing Grant, early intervention State Interagency Coordinating Council, Developmental Disabilities Council, SD Youth Suicide Prevention Advisory Committee, Oral Health Coalition, and Jolene's Law Task Force (child sexual abuse). 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.

The WIC Program completes an annual survey asking recipients how to improve services, food benefits, customer service, and nutrition and breastfeeding education. 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.

In order to assure quality services to Bright Start Home Visiting clients, telephone surveys are completed by site Nurse Coordinators with clients currently receiving services as well as those who have exited the program. Telephone surveys for clients participating in the program are completed 1 to 2 times per year and coordinators contact at least 2 clients per nurse.

As the DOH moves forward through this five year grant cycle and the ongoing development of the state’s action plan, it will continue to identify ways to engage families/consumers in planning, development and evaluation.

All MCH programs attempt to implement processes which result in a workforce that is culturally and linguistically competent and a system that attempts to facilitate the highest quality of care to all communities while acknowledging and respecting the consumer’s health-related beliefs and cultural values. In addition, demographic data was looked at for each population domain during the needs assessment population to identify areas where there were disparities and the potential for new strategies to address those disparities.

The Office of Child and Family Services will be hosting a conference July 2017 that will bring together staff from across the state to provide professional development and networking opportunities. At the conference there will be education sessions provided on Lakota Culture and Toxic Stress and Resilience to better help staff address needs of the people we serve.

As a part of the DOH Strategic Plan a workgroup on cultural competency administered a department-wide needs assessment related to training, cultural competency, and service delivery. The workgroup will utilize the needs assessment data to develop a plan of action to implement late 2017.

II.F.4. Health Reform

South Dakota does not operate a state-based marketplace, which means that under federal law South Dakotans are part of a federally facilitated marketplace. An online portal is available for individuals to enroll through the marketplace in the individual market. In addition, Get Covered South Dakota, a statewide initiative developed by Community Healthcare Association of the Dakotas (CHAD) is available to work with Community Health Centers (CHCs) and other community leaders to find solutions for improving healthcare options throughout the Dakotas. Get Covered South Dakota connects people to affordable healthcare options and enhances access to quality primary care. This initiative links South Dakota residents with enrollment specialists in their local communities. Free impartial assistance is available to help consumers understand and find affordable healthcare coverage. South Dakota MCH programs continue to assist MCH populations served with information and referral to assistance programs to identify what is the best form of insurance coverage available to them. Financial assistance under the Health KiCC continues to be provided as a gap-filler for those families that are uninsured or underinsured.

In March 2015, Governor Daugaard submitted a concept paper to HHS asking the federal government to reconsider how it funds Medicaid services for IHS eligible that are provided outside of the IHS system. Eligible South Dakota Native Americans are served by the Great Plains Indian Health Service Unit. However, actual access to IHS is limited in all areas of the state, and IHS contract care budgets do not meet the demand for healthcare beyond even limited emergency services. As a result, Native Americans eligible for IHS services use non-IHS services at high rates, and often at higher cost than if they were able to access care earlier and closer to home. This project is no longer being considered but ongoing meeting are being convened with tribal partners to address access to care for American Indians and Medicaid funding.

II.F.5. Emerging Issues

SB 28 added vaccination requirements and updated administrative rules that will go into effect at the start of the 2016 school year. Collaborative efforts with the DOH Immunization Program to reach 6th grades in order to meet the new requirements for Tdap and Meningococcal were very successful with immunization rates of 95.9% for Tdap and 95.7% for MCV4. This update highlights the work that is currently underway in the OCFS to include a billing process for immunizations administered by the community health nurses in field. The first full year of utilizing a billing process will be finalized in the fall of 2017 with opportunities beyond immunizations moving forward. There were challenges with billing as a centralized public health entity with insurance companies and the infrastructure needed for follow-up on denied claims.

In June 2016, South Dakota participated in a Learning Collaborative on Improving Quality and Access to Care in Maternal and Child Health. As a part of this planning, South Dakota has been working with our legislative, Medicaid and AAP partners to address NPM 10 focusing on adolescent well visits and SPM 3 to increase early and ongoing prenatal care. With a clear connection between well visits and improving adolescent vaccination rates the team worked to review available data and engage additional partners to improve adolescent well visits. The collaborative learning process is complete and the planning over the last year with Medicaid and AAP has helped to develop a path to work together with interagency partners to share common language and messaging around well visits.

Adolescent health within MCH will be under review in the next year to look for partners and assistance to move the measures and strategies forward. South Dakota is in a good position to look at data and gather information around what would motivate parents to utilize the opportunity of a well visit and how to work with providers on evidence based reminder-recall strategies.

Community Health Service offices are seeing an increased need for interpretation services to improve quality of service and improved outcomes. Currently both in person and phone translation is utilized for WIC and MCH services as well as Home Visiting. Community Health Offices in two locations have scheduled on-site interpreters for specific days so clients who need an interpreter know the services are available. Immigrant populations are increasing in three locations in the state and the need continues to increase. The DOH will monitor the interpreter needs as well as translation of key resources.

Workforce issues arise in communities located in very rural areas. The distance nursing and dietitian staff need to travel to deliver services is increasing in order to assure access. The DOH will be reviewing the current structure of community health services to look at alternate methods of service delivery and look for ways to market programs and staff openings.

II.F.6. Public Input

The DOH made the FY 2018 MCH block grant available for public review and comment via the DOH website, Facebook page, Health KiCC list serve, and twitter. The summary was also provided to all MCH team members asking them to forward to any partners that would be involved in our MCH activities and initiatives. These team members and partners then in turn shared the summary via Facebook pages, websites, list serves, newsletters, and email. A few of the partners reached were SD Parent Connection and the families they serve, tribal representatives, Infant Death Review team members, Birth to 3 Early Intervention families and providers, Behavioral health providers, and DD 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 DOH received one public comment from an Addictions and Mental Health Therapist with thoughts on additional areas of effort to include fetal exposure to alcohol and other substances, co-sleep concerns, breastfeeding and teen drug issues to include the use of marijuana. The DOH will refer to this comment when ongoing needs assessment and State Action Plan activities and measures are reviewed and modified as appropriate.

The MCH program's daily interactions with the MCH population and partners is also 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 Connections 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.

II.F.7. Technical Assistance

The MCH program is committed to assuring all MCH populations in the state receive the highest quality care and have optimal health. The MCH program has currently not identified any technical assistance needs for the FY2017 MCH block grant. As needs are identified, the MCH program will seek technical assistance.

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,097,088	$2,511,344	$2,133,894	$2,476,338
Unobligated Balance	$0	$0	$0	$0
State Funds	$1,615,000	$1,675,612	$1,575,000	$1,766,341
Local Funds	$400,000	$523,814	$450,000	$487,134
Other Funds	$0	$10,348	$0	$22,650
Program Funds	$403,000	$736,796	$625,000	$810,181
SubTotal	$4,515,088	$5,457,914	$4,783,894	$5,562,644
Other Federal Funds	$19,918,149		$19,329,349	$24,556,280
Total	$24,433,237	$5,457,914	$24,113,243	$30,118,924

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,236,264	$2,591,754	$2,476,338	
Unobligated Balance	$0	$0	$0	
State Funds	$1,680,000	$1,920,916	$1,766,341	
Local Funds	$500,000	$87,243	$487,134	
Other Funds	$0	$0	$22,650	
Program Funds	$740,000	$842,904	$810,181	
SubTotal	$5,156,264	$5,442,817	$5,562,644	
Other Federal Funds	$20,239,995	$23,744,990	$20,613,679	
Total	$25,396,259	$29,187,807	$26,176,323	

	2018	
	Budgeted	Expended
Federal Allocation	$2,149,068	
Unobligated Balance	$0	
State Funds	$1,700,080	
Local Funds	$87,000	
Other Funds	$0	
Program Funds	$810,000	
SubTotal	$4,746,148	
Other Federal Funds	$20,193,754	
Total	$24,939,902	

III.A. Expenditures

III. Budget Narrative

III.A. Expenditures

Activities performed by MCH program and field staff that provide services funded by the MCH block grant, 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, immunization administration, travel to provide services, training, networking, quality assurance, and case management).

The budget amounts reflect anticipated activities of program and field staff but actual expenditures can vary based on the state economy and public health events (i.e., outbreaks, natural disasters). 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.B. Budget

III.B. Budget

MCH block grant funds have historically been used to address DOH priorities as outlined in the needs assessment and annual plan of the MCH block grant application. 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 the 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. For this reporting year, South Dakota allocated 32.3% of the federal dollars for CYSHCN. The DOH monitors funding allocations quarterly to ensure compliance. The DOH spends more than one year of federal allocation but is difficult to reflect 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 appropriate by the Legislature), local match, program income, and other sources. The level of funds utilized from each match source varies from one year to the next 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 shifts 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. State MCH programs were first required to use the current format of reporting budgets and expenditures (including levels of the pyramid) in FFY 1999. Since that time, South Dakota has been refining the budget development and expenditure process to meet both state and federal rules and requirements. The DOH continues to work to move to accounting programs that more easily reflect population group and pyramid level reporting requirements. The DOH receives funding for the MIECHV, EHDI, Abstinence, PREP, Family Planning, SSDI, and WIC and continues to partner with other state agencies to plan and implement services related to these grants.

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

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

Supporting Document #01 - CribSafety-Professionals (2).pdf

Supporting Document #02 - ForBabysSakeWebStarts REV0417 AD 3.pdf

Supporting Document #03 - SDOH HPV Rack Card draft.pdf

Supporting Document #04 - South Dakota Suicide Prevention.pdf

Supporting Document #05 - well_child_letter_babyto11.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: South Dakota

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,149,068	
A. Preventive and Primary Care for Children	$ 687,702	(32%)
B. Children with Special Health Care Needs	$ 687,702	(32%)
C. Title V Administrative Costs	$ 85,962	(4%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,700,080	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 87,000	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 810,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,597,080	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 4,746,148	
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)	$ 20,193,754	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 24,939,902	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 159,943
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,428
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 212,897
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,018,486
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,045,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 17,000,000

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,236,264		$ 2,591,754	
A. Preventive and Primary Care for Children	$ 855,741	(38.3%)	$ 777,540	(30%)
B. Children with Special Health Care Needs	$ 737,499	(33%)	$ 811,626	(31.3%)
C. Title V Administrative Costs	$ 59,288	(2.7%)	$ 81,125	(3.2%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,680,000		$ 1,920,916	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 500,000		$ 87,243	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 740,000		$ 842,904	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,920,000		$ 2,851,063	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 5,156,264		$ 5,442,817	
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)	$ 20,239,995		$ 23,744,990	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 25,396,259		$ 29,187,807	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 227,763	$ 274,269
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 105,347	$ 109,870
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,298,277	$ 1,057,387
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 75,104	$ 96,140
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,186,339	$ 993,302
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 17,117,047	$ 20,656,171
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 230,118	$ 138,318
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)		$ 1,388
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention		$ 215,143
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program		$ 203,002

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.	
4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.	
5.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.	

6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**

Field Note:
Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.

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	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 343,851	$ 484,689
2. Infants < 1 year	$ 275,080	$ 268,870
3. Children 1-22 years	$ 687,702	$ 777,540
4. CSHCN	$ 687,702	$ 811,626
5. All Others	$ 68,771	$ 167,904
Federal Total of Individuals Served	$ 2,063,106	$ 2,510,629

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 580,000	$ 472,848
2. Infants < 1 year	$ 510,000	$ 657,918
3. Children 1-22 years	$ 810,000	$ 1,353,170
4. CSHCN	$ 660,000	$ 240,376
5. All Others	$ 52,920	$ 126,751
Non Federal Total of Individuals Served	$ 2,612,920	$ 2,851,063
Federal State MCH Block Grant Partnership Total	$ 4,676,026	$ 5,361,692

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, Federal Total of Individuals Served**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**

Field Note:
This amount does not include administrative costs of $81,125 for a total federal expenditure of $2,591,754

Form 3b
Budget and Expenditure Details by Types of Services

State: South Dakota

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 110,000	$ 131,743
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	$ 110,000	$ 131,743
2. Enabling Services	$ 1,019,534	$ 1,258,993
3. Public Health Services and Systems	$ 1,019,534	$ 1,201,018
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		$ 105,587
Physician/Office Services		$ 9,054
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 5,200
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 2,153
Laboratory Services		$ 9,644
Other		
optometry		$ 105
Direct Services Line 4 Expended Total		$ 131,743
Federal Total	$ 2,149,068	$ 2,591,754

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 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	$ 1,900,000	$ 1,887,494
3. Public Health Services and Systems	$ 693,980	$ 963,569
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		$ 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	$ 2,593,980	$ 2,851,063

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

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

State: South Dakota

Total Births by Occurrence: 12,910

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	12,846 (99.5%)	867	47	47 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methyglutaric aciduria	Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, βeta-thalassemia	S,C disease
Biotinidase deficiency	Cystic fibrosis	Hearing loss	Severe combined immunodeficiences	Classic galactosemia

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

LTFU discontinued July 1, 2015. South Dakota does not provide long-term follow-up after infant has confirmed diagnosis.

Form Notes for Form 4:

CCHD - legislation requiring hospitals to perform - no data collected by DOH. Newborn Hearing - no legislative mandates but DOH collects data under CDC EHDI grant

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: South Dakota

Reporting Year 2016

		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	3,480	92.2	0.0	3.7	4.1	0.0
2. Infants < 1 Year of Age	1,354	92.2	0.0	3.7	4.1	0.0
3. Children 1 to 22 Years of Age	1,264	7.8	0.0	51.0	38.3	2.9
4. Children with Special Health Care Needs	3,000	39.6	0.0	56.4	4.0	0.0
5. Others	1,044	7.6	0.0	44.6	46.0	1.8
Total	10,142					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

None

Form 5b
Total Recipient Count of Individuals Served by Title V

State: South Dakota

Reporting Year 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	12,587
2. Infants < 1 Year of Age	12,911
3. Children 1 to 22 Years of Age	162,983
4. Children with Special Health Care Needs	32,828
5. Others	164,308
Total	385,617

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

None

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

State: South Dakota

Reporting Year 2016

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	12,043	9,042	365	1,822	265	12	389	148
Title V Served	3,300	2,477	100	499	73	3	107	41
Eligible for Title XIX	4,776	2,406	229	1,827	142	22	0	150
2. Total Infants in State	12,419	9,680	257	1,582	176	16	708	0
Title V Served	12,419	9,680	257	1,582	176	16	708	0
Eligible for Title XIX	5,820	2,900	365	2,049	171	60	0	275

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	11,412	624	7	12,043
Title V Served	3,127	171	2	3,300
Eligible for Title XIX	4,634	142	0	4,776
2. Total Infants in State	11,768	651	0	12,419
Title V Served	11,768	651	0	12,419
Eligible for Title XIX	5,548	272	0	5,820

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	2018 Application Year	2016 Reporting 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"	Scarlett Bierne	Scarlett Bierne
4. Contact Person's Telephone Number	(605) 773-4439	(605) 773-4439
5. Number of Calls Received on the State MCH "Hotline"		1,334

B. Other Appropriate Methods	2018 Application Year	2016 Reporting Year
1. Other Toll-Free "Hotline" Names	National Suicide Prevention Lifeline; Suicide Prevention Texting	National Suicide Prevention LIfeline
2. Number of Calls on Other Toll-Free "Hotlines"		1,571
3. State Title V Program Website Address	N/A	N/A
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites	www.MunchCode.org; www.forbabysakesd.com; www.Facebook.com/ForbabysakeSD; www.facebook.com/MunchCodeSD; http://doh.sd.gov/family/wic/; http://doh.sd.gov/family/pregnancy/family-planning.aspx	MunchCode.org; Forbabysakesd.com; www.Facebook.com/ForbabysakeSD; www.facebook.com/MunchCodeSD; http://doh.sd.gov/family/wic/; http://doh.sd.gov/famly/pregnacy/family-planning.aspx
6. Number of Hits to the State Title V Program Social Media Websites		102,478

Form Notes for Form 7:

2018 Application year hope to address changes to MCH Hotline and Title V Program website.
Websites:
-www.MunchCode.org/
-Forbabysakesd.com/
-www.facebook.com/MunchCodeSD/
-www.facebook.com/ForbabysakeSD/
-http://doh.sd.gov/family/wic
-http://doh.sd.gov/family/pregnancy/family-planning.aspx
Social Media Hits:
MunchCode (website) 5,821
MunchCode (Facebook) 19,556
forbabysakeSD (website) 9,591
forbabysakeSD (facebook) 52,849
WIC (website) 13,571
Family Planning (website) 1,090

Form 8
State MCH and CSHCN Directors Contact Information

State: South Dakota

1. Title V Maternal and Child Health (MCH) Director	
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Title	MCH Director
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2. Title V Children with Special Health Care Needs (CSHCN) Director	
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3. State Family or Youth Leader (Optional)	
Name	
Title	
Address 1	
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Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: South Dakota

Application Year 2018

No.	Priority Need
1.	Promote preconception/inter-conception health
2.	Reduce infant mortality
3.	Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)
4.	Improve early identification and referral of developmental delays
5.	Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN
6.	Promote oral health for all populations
7.	Improve state and local surveillance, data collection, and evaluation capacity

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Promote preconception/inter-conception health	New	
2.	Reduce infant mortality	New	
3.	Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)	New	
4.	Improve early identification and referral of developmental delays	New	
5.	Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN	New	
6.	Promote oral health for all populations	New	
7.	Improve state and local surveillance, data collection, and evaluation capacity	New	Impacts all NPM across all domains

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: South Dakota

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

NPM 13A - No data available until Fall of 2017

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
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	70.7 %	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%, 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
2014	125.3	10.4 %	147	11,729
2013	132.3	10.7 %	154	11,645
2012	118.5	10.2 %	136	11,477
2011	132.7	10.9 %	151	11,382
2010	127.9	10.8 %	143	11,179
2009	122.5	10.4 %	140	11,426
2008	98.0	9.4 %	111	11,322

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
2011_2015	28.0	6.8 %	17	60,817
2010_2014	24.9	6.4 %	15	60,292
2009_2013	26.7	6.7 %	16	59,943
2008_2012	16.7	5.3 %	10	59,766
2007_2011	16.7	5.3 %	10	59,923
2006_2010	NR	NR	NR	NR
2005_2009	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 3 - Notes:

None

Data Alerts: None

NOM 4.1 - 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
2015	6.1 %	0.2 %	754	12,328
2014	6.6 %	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%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.0 %	0.1 %	127	12,328
2014	1.0 %	0.1 %	125	12,280
2013	1.0 %	0.1 %	120	12,237
2012	1.1 %	0.1 %	135	12,098
2011	1.1 %	0.1 %	127	11,839
2010	1.3 %	0.1 %	150	11,801
2009	1.1 %	0.1 %	129	11,929

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.1 %	0.2 %	627	12,328
2014	5.5 %	0.2 %	679	12,280
2013	5.3 %	0.2 %	646	12,237
2012	5.1 %	0.2 %	613	12,098
2011	5.2 %	0.2 %	617	11,839
2010	5.6 %	0.2 %	656	11,801
2009	4.8 %	0.2 %	567	11,929

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.0 %	0.1 %	252	12,325
2014	2.1 %	0.1 %	261	12,268
2013	2.0 %	0.1 %	241	12,221
2012	2.2 %	0.1 %	267	12,084
2011	2.2 %	0.1 %	257	11,832
2010	2.5 %	0.1 %	298	11,788
2009	2.1 %	0.1 %	244	11,912

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.5 %	0.2 %	801	12,325
2014	6.4 %	0.2 %	779	12,268
2013	6.2 %	0.2 %	752	12,221
2012	5.6 %	0.2 %	679	12,084
2011	5.8 %	0.2 %	683	11,832
2010	6.1 %	0.2 %	715	11,788
2009	5.9 %	0.2 %	700	11,912

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5.3 - 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
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%, 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
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:

Indicator results were based on a shorter time period than required for reporting

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
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
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
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
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	2.5	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
2014	138.4	33.6 %	17	12,283
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

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

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related 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
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 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	4.3	0.6 %	50	11,730
2013	2.8	0.5 %	33	11,645
2012	2.4	0.5 %	27	11,477
2011	2.6	0.5 %	29	11,382
2010	2.8	0.5 %	31	11,179
2009	1.5	0.4 %	17	11,426
2008	1.2	0.3 %	13	11,322

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)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

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 12 months

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	17.3 %	1.3 %	32,842	190,188

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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
2015	24.8	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
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	43.8	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
2013_2015	14.6	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	29.4	4.1 %	51	173,766
2008_2010	33.2	4.4 %	58	174,643
2007_2009	35.2	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
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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	14.8 %	1.1 %	29,885	201,731
2007	17.4 %	1.1 %	33,703	194,049
2003	16.0 %	1.0 %	30,767	192,623

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	17.6 %	3.1 %	3,877	22,073

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children 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
2011_2012	1.7 %	0.4 %	2,902	168,545
2007	0.7 %	0.2 %	1,137	160,112

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children 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
2011_2012	7.0 %	0.9 %	11,757	168,655
2007	6.2 %	0.8 %	9,969	160,047

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children 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
2011_2012	63.6 %	6.1 %	8,053	12,661
2007	69.7 %	6.0 %	7,895	11,325
2003	72.9 %	5.4 %	8,328	11,421

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children 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
2011_2012	91.7 %	0.8 %	185,027	201,731
2007	90.1 %	0.9 %	174,735	194,049
2003	89.0 %	0.9 %	171,361	192,623

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.5 %	2.1 %	22,299	84,051
2007	28.4 %	2.0 %	24,048	84,664
2003	25.8 %	1.9 %	23,768	92,091

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	36.1 %	0.7 %	1,868	5,179
2012	32.2 %	0.5 %	2,579	8,020
2010	37.1 %	0.5 %	2,926	7,884
2008	36.0 %	0.6 %	2,502	6,946

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	29.2 %	1.8 %	11,038	37,746
2013	25.1 %	1.6 %	9,491	37,874
2011	23.9 %	1.3 %	9,309	38,957
2009	22.0 %	1.3 %	8,451	38,353
2007	23.4 %	1.2 %	9,544	40,789
2005	24.4 %	1.6 %	10,009	41,028

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	75.6 %	3.5 %	13,599	17,989
2014	76.3 %	4.2 %	13,098	17,159
2013	73.9 %	3.9 %	12,072	16,346
2012	63.6 %	3.3 %	10,370	16,301
2011	62.9 %	5.3 %	10,532	16,741
2010	48.7 %	3.5 %	8,257	16,951
2009	42.8 %	3.6 %	7,179	16,786

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 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
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 95% confidence interval half-width/estimate > 0.6

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 (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	53.2 %	4.6 %	14,358	26,984
2014	61.0 %	4.8 %	16,366	26,826
2013	56.0 %	4.9 %	15,038	26,838
2012	51.0 %	5.1 %	13,523	26,499
2011	58.1 %	7.0 %	15,380	26,460
2010	68.8 %	4.0 %	18,651	27,098
2009	62.4 %	4.5 %	16,790	26,900

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	39.2 %	4.3 %	11,270	28,749
2014	34.4 %	4.7 %	9,846	28,613
2013	22.1 %	3.6 %	6,263	28,360
2012	19.8 %	4.2 %	5,518	27,870
2011	NR	NR	NR	NR

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: South Dakota

NPM 1 - Percent of women with a past year preventive medical visit

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	70.7
Annual Indicator	69.8
Numerator	98,560
Denominator	141,180
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	71.0	71.6	72.2	72.8	73.5	74.1

Field Level Notes for Form 10a NPMs:

None

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

FAD for this measure is not available for the State.

State Provided Data	
	2016
Annual Objective	88.2
Annual Indicator	86.7
Numerator	9,607
Denominator	11,078
Data Source	SD PRAMS LIke Survey
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	88.9	89.6	90.3	91.1	91.8	92.5

Field Level Notes for Form 10a NPMs:

None

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	23.8
Annual Indicator	23.5
Numerator	12,793
Denominator	54,515
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	24.2	24.4	24.6	24.8	25.0	25.2

Field Level Notes for Form 10a NPMs:

None

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Adolescent Health)

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - ADOLESCENT	
	2016
Annual Objective	337.2
Annual Indicator	335.0
Numerator	379
Denominator	113,144
Data Source	SID-ADOLESCENT
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	328.4	326.2	324.0	321.8	319.6	317.4

Field Level Notes for Form 10a NPMs:

None

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
Annual Objective	74.3
Annual Indicator	72.6
Numerator	45,469
Denominator	62,654
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	75.2	75.7	76.3	76.8	77.3	77.8

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	53.9
Annual Indicator	52.7
Numerator	15,450
Denominator	29,333
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	54.6	55.0	55.4	55.7	56.1	56.5

Field Level Notes for Form 10a NPMs:

None

NPM 13 - A) Percent of women who had a dental visit during pregnancy

FAD for this measure is not available for the State.

State Provided Data	
	2016
Annual Objective	48.1
Annual Indicator	47.8
Numerator	5,472
Denominator	11,447
Data Source	SD PRAMS-like survey
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	48.2	48.7	49.0	49.4	49.7	50.1

Field Level Notes for Form 10a NPMs:

None

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	79.7
Annual Indicator	77.8
Numerator	147,938
Denominator	190,201
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	80.8	81.4	82.0	82.6	83.2	83.8

Field Level Notes for Form 10a NPMs:

None

NPM 14 - A) Percent of women who smoke during pregnancy

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	12.6
Annual Indicator	14.0
Numerator	1,714
Denominator	12,279
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	11.7	10.6	9.4	8.3	7.1	6.0

Field Level Notes for Form 10a NPMs:

None

NPM 14 - B) Percent of children who live in households where someone smokes

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	26.8
Annual Indicator	27.5
Numerator	55,055
Denominator	200,548
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	26.1	25.8	25.5	25.3	25.0	24.7

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: South Dakota

SPM 1 - Percent of suicide attempts by adolescents 14 through 18 years of age

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	8.4
Numerator	98
Denominator	1,166
Data Source	YRBS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.2	6.6	6.0	5.4	4.7	4.1

Field Level Notes for Form 10a SPMs:

None

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
Annual Objective	
Annual Indicator	36.1
Numerator	1,868
Denominator	5,179
Data Source	FAD NOM 20 WIC data
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.4	27.2	25.0	22.8	20.5	18.3

Field Level Notes for Form 10a SPMs:

None

SPM 3 - Percent of women (15-44 years of age) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80%

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	78.1
Numerator	9,457
Denominator	12,102
Data Source	SD Vital Records
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	79.3	79.9	80.5	81.1	81.6	82.2

Field Level Notes for Form 10a SPMs:

None

SPM 4 - MCH data is analyzed and disseminated

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	NA
Data Source Year	NA
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: South Dakota

ESM 1.1 - Number of partners who collaborate to promote well women visits

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	9
Numerator	
Denominator	
Data Source	meeting notes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	9.0	9.0	9.0	9.0	9.0	10.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.1 - Number of page engagements to the For Baby's Sake Facebook page

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	52,849
Numerator	
Denominator	
Data Source	For Babys Sake Facebook Page Count
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	53,729.0	54,609.0	55,489.0	56,369.0	57,249.0	58,129.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.2 - Percent of Sudden Unexpected Infant Deaths reviewed for which a SUIDI reporting form was received and reviewed as part of the Infant Death Review Team meeting.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	70
Numerator	70
Denominator	100
Data Source	SUIDI reporting system
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	70.0	70.0	70.0	80.0	80.0	90.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - Number of partners who collaborate to promote early childhood screening

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	6
Numerator	
Denominator	
Data Source	meeting notes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	6.0	6.0	7.0	7.0	7.0	7.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.1 - Number of partners who collaborate to promote motor vehicle safety activities

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	meeting minutes
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	2.0	3.0	3.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.1 - Number of publications/mailings promoting outreach regarding Bright Futures

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	number of mailings
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - Number of trainings for providers on components of medical home model

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	training list
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.1 - Number of media platforms (i.e., websites, Facebook, TV, radio, print) that promote oral health messaging

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	3
Numerator	
Denominator	
Data Source	media platform count
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	3.0	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.1 - Number of media platforms (i.e., websites, Facebook, TV, radio, print) that include tobacco prevention/cessation messages

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	10
Numerator	
Denominator	
Data Source	media platform count
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	10.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: South Dakota

SPM 1 - Percent of suicide attempts by adolescents 14 through 18 years of age
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Promote positive child and youth development to reduce morbidity and mortality
Definition:	**Numerator:** # of students who actually attempted suicide one or more times during the past 12 months **Denominator:** # of students who completed survey **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MHMD-2: Reduce suicide attempts by adolescents
Data Sources and Data Issues:	YRBS
Significance:	In 2013, South Dakota had the 14th highest suicide rate in the U.S. and the rate of attempted suicides has increased significantly between 2009 and 2013 (http://doh.sd.gov/documents/Bulletin/July 2015.pdf)

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:	**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 **Unit Type:** Percentage **Unit Number:** 100
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:	FAD NOM 20 WIC data
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.

SPM 3 - Percent of women (15-44 years of age) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80%
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Promote preconception/interconception health and reduce infant mortality
Definition:	**Numerator:** # of pregnant women aged 15-44 with a live birth whose observed to expected prenatal visits are greater than or equal to 80% **Denominator:** # of women aged 15-44 with a life birth **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-10.2: Increase the proportion of pregnant women who receive early and adequate prenatal care
Data Sources and Data Issues:	DOH Vital Records. NOTE: The EVINDEX variable in the Kotelchuck program will be used to calculate observed to expected prenatal visits. A gestational age equivalent will be imputed from birth weight for those records with missing gestational age (within Kotelchuck SAS program).
Significance:	Barriers to a healthy pregnancy and birth include lack of appropriate health care before and during pregnancy. Insuring that a mother attends prenatal care visits can provide an opportunity to identify health risks and increase her knowledge of the importance of preconception/interconception health.

SPM 4 - MCH data is analyzed and disseminated
Population Domain(s) – Cross-Cutting/Life Course

Measure Status:	Active
Goal:	Improve state and local surveillance, data collection, and evaluation capacity
Definition:	**Numerator:** 2 (# of reports developed and disseminated) **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	N/A
Significance:	Important for program to make data driven decisions and collaborate with partners.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: South Dakota

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: South Dakota

ESM 1.1 - Number of partners who collaborate to promote well women visits
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	Combine efforts to most effectively and efficiently increase awareness and promotion of importance of well woman visits
Definition:	**Numerator:** # of partners **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Meeting minutes/contact sheets identifying partners and collaboration efforts
Significance:	Collaborating with partners in awareness and promotion of well women visits will assist in ensuring that all women are aware of this important preventive medical visit. It will also assist with more consistent and effective messaging.

ESM 5.1 - Number of page engagements to the For Baby's Sake Facebook page
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	Increase the awareness of safe sleep environments through Facebook messaging
Definition:	**Numerator:** # of page engagements **Denominator:** NA **Unit Type:** Count **Unit Number:** 60,000
Data Sources and Data Issues:	"For Baby's Sake" Facebook data
Significance:	Consumers, especially the younger generation, use social media to research and make health decisions. "For Baby's Sake" already has an established following and is an excellent way to reach young mothers.

ESM 5.2 - Percent of Sudden Unexpected Infant Deaths reviewed for which a SUIDI reporting form was received and reviewed as part of the Infant Death Review Team meeting.
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	Collect data on causes of infant deaths to better inform efforts on education and reduction in numbers
Definition:	**Numerator:** # of completed SUIDI forms **Denominator:** # of SUID cases reviewed **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Child Death Review Case Reporting System
Significance:	Provides information that can be used to recognize and inform on risk factors of SUID and SIDS.

ESM 6.1 - Number of partners who collaborate to promote early childhood screening
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	Combine efforts to most effectively and efficiently increase awareness and completion of developmental screenings
Definition:	**Numerator:** # of partners **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Meeting minutes/contact sheets identifying partners and collaboration efforts
Significance:	Collaborating with partners to ensure more children receive developmental screenings and decrease duplicate screenings by multiple providers

ESM 7.1 - Number of partners who collaborate to promote motor vehicle safety activities
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Measure Status:	Active
Goal:	Combine efforts to most effectively and efficiently increase awareness and promotion of motor vehicle safety activities.
Definition:	**Numerator:** # of partners **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Meeting minutes/contact sheets identifying partners and collaboration efforts
Significance:	Collaborating with partners in awareness and promotion will assist in implementing more consistent and effective messaging and pooling of resources to best meet the needs and challenges around motor vehicle safety in a rural state with a young driving age.

ESM 10.1 - Number of publications/mailings promoting outreach regarding Bright Futures
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase awareness and understanding of the importance and components of an adolescent well visit
Definition:	**Numerator:** # of publications/mailings **Denominator:** N/A **Unit Type:** Count **Unit Number:** 2
Data Sources and Data Issues:	Count of number of publications/mailings
Significance:	Bright Future Guidelines provide theory-based and evidence-driven guidance for all preventive care screenings and well-child visits. Ensuring providers are aware of and using this resource will ensure well visits are effective in identifying and meeting the needs of adolescents.

ESM 11.1 - Number of trainings for providers on components of medical home model
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	Increase the number of providers implementing medical home components
Definition:	**Numerator:** # of trainings for providers **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	Training logs
Significance:	Providing comprehensive care to children in a medical home is the standard of pediatric practice. Children with a stable and continuous source of healthcare are more likely to receive appropriate preventive care, are less likely to be hospitalized, and are more likely to be diagnosed early for chronic conditions.

ESM 13.1 - Number of media platforms (i.e., websites, Facebook, TV, radio, print) that promote oral health messaging
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Promote oral health for all populations
Definition:	**Numerator:** # of media platforms that have oral health messaging **Denominator:** N/A **Unit Type:** Count **Unit Number:** 5
Data Sources and Data Issues:	Media platform messages on oral health
Significance:	Education on the importance of oral health will assist in early dental visits and overall dental care/visits.

ESM 14.1 - Number of media platforms (i.e., websites, Facebook, TV, radio, print) that include tobacco prevention/cessation messages
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Measure Status:	Active
Goal:	Promote tobacco prevention and cessation
Definition:	**Numerator:** # of media platforms that have tobacco prevention/cessation messaging **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Media platforms promoting tobacco prevention/cessation
Significance:	Awareness of effects of smoking during pregnancy and exposure to secondhand smoke

Form 11
Other State Data

State: South Dakota

The Form 11 data are available for review via the link below.

Form 11 Data

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

Abbreviated State Action Plan Table

State: South Dakota

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Promote preconception/inter-conception health	NPM 1 - Well-Woman Visit	ESM 1.1	
Promote preconception/inter-conception health			SPM 3

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce infant mortality	NPM 5 - Safe Sleep	ESM 5.1 ESM 5.2	

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)			SPM 2
Improve early identification and referral of developmental delays	NPM 6 - Developmental Screening	ESM 6.1	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)	NPM 7 - Injury Hospitalization	ESM 7.1	
Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN	NPM 10 - Adolescent Well-Visit	ESM 10.1	
Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)	NPM 10 - Adolescent Well-Visit	ESM 10.1	
Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)			SPM 1

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN	NPM 11 - Medical Home	ESM 11.1	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Promote oral health for all populations	NPM 13 - Preventive Dental Visit	ESM 13.1	
Improve state and local surveillance, data collection, and evaluation capacity			SPM 4
Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)	NPM 14 - Smoking	ESM 14.1	