Maternal and Child Health Services Title V Block Grant

South Dakota

FY 2023 Application/ FY 2021 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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SOUTH DAKOTA DEPARTMENT OF HEALTH

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

July 18, 2022

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 2023 South Dakota Maternal and Child Health Block Grant application and annual report. Should you have any questions concerning this application, please contact Jennifer Folliard at 605.367.5374.

Sincerely,

Linda Ahrendt

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

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

II. Logic Model

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

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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

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

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

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

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

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

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

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

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

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

Role of State Title V

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

Partnerships

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

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

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

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

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

III.A.3. MCH Success Story

Each year in South Dakota, there is an average of seven pregnancy-associated deaths. Maternal mortality can indicate systemic and social challenges and is a critical indicator of a nation's health. The South Dakota DOH, in cooperation with the CDC Review to Action, saw the successful formation of a Maternal Mortality Review Committee (MMRC) in 2021 to improve the lives of childbearing women in the state.

The committee encompasses a diverse group of individuals from healthcare, public health, native women's health, and other maternal health experts.

The MMRC utilizes a variety of data sources to tell the stories of the women who died during pregnancy or within the year following childbirth. The goal of the committee is to identify reasons, barriers, and themes in their stories that may ultimately assist with improving outcomes for future mothers. The purpose of reviewing all maternal deaths is to make actionable recommendations that may decrease maternal morbidity and prevent future deaths.

The newly formed committee prioritized understanding of social determinants of health and discrimination in the health care system by taking part in a research project sponsored by the Texas Department of State Health Services titled the *Discrimination Assessment and Social Determinants of Health (DASH) Facilitated Discussion Tool Evaluation*. The purpose of the study was to assess the feasibility and acceptability of the DASH tool in facilitating and guiding discussions during review committee meetings. It was also used to develop and refine standard methodology for the discrimination contributing factor domain on the Committee Decisions Form. The team utilized the tool to objectively analyze discrimination and social determinants of health from all data sources. The MMRC modified the tool to incorporate SD-specific socio spatial elements and continues to use it after the study concluded. The insight into neighborhood specific social determinants of health will drive population specific initiatives to improve health and decrease morbidity and mortality of childbearing women in our state.

III.B. Overview of the State

Demographics, Geography, Economy

South Dakota traverses over 75,000 square miles in the upper Midwest and is one of the United States' most rural and frontier geographic areas. SD is home to diverse landscape that is divided into east and west by the Missouri River. As of 2021, there are 886,667 living in SD with an average population density of 10.7 people per square mile. Of SD's 66 counties, 30 are rural and 34 are frontier (less than 6 people per sq. mile). The states' two most populated counties are located on opposite sides of the state. There are nine federally recognized American Indian tribes within the SD borders.

The state's population by race and Hispanic origin as of 2021 is 84.6% White, 9% American Indian (AI), 2.3% Black, 1.5% Asian, 2.5% Two or More Races and 4.2% Hispanic or Latino. The population by sex is 49.5% female and 50.5% male. Just under 25% of the state's population are persons under the age of 18, with 6.9% of persons under 5 years of age. Approximately 37% of the state's female population is of childbearing age, 15 through 44.

South Dakota's 2021 median household income was $58,275. Nearly 13% of SD households live below 100% of the Federal Poverty Level (FPL), with the 10 poorest counties either part of or adjacent to SD's AI reservations. Reservations experience significantly higher poverty levels ranging from 22.3%-48.6%. 12.2% of persons under 65 years of age lack health insurance. In addition, 91.7% of persons aged 25 years and older are high school graduates or higher and 28.8% have a bachelor's degree or higher. Key industries that shape SD's economy include agriculture, mining, finance, healthcare, manufacturing, and tourism.

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

Strengths and Challenges

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

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

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

Despite the growth in the healthcare industry and strategies to address the healthcare workforce, SD residents are challenged by the limited access to healthcare. Over two-thirds of the state is designated by the federal government as a Health Professional Shortage Area (HPSA). Health care provider shortages exist in primary care, dental health, and mental health. There are also 71 Medically Underserved Areas/Populations (MUA/P), including a shortage of primary care health services across the state. As of June 2022, there were 5613 licensed physicians and 736 physician assistants licensed in SD. In addition, in 2021 there were 1,145 actively licensed nurse practitioners and 48 actively licensed certified nurse midwives.

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

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

Roles, Responsibilities and Targeted Interests of State Health Agency

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

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

The strategic plan addresses the following goals:

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

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

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

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

To fill the gaps, OCFS has approval to purchase two mobile units that will be equipped to provide satellite public health services including WIC, Immunizations, Fluoride Varnish, Pregnancy Care support, and other public health programs. Trained OCFS staff will take services "on the road" to areas that have been identified as underserved. Initially, the primary focus will be on services for the MCH population. Communities that will be targeted include those without an acceptable location for a permanent site or a caseload too small to support one, and areas with transportation challenges prevent families from accessing services to which they are entitled.

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

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

South Dakota Systems of Care

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

The Departments of Health and Social Services continue to prioritize and focus on social needs and behavioral health services integration. The OCFS is the outreach arm and community presence of the DOH and works closely with DSS programs that support health, social needs and behavioral health including Medicaid, Temporary

Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). These programs work directly with the community health offices that administer WIC program and the Bright Start home visiting program. These programs are also forging new partnerships and services to address behavioral health needs as an emerging issue within the state.

In state fiscal year 2020 141,620 South Dakotans participated in Medicaid for their healthcare. The vast majority, 68%, are children. Half of the children born in SD each year will be on Medicaid during their first year of life and 38% of all Medicaid recipients are American Indian (SD Medicaid). Medicaid eligibility for FY20 includes pregnant women at 138% FPL; children under 6 at 182% FPL, children age 6-19 at 116% FPL, parent/caregiver/relatives of low-income children at 52% FPL; CHIP (Children's Health Insurance Program) at 209% FPL. Findings from a secondary analysis done by the IPUMS-USA, University of Minnesota of the American Community Survey note that 14.6% of women of childbearing age and 6.5 % of children are not insured by public or private insurance.

III.C. Needs Assessment
FY 2023 Application/FY 2021 Annual Report Update

Needs Assessment Update

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

Ongoing Data Collection and Needs Assessment Activities

The MCH epidemiologist sent out a survey to stakeholders in 2021 to determine the data needs of our partners and the primary reasons they use data. Overall, partners wanted more data at a county and local level, and wanted data shared through dashboards. Partners indicated that evaluation of a program was the most common reason they used SDDOH data, followed closely by applying for grants and supporting a new program. This and other information from the survey will be used to inform data collection work for the next year.

As part of the ongoing needs assessment, the Office of Child and Family Services data team led by the MCH epidemiologist and the MCH Director assessed and compiled the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children needs assessments. This WIC needs assessment is completed yearly in the community health offices statewide, but results were never looked at collectively to identify statewide needs, assets, and weaknesses. MCH intern Rachel Greiner, an undergraduate honors student in public health, completed her thesis, *Qualitative Analysis of South Dakota Community Health Needs Assessments*, with direction from the WIC data analyst and the MCH Director. Rachel identified strengths and weaknesses, but more importantly, she recognized the need to improve the process and utilization of these needs assessments. This process led to the development of the Strategic Community Outreach and Outcomes Plan (SCOOP), being implemented in the community health offices statewide.

The Sanford Patient Navigation Program surveys families of children with special healthcare needs as well as their affiliated professionals to gain ongoing perspective of the needs faced by this population and the professionals that provide services to them. This information is used by the CYSHCN Program to continue shaping the Patient Navigation Program to fill gaps in services and improve outcomes for these children and their families. In 2022, the program began to evaluate the impact of adding a nurse practitioner to the program on health outcomes for patients as well as the mental health of their caregivers.

The South Dakota Newborn Screening Advisory Committee provides support and recommendations to the South Dakota Department of Health (SDDOH) Newborn Screening Program regarding programmatic decisions. The group convenes on an annual basis to receive updates on the status of the newborn screen program and to discuss the addition of new disorders to the South Dakota panel of disorders. The advisory committee consists of newborn screening stakeholders and partners, including pediatric specialists, laboratory personnel, nurses, pediatricians, and family and community members interested in learning about newborn screening.

South Dakota has begun reviewing all child deaths from infant up to age 13. Two multidisciplinary teams located on the east and west side of the state use a common data collection tool, Child Death Review Case Reporting System to report findings for the state-wide Preventable Death advisory committee to review. The state-wide Preventable Death advisory committee is comprised of volunteers from law enforcement, Child Protection Services, hospital staff, fire departments, emergency medical services, public health, behavioral health, forensic pathology, the Bureau of Indian Affairs, Indian Health Services, the Great Plains Tribal Leader's Health Board, and the States Attorney's and U.S. Attorney's offices and meets bi-annually to review the data and make data-driven recommendations for programming and prevention efforts.

The SD DOH formed a Maternal Mortality Review Committee (MMRC) in 2021 to review maternal death cases and determine leading causes of maternal mortality in South Dakota. A maternal mortality abstractor was hired and has access to the necessary medical records from the three major health systems in the state. In addition, the abstractor

can analyze data collected from the health information exchange, vital records, WIC, and Medicaid. The first case review meeting was held in October 2021. The SD MMRC is also participating in the Texas DASH pilot study to assess discrimination and social determinants of health as a factor in maternal deaths.

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

Noted Changes in Health Status

The SDDOH continues to respond to changes in health status and emerging needs of the state's MCH population, including efforts to combat the COVID-19 pandemic. Contact tracing activities continue and are carried out primarily through electronic means. Vaccinations are available at community health offices, pharmacies, and the state's health systems. Free ride sharing services are available to get to vaccination appointments. Currently, over 70% of the state's population has received at least one dose of a COVID-19 vaccination. The DOH has been utilizing data dashboards, press releases, and social media to communicate case updates and stress the importance of vaccinations and efforts that prevent the spread. The DOH also provides resources for children and adults for coping with the effects the pandemic has had on mental health.

The SD Department of Health continues to monitor the state's severe rise in syphilis cases. As of spring 2022, syphilis cases have increased over 1800% above the five-year median. Congenital syphilis cases are also on the rise in South Dakota, increasing 700% over the five-year median. Due to the sharp rise, the MCH Program is partnering with the DOH Office of Disease Prevention to launch a media campaign to raise awareness of congenital syphilis and direct the public to available resources.

South Dakota has also seen a sharp rise in suicide cases. Provisional data from South Dakota Suicide Prevention (SDSP) shows suicides in the state have been on the rise since 2011, with 2021 showing the highest recorded number of suicides since tracking has been in place. SDSP data shows suicide is the leading cause of death in SD among ages 10 to 19. The data also shows the SD American Indian suicide rate is 2.5 times higher than the SD White suicide rate for 2011-2020. The MCH adolescent domain has made mental health and suicide prevention one of their top priorities. The adolescent domain leader leads a workgroup comprised of stakeholders in the areas of medical consultation, Helpline Center, Department of Social Services, DOH Injury Prevention, University of South Dakota, and Lutheran Social Services. The group promotes evidence-based programs and practices that increase protection from suicide risk, promote positive youth development, and develop and disseminate equitable and accessible Suicide Prevention education material, resources, and messaging. The women's domain is also focused on mental health and substance misuse and provides depression screening in the community health offices.

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

Title V Program Capacity

The MCH Title V Program has made recent efforts to expand internal staffing, so each domain leader can focus on one domain population. The goal of this change is to expand the capacity of each domain leader to address MCH priorities and emerging health issues for their domain through strategic partnerships, networking, and oversight. In 2022 the maternal mortality case abstractor began leading the MCH women's domain. This change allows the previous women and infant domain leader to focus on the infant domain priorities. In addition, after data collection began with Child Death Review the DOH Injury Prevention Coordinator was brought in to lead the MCH Child domain and focus on development of injury prevention education for parents in addition to monitoring developmental

screening efforts. This change allows the CYSHCN Director, who was previously overseeing the Child domain, to focus on CYSHCN priorities. The Injury Prevention Coordinator position has recently become vacant, and recruitment is underway to fill that position.

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

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

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

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

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

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

In 2021, these categories were used to develop five implementation teams focused on external partnerships, communications, digital services delivery, program data/CQI evaluation, and school projects. Each of the implementation teams have begun meeting regularly to work on the prioritized strategies in their implementation plan.

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

The goal of this reorganization is to:

- Deliver the right care at the right time - staff each working at highest scope of practice
- Build capacity and autonomy for regional and local responsiveness
- Prioritize and lean into the "gap-filling" function of OCFS

- Reduce overall costs of service delivery model
- Develop and commit to an OCFS-wide long-term strategy with the tribes, and other specific populations, to address health inequities

Regional leadership teams will:

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

The five implementation teams that were developed in 2021 will continue to meet regularly over the next couple years to carry out the identified priorities and monitor progress toward reaching the identified goals.

Title V Partnerships and Collaborations

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

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

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

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

The State Systems Development Initiative (SSDI) grant was awarded to SD in 2020 that coordinates with and directly supports the work of the MCH Title V Block Grant. SD's SSDI grant supports an epidemiologist focused on maternal and child health, the South Dakota PRAMS, and facilitation of the identified SPM to better coordinate and disseminate data.

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

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serves participants through 74 community health offices across the state. The program works cooperatively with the Cheyenne River, Rosebud Sioux and Standing Rock tribal reservations to ensure every county in South Dakota has access to WIC services.

From October 2020 to September 2021, WIC served an average of 14,474 participants per month.

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

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

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

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

SD Family Planning Program (SDFP) delivers statewide services through a network of 22 sites and provides services to low-income individuals to increase healthy maternal/infant outcomes. The Title X Project Director will be actively engaged with the workgroup implementing strategies under NPM 1.

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

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

Other Programs Within the DOH: Child Death Review (CDR), through a (MOU) between DOH and member agencies, volunteer professionals across the state conduct IDR. Two regional teams, East and West River, are made

up of members from law enforcement, DSS Child Protection Services and Behavioral Health, DOH, hospital staff, fire departments, Emergency Medical Services (EMS), Forensic Pathology, Division of Criminal Investigation (DCI), Bureau of Indian Affairs (BIA), IHS, Great Plains Tribal Chairman's Health Board, and the States Attorney's offices. DOH's Office of Data, Statistics and Vital Records provides data for the review process. CDR is funded exclusively by MCH dollars.

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

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

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

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

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

Operationalization of Needs Assessment Findings

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

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

The MCH domain leaders have formed diverse workgroups that meet quarterly to inform and help carry out the activities in the domain action plans. Domain leaders also track their collaboration efforts utilizing the Wilder Collaboration Index and carry out ongoing evaluations of their programs. They continue to evaluate the needs of the populations they serve through surveys and data analysis.

Organizational Structure and Leadership

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

Linda Ahrendt, M.Ed is the OCFS and Title V Administrator and has been with the DOH for 22 years. Jennifer Folliard, MPH RDN is the OCFS Assistant Administrator and MCH Director and has been with the DOH for 2 years. Whitney Brunner serves as the CYSHCN Director and has been with the DOH for 2 years. Other OCFS team members that work with MCH include the following:

- Rhonda Buntrock, OCFS Assistant Administrator- WIC Program Administrator
- Peggy Seurer, OCFS Assistant Administrator- Public Health/Clinical Services
- Carrie Churchill, Bright Start Home Visiting Program Manager
- Bernadette Boes, Newborn Screening Coordinator
- Timaree Axlund, South Dakota Family Planning (SDFP) Program Nurse Manager
- Hope Kleine, SDFP Nurse Consultant
- Jill Munger, MCH Nurse Consultant/ Child Death Review Coordinator, Infant domain lead
- Sarah Barclay, MCH Adolescent Coordinator
- Christine Catts, Maternal Mortality Case Abstractor, MCH Women's domain lead
- Amy Mattke, Case Management
- Tim Heath, Immunization Program
- Mark Gildemaster, Manager, Data and Statistics
- Katelyn Strasser, MCH Epidemiologist
- Isaac Snaza, OCFS Epidemiologist
- Caleb Van Wagoner, OCFS Health Informatics Analyst
- Joel Arriolacolmenares, OCFS Business Operations Coordinator

- EA Martin, SDSU contractor, MCH and home visiting epidemiology

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

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

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,149,068	$2,074,993	$2,147,032	$1,730,405
State Funds	$1,695,079	$1,609,382	$1,611,368	$1,637,090
Local Funds	$117,472	$39,373	$149,570	$21,313
Other Funds	$0	$0	$0	$0
Program Funds	$1,378,312	$1,153,643	$1,224,994	$1,106,777
SubTotal	$5,339,931	$4,877,391	$5,132,964	$4,495,585
Other Federal Funds	$20,487,960	$21,996,626	$19,703,960	$21,177,769
Total	$25,827,891	$26,874,017	$24,836,924	$25,673,354

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,194,925	$1,396,200	$2,319,160	
State Funds	$514,881	$1,557,960	$1,035,794	
Local Funds	$40,940	$88,093	$13,485	
Other Funds	$0	$0	$0	
Program Funds	$1,100,000	$932,445	$700,263	
SubTotal	$3,850,746	$3,974,698	$4,068,702	
Other Federal Funds	$21,996,626	$19,771,485	$20,895,980	
Total	$25,847,372	$23,746,183	$24,964,682	

	2023	
	Budgeted	Expended
Federal Allocation	$2,458,310	
State Funds	$1,735,315	
Local Funds	$93,379	
Other Funds	$114,005	
Program Funds	$988,392	
SubTotal	$5,389,401	
Other Federal Funds	$20,150,177	
Total	$25,539,578	

III.D.1. Expenditures

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

The OCFS is divided into three sections: Community Health Services, WIC, and MCH. These sections work collaboratively to utilize funding appropriately to support outreach to underserved populations through nurses and dietitians located in 74 community health offices across the state. SD has an MCH staff comprised of six program coordinators and the MCH Director that work with internal and external partners to implement the state action plans. The MCH program shares an epidemiologist with other OCFS programs.

For FFY 2021 expenditures, SD met federal Title V requirements that at least 30 percent of federal funds support CYSHCN activities. In addition, at least 30 percent of federal funding was used for preventive and primary care for child and adolescent activities. SD did not exceed the 10% administrative requirement. South Dakota's maintenance of effort was fully met.

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

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

CYSHCN	$765,226
Pregnant Women/Infants	$1,113,232
Child/Adolescents	$1,086,745
All others	$54,690

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

Direct Services	$33,909
Enabling Services	$1,686,523
Public Health Services and Systems	$2,254,266

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

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

Office of Child and Family Services

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

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

Women and Infants:

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

Child and Adolescent:

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

Children and Youth with Special Health Care Needs

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

Budgeted versus expended:

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

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

The amount expended this year is significantly less than the amount budgeted. This is due to many staff responding to the COVID 19 pandemic and coding that time to COVID funding. In addition, many families opted to hold off on receiving services in our clinics due to the risk of infection, resulting in less staff time coding to MCH funds.

Significance of federal MCH Block Grant funding support:

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

Accountability:

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

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

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

Opportunities:

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

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

Challenges:

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

III.D.2. Budget

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

The budget outlines areas for which Title V funds will be allocated. Development of the budget complies with the "30-30" requirement for primary and preventive care and special health care needs for children and adolescents and is consistent with the requirements to limit administrative costs to no more than ten percent. The DOH maintains the overall level of funds for MCH at the level established in FFY 1989 and monitors funding allocations quarterly to ensure compliance. Most years the DOH spends more than the federal allocation but it is difficult to reflect this due to the overlapping periods of obligation under the previous fiscal year and the spending of funds in the current fiscal year. In FY21 MCH spending was greatly affected by the COVID 19 pandemic and the availability of COVID funding. The DOH continues to align funding resources to support the MCH priority areas and selected measures.

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

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

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

Proposed budget for FY2023 reflects:

- A shift to a more sustainable revenue-based model through review of the operations and implementation of services in local communities. This is reflected by an increase in program income being utilized to support efforts for the MCH populations.
- Ongoing efforts for federal spending to be maintained within one federal year’s allocation. The COVID pandemic response as well as the influx of additional COVID funds has made spending the federal year’s allocation challenging, as staff shift their time and focus to response efforts, however, the MCH program is committed to enhancing services and programs through new initiatives, as well as supporting our partners that serve the MCH population. As a part of the Office of Child and Family Services needs assessment process, a review of the service delivery structure will also assist in meeting the federal funding allocation.

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

For the FY23 budgeted amounts, our agency used FY19 expended amounts when creating the budgeted amounts. The expenses for FY20 and FY21 were not typical due to COVID response and the availability of COVID funding. We felt budgeting based on those FY20 and FY21 expenses would not provide the most accurate budgeted amount. We based our budgets more on the percentage of the federal allocation.

III.E. Five-Year State Action Plan

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

State: South Dakota

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

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

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

Programs for Infants & Young Children

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

Programs for Children & Adolescents

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

Programs for Pregnant & Postpartum Women

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

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

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

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

The Life Course Theory and Health Equity Model shaped the needs assessment process and planning. During that process it became clear that to diagnose health disparities and begin to address health inequities, there is a need for focused data systems building and reporting. Systems building requires sustained efforts, and intentional culturally appropriate outreach. The MCH domain leaders will engage with the MCH epidemiologist, who lead SPM 2 and now leads the new SPM 3, to ensure data needs are communicated. Challenges may arise with interagency data sharing, data privacy concerns and data coordination with Indigenous nations.

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

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

The DOH released its 2020-2025 Strategic Plan in January of 2020. The plan provides a road map for the future and guides staff working together to achieve meaningful outcomes. Goal 5 of the Strategic Plan, *strengthen and support a qualified workforce*, was developed to address the workforce needs of the Department. The first objective under this goal is to establish a DOH Workforce Development plan by 2021. The plan has been created and the department is currently working on finding resources to utilize the information obtained from surveys and strategies will be reflected in the statewide health improvement plan. This presents an opportunity to provide insights from the Title V Needs Assessment regarding long-term pathways for MCH professional development and short-term training for domain leaders and field staff. While the first 6 months of the state's strategic plan was disrupted by COVID-19, the Department of Health's quick and responsive innovations to the crisis will also advance workforce development and will inform future planning.

In October 2019, the DOH began to explore accreditation through the Public Health Accreditation Board (PHAB) and has recently been reinvigorated. Domain teams were established to review accreditation requirements and identify gaps and weaknesses. The Department is now focusing on operationalizing the quality improvement and performance management program and has recently taken steps to create a new Health Improvement Coalition that will guide the department in establishing the health improvement plan.

The Division of Family and Community Health is the service delivery arm of the DOH and administers MCH services and programs within the Title V Block Grant. The Office of Child and Family Services (OCFS) provides leadership and technical assistance to assure health, public health, and social systems are promoting the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. MCH domain leads provide training and ongoing technical assistance to DOH field staff as well as private healthcare providers who deliver MCH services and programs. In 2021, OCFS went through a reorganization of regional community health structure and teams toward a public health model through a theory of change. This reorganization offers more opportunities for advancement in the MCH dietitian and nurse professional fields and development of a core of paraprofessionals. Over the next year, MCH domain leaders will utilize the TRAIN platform to systematize training and offer guidance around quality improvement and assurance for new community health staff. The MCH Title V program also began a restructure in 2021 to add additional staff so each domain has a unique domain lead. This change allows domain leads to focus on one domain area, improving their capacity for program development and networking.

Over the last year, MCH domain leads have built off the training provided through the National Center for Education in MCH on evidenced-based practice when developing strategies relevant to the delivery of MCH services. The MCH and other OCFS administrative staff have participated in health equity, family engagement skills building sessions through the MCH Workforce Development Center to support the upcoming community health offices transition. The MCH Director and the CYSHCN Director completed the Building Expertise in Administration and Management, BEAM, training in summer of 2021. The MCH team works closely with field staff on data collection for federal and state reports and program evaluation. These efforts were initially enhanced through SPM 2 and will continue to be enhanced through SPM 3 Percent of data equity principles implemented in South Dakota MCH projects, which replaced SPM 2 in late 2021 and exposes a need for data interpretation training and peer learning with MCH domain leads and field staff. In 2021 the MCH and OCFS epis took a Tableau training to gain the skills needed to create data dashboards to enhance data sharing capacity.

MCH workforce development includes internal training/staff development opportunities. Staff orientation modules have been developed to assist new hires in acclimating to the OCFS infrastructure and program delivery. Formal needs assessments are conducted every other year to assist in identifying training needs of all OCFS staff. In addition, as a part of our performance appraisal system there is a section devoted to continuous learning and

development. Staff are to identify at least one behavior or performance expectation to develop over the coming year and define how progress will be evaluated. In addition, the state's Bureau of Human Resources provides a wide selection of trainings and team building courses that staff can opt to attend either in person or online throughout the year.

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

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

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

Additional strategies to assist in staff retention and recruitment include:

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

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

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

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

The needs assessment brought to light the need for more engagement with external partners (outside state government), including those impacted by the programs and strategies that each workgroup will develop and implement. To build and continue to develop community-based partners and family leaders, the OCFS has developed a broad strategy for engagement leveraging our 74 community health offices. The OCFS recent completion of the office-wide services assessment and resulting change in regional and leadership structure will facilitate this approach to outreach and engagement.

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

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

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

Communication and Outreach

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

Develop Community and Family Leaders

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

Program Development, Improvement and Evaluation

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

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

Training and Professional Development

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

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

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

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

South Dakota Department of Health supports one FTE for epidemiology, Katelyn Strasser, Maternal Child Health Epidemiologist. Katelyn has a Master of Public Health degree and completed the CityMatch beginner/intermediate MCH Epidemiology course in 2019 and is taking the intermediate advanced course in June 2022. Katelyn works on data across the Office of Child and Family Services on infant and maternal mortality data, MCH FAD data, WIC data, and other MCH program related data needs. She also works with SD PRAMS to translate data into action and coordinates the PRAMS steering committee. She co-leads and serves as the analyst for the South Dakota MMRC and serves as the workgroup leader for SPM 3, which replaced SPM 2 and focuses on equitable data sharing and collaboration. She created and leads the Strategic Community Outreach and Outcomes Plan (SCOOP), which is an office wide action planning process.

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

SDDOH is currently hiring a Bright Start Epidemiologist to work with home visiting data and pregnancy care program data from the OCFS electronic health record. The SD Legislature recently funded statewide expansion of Bright Start home visiting, which brought the opportunity to hire full-time staff in this role. This position will be funded with a combination of HRSA MIECHV, Medicaid, and TANF. This additional data support will give the MCH team another piece of data around maternal and infant outcomes in South Dakota.

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

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

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

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

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

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

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

SSDI has also supported several data presentations and reports. In 2021, PRAMS opioid data was presented to the South Dakota Opioid Advisory Committee. Maternal mortality and PRAMS data were presented to the SD Perinatal Association. Maternal mortality data was presented to the South Dakota Preventable Death Committee, and PRAMS Covid-19 data was presented at the MCH annual update meeting. The SD DOH has also created several data reports from PRAMS data over the last year on topics that affect the MCH population. These include a 2019

PRAMS data report, PRAMS surveillance report, Opioid Supplement Summary, Disability Supplement Summary, Summary Report by WIC Participation, and a Summary Report among WIC Participants by Health Service Region. In addition, the MCH epi created a FAD Data Summary report and a Sexual Violence in South Dakota 2019 report.

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

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

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

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

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

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

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

The MCH Epidemiologist frequently builds MCH data capacity with MPH students. The MCH Director, MCH Epidemiologist and WIC data analyst supported a University of South Dakota honors public health student's research, which resulted in a thematic analysis of the (then) 76 community health clinics' community health needs assessments. The MCH Epidemiologist also applied to host an MCH epi intern for the summer of 2021 and was matched with a Masters of Epidemiology student from Emory. This project focused on creating a plan for officewide data reporting and visualization that includes overarching MCH outcomes and program specific data. The intern researched the outcomes from the OCFS theory of change (e.g. reduce obesity, reduce youth suicide, and increase breastfeeding rates) to find the best data sources and indicators for each outcome. The intern will also decide how to report that data (e.g. at state or county level, by race/ethnicity, by other demographic characteristics, etc.) The data team then used this data to create an internal data dashboard using Tableau that is used to support SCOOP. The intern also created a tool for equity in data visualization to be used for data projects. The MCH Epidemiologist

currently has a MPH student creating a women's health data report card. The MCH Epidemiologist and MCH Director are advising one GSEP intern and two MCH/Title V interns during the summer of 2022. They will be working on projects related to the outreach goals in SCOOP.
South Dakota also hired a contracted epidemiologist to work with the MCH Epidemiologist on projects across OCFS. The epidemiologist assisted with SCOOP, creating an evidence-based strategy library for the goal areas of breastfeeding, nutrition, outreach, and infant mortality. The epidemiologist has also taken over data for the child death review and is working to move data and recommendations to prevention. The epidemiologist is working with the FAD data to create data one-pagers that can inform the MCH domains.

In September 2021, OCFS hired a health informatics analyst. This person's primary duty is to manage the data reporting and analysis coming for the new electronic health record which launched in January 2022. The electronic health record captures data on many MCH funded or related services such as immunizations, ASQs, pregnancy care, and home visiting.

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

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

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

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

The SDEOF will function as a framework amongst emergency plans managed and maintained within and outside of SDDOH. The plans are maintained separately, but OPHPR is involved in the process for updating these plans as well as this framework. One of these plans is the SDDOH Continuity of Operations Plan (COOP). In late 2021, the SDDOH created a committee to take a fresh look at the agency's COOP. The OCFS business operations coordinator, who has a strong background in military emergency response, represents the OCFS on this committee and is tasked with creating a more detailed plan for the role OCFS staff will play in keeping essential services going in the event of an emergency.

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

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

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

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

MCH population.

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

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

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

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

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

In the last year, the MCH program has partnered more intentionally with the University of South Dakota's Center for the Prevention of Child Maltreatment (CPCM). Substantial support from the Title V Director and the MIECHV Director helped to secure funding through the HRSA Early Childhood Compressive Systems. This effort also included support from Departments of Education, Social Services and Health. This funding award supports South Dakota's first attempt to align, coordinate and ultimately improve early childhood services and systems. The MCH Director and MIECHV Director serve on the SD Early Childhood Comprehensive Systems (SD-ECCS) Cross-Sector Advisory Council that was created as a result of this effort. MCH staff have also served on focus groups conducted by CPCM to gather information on what services are available in South Dakota for the MCH population and areas where they can assist the MCH program.

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

In 2021, the MCH Program joined Medicaid's efforts to address two new initiatives. The first initiative is to build state capacity to address maternal mortality for Medicaid-eligible pregnant and parenting women. The MCH Epi is a member of the South Dakota team to provide data support. The epi started working with an ArcGIS consultant to map all 2020 Medicaid births and the travel times between their place of residence and the facility where they delivered. This will help inform a policy proposal for pregnancy as a qualifying condition for a medical home.

The second initiative is to increase the rate of well child visits to 6 visits for 0-15 months for the American Indian/Alaskan Native population by 10% by December 2023. The MCH program assisted with securing technical

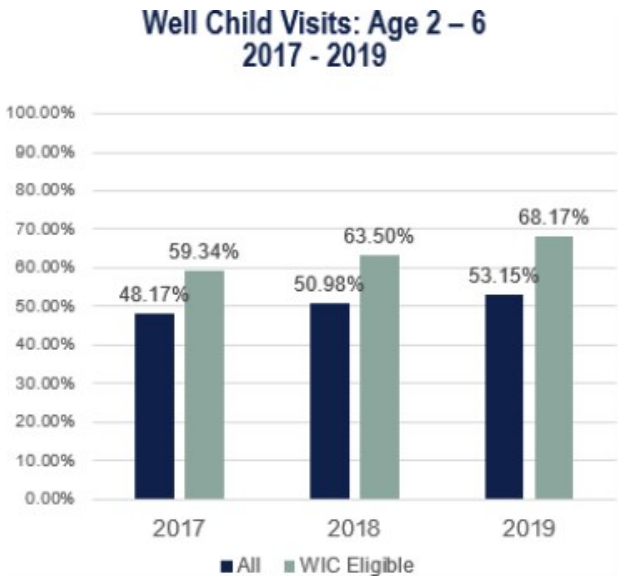
assistance for this initiative. The MCH Child coordinator/CYSHCN Director serves on the workgroup for this initiative and has co-lead a change idea to distribute educational well-child rack cards to families at nine WIC sites and three Horizon Healthcare sites that primarily serve the target population.

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

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

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

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



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

The three goals of this initiative are as follows:

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

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

This initiative has five goals:

- Goal 1: Educate pregnant and post-partum women about the importance of well-child visits by working with providers.
- Goal 2: Target messaging to primary care providers to encourage them to get their patients in for well visits.
- Goal 3: Explore alternative methods to email for communicating with recipients.
- Goal 4: Increase collaboration with IHS, Tribal 638, and WIC providers to encourage AIAN recipients to come in for well-child visits.
- Goal 5: Utilize claims data to track the rates of well-child visits for Medicaid beneficiaries.

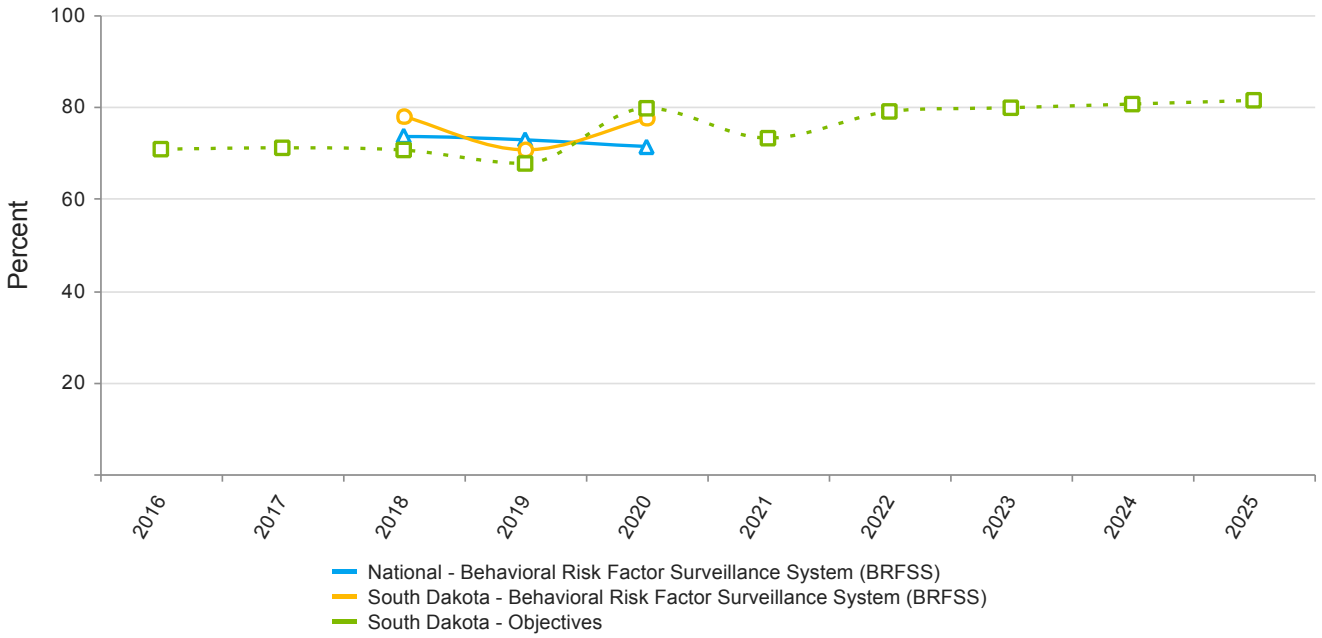
This is a two year initiative with expected completion in December 2023.

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

Women/Maternal Health

National Performance Measures

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



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				79.6	73.1
Annual Indicator			77.6	70.4	77.3
Numerator			110,174	101,908	110,595
Denominator			141,888	144,765	143,127
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

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

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	78.9	79.7	80.5	81.3

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator			0
Numerator			0
Denominator			100
Data Source			DOH EMR
Data Source Year			2020
Provisional or Final ?			Provisional

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

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

Measure Status:			Active
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			100
Annual Indicator			0
Numerator			0
Denominator			100
Data Source			2021
Data Source Year			DOH EMR
Provisional or Final ?			Provisional

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

ESM 1.3 - # of messages posted promoting well women care

Measure Status:			Active
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	13.0	14.0	15.0

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

Measure Status:			Active
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (South Dakota) - Women/Maternal Health - Entry 1	
Priority Need	
Mental Health/Substance Misuse	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
Increase the percent of women, ages 18 through 44, with a preventative medical visit in the past year from 77.3% (2020) to 85.4% in 2025.	
Strategies	
1.1: Develop partnerships with diverse, multisector stakeholders to promote preventative care for women of childbearing age.	
1.2: Create toolkit of resources on Maternal Mental Health/Substance Misuse and Health Equity for OCFS field offices.	
1.3: Increase depression screening and referrals to PCP among low-income women on the SD WIC program.	
1.4: Develop a policy recommendation with Department of Social Services to create Maternal Medical Homes.	
ESMs	Status
ESM 1.1 - % of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening	Active
ESM 1.2 - % of WIC clients whose PHQ 9 score met criteria for a referral and were referred	Active
ESM 1.3 - # of messages posted promoting well women care	Active
ESM 1.4 - % of women with positive depression screen who are referred to their PCP within OCFS field offices	Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

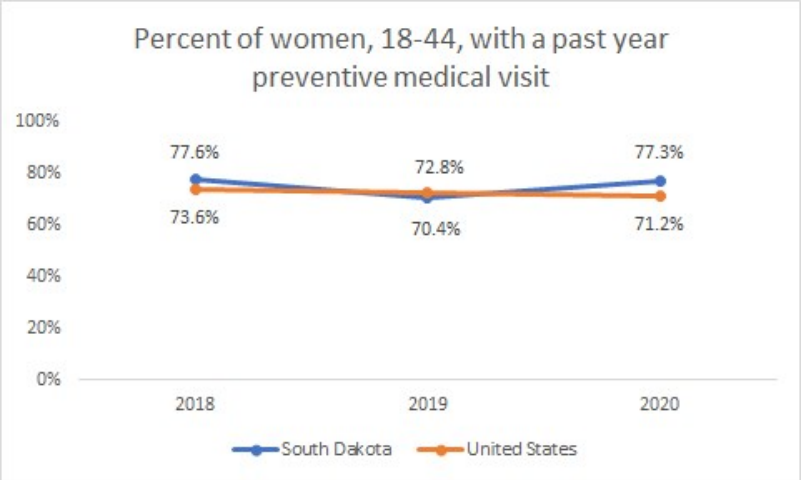
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Women/Maternal Health - Annual Report

Women/Maternal Domain: Annual Report (October 1, 2020 – September 30, 2021)

Priorities: Mental Health/Substance Misuse

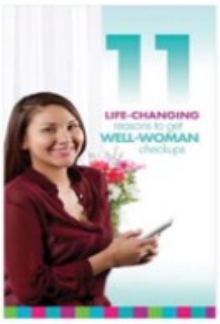
NPM 1: Well Woman Visit: Percent of women, 18-44, with a past year preventive medical visit



South Dakota exceeded the 2020 target of 71.8% with 77.3% of women, 18-44, having a past year preventative medical visit. South Dakota ranked 5th in the nation with a higher rate than the U.S. rate of 71.2% (BRFSS, 2020).

MCH Needs Assessment findings (2019-2020) indicated the importance of a yearly well women visit with a Primary Care Provider (PCP) as a care coordination and referral starting point for women of childbearing age. A well woman visit provides a comprehensive assessment of a women's overall health including her mental health. Preventative care is important to stop diseases or conditions before they start. Mental health screenings are a component of a well women visit and can identify women who may be suffering needlessly. Throughout this grant year Title V continued to collaborate with Title X, the SD WIC program, and Bright Start Nurse Home Visiting to promote a medical home and annual Well Women check-up with their clients. All three programs are located within the Office of Child and Family Services and have representatives on the National Performance Measure (NPM) #1 workgroup making collaboration easier.

Other strategies the MCH team utilized to promote annual Well Women visits included continuation of a social media campaign on For Baby's Sake website, For Baby's Sake Facebook page and advertising in parenting magazines. Facebook posts related to well women and the mental health priority are included on the social media metric table below. Information about well women visits (It Starts with You) and Perinatal Depression (You and Baby) can be found on the For Baby's Sake website at For Baby's Sake | Healthier moms + Healthier babies (forbabysakesd.com).

POST IMAGE	TITLE	TYPE (Paid/Organic)	CUMULATIVE REACH	AVERAGE FREQUENCY
	An Ounce of Prevention	PAID	39,853	3.83
	11 Reasons to Get Well-Woman Checkups	PAID	29,112	2.69
	11 Reasons to Get Well-Woman Checkups Snapchat	PAID	100,361	15.4
	9 Symptoms of Post Partum Depression	PAID	37,929	6.38
	Is It Baby Blues?	PAID	33,345	5.10
CUMULATIVE TOTALS ALL POSTS (unduplicated reach)			**78,069**	**7.49**

The end of calendar year 2020 (or the beginning of fiscal year 2021) was a challenging time for MCH and moving the needle on this initiative. The Office of Child and Family Services (OCFS) including the MCH program staff were emersed in pandemic response. The MCH Women's facilitator was splitting time between active COVID investigations and regular job responsibilities as were OCFS field staff in the 74 Community Health Offices across the state. More than half of the field staff were re-assigned to COVID investigations full time for the first half of this grant period and the remaining staff covered DOH programs to maintain continuity of care for clients. This strongly affected activities for NPM #1 related to promotion of the well women visit and the mental health priority. Staff were scheduled to begin Depression screening with WIC moms in July of 2021. Instead of being a year of screening it ended up being a year of preparation.

NPM #1 Objective: Decrease percentage of women on the SD WIC program who experience Postpartum Depressive Symptoms following a recent live birth from 17.1% in 2019 to 16.2% by 2025. (PRAMS)

Data statement:

South Dakota did not meet the 2020 target of 16.6%. The percentage of women on the SD WIC program who experienced Postpartum Depressive Symptoms following a recent live birth rose from 17.1% in 2019 to 21.9% in 2020.

Strategies 1.1 and 1.2: MCH Mental Health Initiative

Data to Action: According to the 2020 SD PRAMS data, 21.9% of postpartum women on the WIC program reported experiencing Postpartum Depression versus 9.6% of non-WIC mothers. WIC moms also reported having Depression during pregnancy at a rate of 31.6% vs.12.5% for non-WIC participants.

Figure 1: WIC vs. Non-WIC Postpartum Depression (2020 PRAMS)

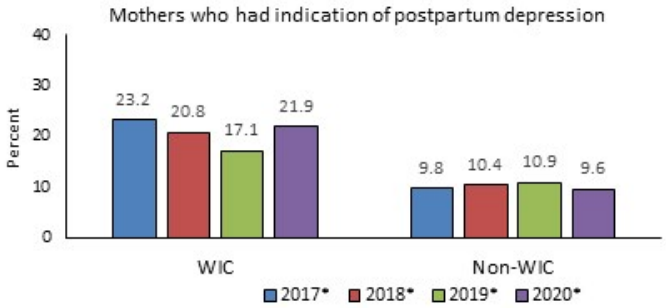
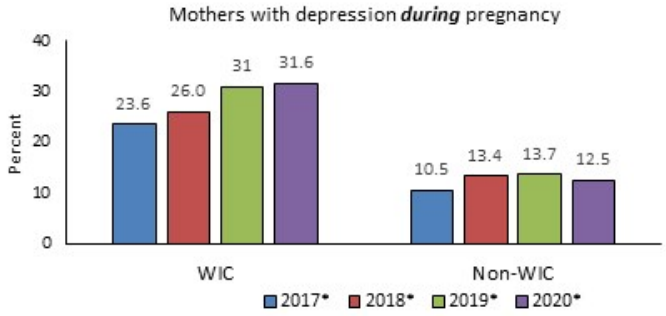


Figure 2: WIC vs. Non-WIC Depression During Pregnancy (2020 PRAMS)



The Well Women workgroup composed of multisector partners (Strategy 1.3) utilized this data and added a depression screening initiative to the NPM #1 state action plan. The goal was to identify WIC clients who may be experiencing depressive symptoms and refer them for evaluation and possible treatment.

NPM #1 workgroup members included:

- Health Coordinator (Sisseton Wahpeton Oyate)
- Title X Coordinator
- DSS Behavioral Health Assistant Director
- OCFS Assistant Administrator/Community Health
- WIC Program Quality Specialist
- MIECHV home visiting nurse
- Maternal Mortality Abstractor/Maternal Health Consultant
- DOH's Tobacco Program Disparities Coordinator
- DOH's Perinatal Nurse Consultant

Title V continued to work with Hot Pink Media Agency to target messaging to our tribal communities where the largest disparities exist. (25.9% of American Indian mothers' experience postpartum depressive symptoms vs. 9.7% of Non-Hispanic White according to 2019 PRAMS). A Facebook post featuring a native woman was developed and added to the rotation as well as radio ads spoken by native voices. The following is an example of a 60 second radio

spot focusing on Postpartum Depression:

While children are a welcome blessing, a new baby brings many emotions. Why do some mothers feel sad or lost? Well, baby blues are normal. But if you are having trouble getting through the day, feel overwhelmed or hopeless – Be brave. Reach out. Postpartum Depression is serious. It is a real condition, common among our people today, and - IT IS NOT.YOUR. FAULT. There are ways to treat it and build a circle of support that will help you celebrate being a mother and honor this new sacred life. You are not alone. Share your truth with people you love and trust. Ask for help. If you think you have Postpartum Depression or are worried about someone else, call the Depression After Delivery Hotline – One eight hundred – nine four – four seven three or visit For Baby's Sake SD dot com today.

The SD Department of Health's strategic plan Goal #1 is: *Enhance the accessibility, quality, and effective use of health resources*. Objective A of this goal states *Increase the percentage of mothers on the SD WIC Program who are screened for depression using a validated tool within 3 months of child's birth from 98% to 100% by 2025.* The strategies added to the NPM #1 state action plan were designed to do just that.

The SD WIC team consists of RNs, LPNs, Licensed Dieticians, Nutrition Educators and Public Health Assistants (PHA) located in 74 Community Health Offices across the state. There are over 100 staff providing WIC services. One of the challenges faced early on was the determination that scoring, counseling, and referring someone with a positive PHQ-9 was not within the scope of practice for a licensed dietician, nutrition educator, or PHA in SD. The MCH team had to pivot and change the way screening would be initiated.

The team collaborated with DSS' Behavioral Health program and their SAMHSA SBIRT grant to provide training to all WIC staff. The rationale for including all staff was that all staff could benefit from training even if they weren't able to administer the PHQ-9, counsel, or refer. The first training *Applying Screening, Brief Intervention & Referral to Treatment to Perinatal Health Screenings* was provided by Dr. Maridee Shogren and Dr. Christine Harsell at Mountain Plains ATTC over ZOOM. The objectives included:

- Identify the symptoms of perinatal depression
- Recognize the need to screen women for perinatal depression
- Recognize the need for substance use disorder screening for women in the perinatal period
- Demonstrate knowledge of the SBIRT intervention
- Discuss a brief intervention utilizing the FLO algorithm

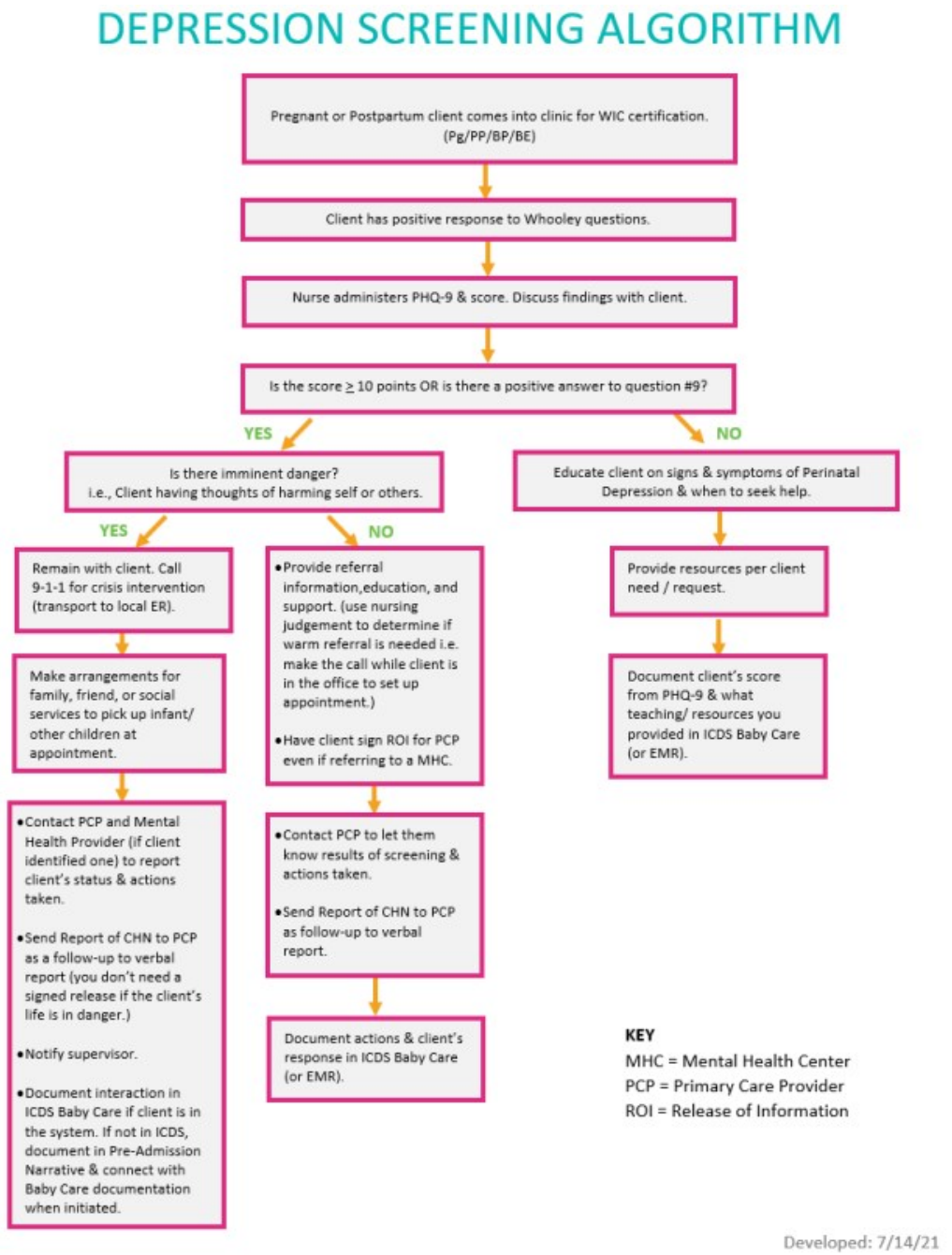
OCFS nurses participated in a second ZOOM training *I've Screened, Now What? Perinatal Depression Screening and Response* provided by Mountain Plains Mental Health Technology Transfer Center Network (through the SBIRT grant). Objectives for this training included:

- Best practices when screening perinatal populations for depression
- How to implement a team-based response to patients expressing thoughts of suicide
- Examine unique barriers experienced by perinatal persons when seeking care
- Discuss the importance of referral pathways for connecting individuals to care

The following Depression Screening Algorithm was designed for nurses as an equitable and accessible referral pathway for clients with a positive PHQ-9 screening:

OCFS field office resource guides were updated to include a listing of DSS Mental Health Centers for referral purposes, teaching tools on perinatal depression and informational materials for clients.

At the end of this grant year an email was sent to OCFS nursing staff to initiate depression screening using the PHQ-9. For this reason, the MCH team is unable to assess the overall effectiveness of the depression screening initiative or measures. While we couldn't initiate depression screening this grant year as intended, we laid the groundwork for it to happen next fiscal year.



<u>Other MCH activities related to Women's Domain</u>:

Maternal Mortality Review: The South Dakota Maternal Mortality Review Committee (MMRC) formed in calendar year 2021 and conducted their first meeting in July 2021. The committee is a multi-disciplinary group of volunteer health care providers and public health practitioners who review maternal deaths (deaths that occur up to one year after pregnancy). Vital records, hospital and law enforcement records, and informant interviews give a complete picture of the circumstances surrounding the maternal deaths. The committee discusses prevention strategies and shares their findings with the Statewide Preventable Death Committee to put data into action.

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

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

Mental Health/Suicide Prevention resources: The MCH Adolescent Health Coordinator attended the *Suicide Prevention in Rural Primary Care* two-part webinar series. One take away was that people who die by suicide are likely to have been seen by a Primary Care Provider in the previous month before their death. This is especially true in rural areas where behavioral health resources are fewer and stigma around mental health is greater. The training walked through strategies for primary care providers and provided a step by step Suicide Prevention Toolkit. One activity mentioned was putting materials in office waiting rooms to create an environment that the patient feels comfortable sharing concerns and to share what types of services are available in the community. The Title V team began brainstorming ways it could coordinate efforts in the 74 Community Health Clinic/WIC offices across the state. At the same time, **the NPM 1 Well Women workgroup** was beginning to look at how to initiate depression screening in Community Health offices. The NPM 1 and NPM 7.2 coordinators collaborated to develop two mental health/suicide prevention resources:

1. Suicide Prevention and Mental Health rack card-provides South Dakota resources and mental health/suicide prevention apps.
2. Mental Health poster that could be posted in waiting rooms or exam rooms. (see below)

Women/Maternal Health - Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Women's/Maternal Health Domain for the period October 1, 2022, through September 30, 2023. Priority needs identified in the 2019-2020 Needs Assessment process were: mental health; substance misuse; access to healthcare services; and social needs such as lack of transportation, desirable employment, education, and adequate housing. After reviewing the data, the NPM #1 workgroup agrees that mental health and substance misuse continue to be top priorities for this population and that a caregiver's health can affect the health of the entire family. After discussions at our 2021 block grant review and a follow-up meeting with HRSA Epidemiologists in April 2022, the MCH team revised the NPM #1 objective to keep the focus on the yearly well women visit.

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

Objective:

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

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

Priority Needs: Mental Health/Substance Misuse

Evidence-based Strategy Measures:

Former ESMs:

- Percentage of WIC clients with a positive response to the Whooley questions that received a PHQ 9 screening.
- Percentage of WIC clients whose PHQ 9 score met criteria for a referral and were referred.

New ESMs:

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

Significance

After reviewing our ESMs with the national reviewers and HRSA Epidemiologists, the MCH team along with the Well Women workgroup decided to change the overall focus to the promotion of well women care (vs. the process of depression screening). The new strategies identified below steer us in that direction with the overall goal: getting more women in for a yearly preventive visit with their PCP.

Proposed Strategies:

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

This strategy has been met. The PHQ-9 screening tool and referral protocol were implemented on October 1, 2021, in all OCFS Community Health Offices (WIC) across the state.

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

Significance

The MCH team decided if we were going to reach all women of childbearing age with the well women message, we needed to develop multisector partnerships. No single organization or sector has full control over the determinants of population health, effective solutions require interorganizational coordination and collaboration. Multisector partnerships across local, regional and state agencies improve delivery of health and social services to vulnerable populations. http://www.cdc.gov/pcd/issues/201 0/nov/10_0104.htm

New Efforts

- Recruitment of more members with expertise from national women's support groups, family planning, frontline clinicians, and regional health care

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

Significance

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

Activities done to this point

Members of the Well Women workgroup shared mental health resources including accessible treatment options for women with Perinatal Depression/Anxiety. These resources have been added to field staff's toolkit to address client's mental health concerns. DOH SBIRT SD BH Resources 2.23.2021.pdf

New Efforts

- Planning for the next fiscal year includes adding additional resources to screen for and address substance misuse through a quality framework.
    - Training on Motivational Interviewing is already underway to empower field staff to adequately screen and refer women.
    - Continuing education on substances of misuse to better inform field staff to appropriately direct care

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

The former strategy was revised and incorporated into new strategy 1.1.

New strategy 1.3: Increase depression screening and referrals to PCP among low-income women on the SD WIC program

Significance

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

Activities done to this point

An evidence-based depression screening policy and procedure was developed by MCH Leads and forwarded to OCFS Nurse Team Leads for final evaluation and implementation. Nurse team leads train and evaluate field staff

within the OCFS.

New Efforts

- Develop CQI tool to measure compliance with depression screening protocol and referral process.

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

Significance

Rates of maternal mortality and morbidity from pregnancy related complications in the United States have increased with an average of over 750 deaths per year. Complex medical, social, and behavioral risks increase the likelihood of major morbidities and death. Low birthweight, short interpregnancy spacing, gestational diabetes, and social determinants of health and disparities increase the likelihood of adverse outcomes. Some of these risk factors could be minimized through pregnancy care management in a medical home model.

South Dakota is designated as a frontier state by the Affordable Care Act. The frontier nature of South Dakota presents barriers when it comes to accessing a variety of health care services, including primary, prenatal, obstetrical, and postpartum care. According to the Health Resources and Services Administration (HRSA), 58 of South Dakota's 66 counties are designated as Medically Underserved Areas; residents lack access to primary care services.

Problem

Due to the way the health home program is set up in South Dakota, attributing pregnant women based on claims to a pregnancy health home would be difficult. It may also be difficult to get OBGYNs to enroll as health home providers. Historically they have not had the staff or the time to do case management. The maternity medical home offers a way to organize interventions, and ensure coordination of social, behavioral, and health services.

Activities done to this point

- National Academy for State Health Policy Maternal and Child Health Policy Innovations Program Policy Academy (NASHP) is a two-year policy academy comprised of representatives from state Medicaid agencies, public health agencies, and other state stakeholders.
    - Identify, develop, and implement policy changes or develop specific plans for policy changes and/or strategies necessary to build state capacity to address maternal mortality for Medicaid-eligible pregnant and parenting women, with the goal of improving access to quality care.
    - technical assistance to improve health care delivery systems and related supports for Medicaid-eligible pregnant and parenting women, with a particular focus on implementing policies or health system transformation that address racial disparities in maternal mortality
- Bright Start current state-South Dakota DOH has a 20-year history of providing Bright Start nursing services to families in specific communities across the state, but the program has never been available statewide due to funding limitations. The Bright Start program implements the evidence-based Nurse Family Partnership (NFP) model as well as an adapted curriculum with clients who do not fit the NFP model requirements but are still in need
    - In FY21 Bright Start served 604 families
    - In FY20, 596 families were served
    - SD has an average of 850 first-time pregnant moms covered by Medicaid each year
- Data from PRAMS and March of Dimes (MOD) to inform risk factors.
- The Association of State and Territorial Health Officials (ASTHO) links PRAMS data to Medicaid claims to understand the cost for risk factors identified in the payment model

New Efforts

- North Dakota-South Dakota (NDSD) PQC-quality improvement work across the state to address maternal morbidities. Education and implementation of a hypertension bundle was initiated, and work continues in this area.
- The maternal mortality review committee (MMRC) has provided information and trends on pregnancy related

deaths. They have also identified barriers to health care access and the impact of social determinants of health.

- Bright Start expansion- Approval from state legislature for funding to expand the Bright Start program to include more counties across the state.
- Expansion of Pregnancy Care within the office of child and family services (OCFS) -modified case management available for all women regardless of status as non-contract county.
- Work toward Maternal Medical Homes continues with the plan for a pilot maternal medical home in one location with a Pregnancy Care nurse and obstetric provider in the next several months.

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

- Continue to educate all women on the importance of yearly preventive visits which address mental health as well as physical health in Community Health Offices across the state.

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

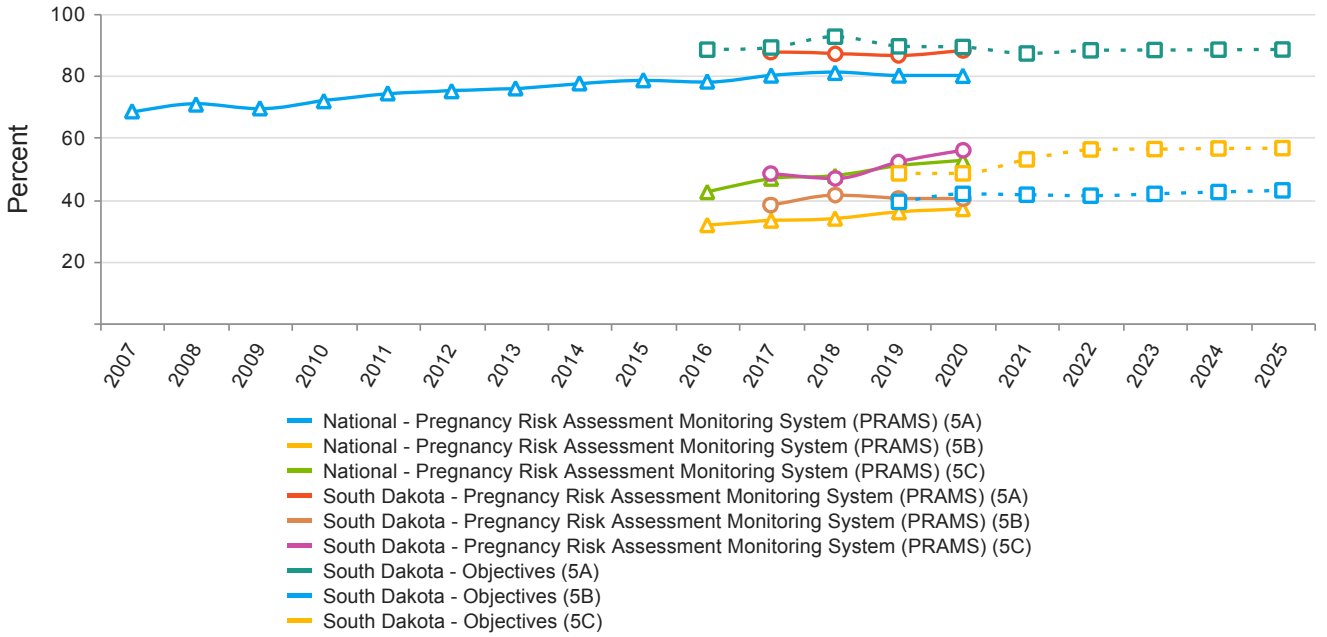
- Continue to partner with Title X, Bright Start Home Visiting, the SD WIC program, and other community partners to promote yearly check-ups for women of childbearing years and their families.

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

Perinatal/Infant Health

National Performance Measures

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



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

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

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	88.9	92.4	89.3	89.1	87
Annual Indicator	91.7				
Numerator	10,013				
Denominator	10,922				
Data Source	SD PRAMS Like Survey				
Data Source Year	2016				
Provisional or Final ?	Final				

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	88.0	88.1	88.2	88.3

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

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

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			39.2	41.8	41.5
Annual Indicator	26				
Numerator	2,821				
Denominator	10,844				
Data Source	SD PRAMS Like Survey				
Data Source Year	2016				
Provisional or Final ?	Final				

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	41.2	41.8	42.4	42.9

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

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

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			48.4	48.4	52.9
Annual Indicator	44.7				
Numerator	4,681				
Denominator	10,472				
Data Source	SD PRAMS Like Survey				
Data Source Year	2016				
Provisional or Final ?	Final				

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	56.1	56.2	56.4	56.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator			100
Numerator			10
Denominator			10
Data Source			Post test results
Data Source Year			2021
Provisional or Final ?			Provisional

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

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

Measure Status:	Inactive - Recent data shows 80% of infants died in SD while under a parent's care. 3% in daycare. For this reason, this measure has been discontinued.

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator			0
Numerator			0
Denominator			100
Data Source			Survey distributed to daycares
Data Source Year			2021
Provisional or Final ?			Final

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

Measure Status:	Active

Baseline data was not available/provided.

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

State Action Plan Table

State Action Plan Table (South Dakota) - Perinatal/Infant Health - Entry 1	
Priority Need	
Safe Sleep	
NPM	
NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	
Objectives	
Reduce the number of SUID deaths related to unsafe sleep environment from 139.8/100,000 in 2019 to 103.9/100,000 by 2025 (NVSS)	
Increase the percent of infants placed to sleep without soft objects or loose bedding from 55.8% in 2020 to 57.2% in 2025 (PRAMS)	
Strategies	
5.1: Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media and print.	
5.2: Collaborate with diverse community partners to provide Child Death Review and disseminate findings to all South Dakotans.	
5.3: Collaborate with diverse, multi-sector organizations/agencies to promote safe sleep.	
ESMs	**Status**
ESM 5.1 - % of Child Death Review (CDR) team members who scored above 80% on a post-test	Active
ESM 5.2 - % of daycares who respond to survey and indicate that they follow safe sleep guidelines	Inactive
ESM 5.3 - % of birthing hospitals that receive information on certification process that become safe sleep certified	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

Perinatal/Infant Health - Annual Report

Perinatal/Infant Domain: Annual Report (October 1, 2020 – September 30, 2021)

Priority: Safe Sleep

National Performance Measure 5:

1. Percent of infants placed to sleep on their backs

South Dakota exceeded the 2020 target of 86.8% with 87.8% of infants placed to sleep on their backs in 2020. South Dakota ranked 6th in the nation with a significantly higher rate than the U.S. rate of 79.8%.

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

South Dakota did not exceed the 2020 target of 41% with 40.1% of infants placed to sleep on a separate approved sleep surface in 2020. The percentage dropped from 40.5% to 40.1% from 2019 to 2020. South Dakota ranked 11th in the nation with a higher rate than the U.S. rate of 36.9%.

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

South Dakota exceeded the 2020 target of 52.5% with 55.8% of infants placed to sleep without soft objects or loose bedding in 2020. South Dakota ranked 16th in the nation with a higher rate than the U.S. rate of 52.5%.

Reducing infant mortality is a public health priority in SD. Although the state's rate has been steadily declining, the post neonatal and Sudden Unexpected Infant Death (SUID) mortality rates remain high and wide disparities persist across races. Infant mortality rates of American Indian, non-Hispanic infants have historically been 2-3 times higher than that of white, non-Hispanic infants in SD.

Most infant deaths in the post-neonatal period are related to infant sleep. Of the 95 sleep related deaths that occurred post hospital discharge, nearly 80% occurred in an unsafe sleep environment (SD Child Death Review 2016-2020). SUID rates remain higher in SD than the national average. According to the National Center for Health Statistics (NCHS) 2016-2019 SUID data, SD's SUID rate is 135/100,000 compared to the national rate of 91.

To address these issues, the SD Department of Health's Strategic Plan Goal 2 *Provide Services to Improve Public Health* includes 2 strategies the MCH team/NPM #5 workgroup are responsible for:

- Collaborate with birthing hospitals in SD to become Cribs for Kids Safe Sleep Certified
- Share infant mortality prevention strategies with 3 healthcare associations

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

1. Assistant Vice President of Inpatient Nursing Services, Avera McKennan Hospital
2. Clinical Nurse Specialist, Sanford Children's Hospital NICU
3. Director, Department of Social Services (DSS) Childcare Services
4. Early Childhood Field Specialist, SDSU Extension Services
5. Death Review Abstractor, Child Death Review (CDR)/National Violent Death Review (NVDR)
6. Family Advocate – Lach's Legacy founder
7. Executive Director, Sanford Children's Hospital/Clinics/Community Services
8. Clinical Research Manager, Avera Research Institute, Pine Ridge Reservation
9. MCH team lead, Infants Domain/State CDR Coordinator

The beginning of this grant year was a challenging time for MCH as well as workgroup members. The workgroup facilitator and many partners were emersed in COVID response efforts across the state. The workgroup met on ZOOM three times and moved forward with activities on the NPM #5 state action plan at a slower pace than was anticipated. A summary of our progress follows.

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

Data Statement: In 2018, South Dakota's (SD) SUID death rate related to unsafe sleep environment was 168.2/100,000. SD met the 2019 annual target of 157.5/100,000 with a rate of 139.8/100,000. SD ranked 41st in the nation (2019) and had a higher rate than the U.S. rate of 89.8/100,000. The change from the base year (2015) to the current year is not significant.

Objective: Increase the percent of infants placed to sleep without soft objects or loose bedding from 55.8% in 2019 to 57.2% by 2025 (PRAMS)

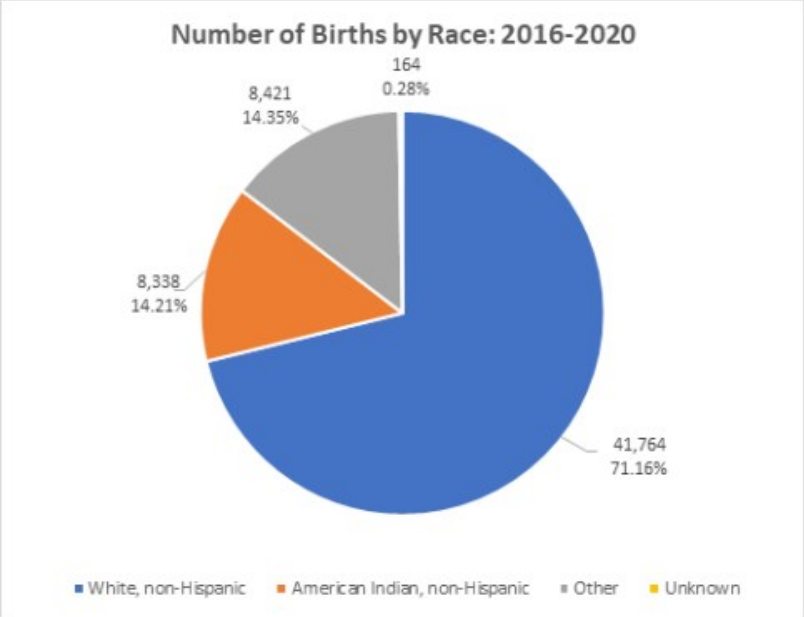
Data Statement: In 2019, SD's percent of infants placed to sleep without soft objects or loose bedding was 52%. SD exceeded the previous 2025 target of 54.8% with 55.8% of infants being placed to sleep without soft objects or loose bedding in 2020. SD ranked 16th in the nation (2020) with a higher percentage than the U.S. at 52.5%.

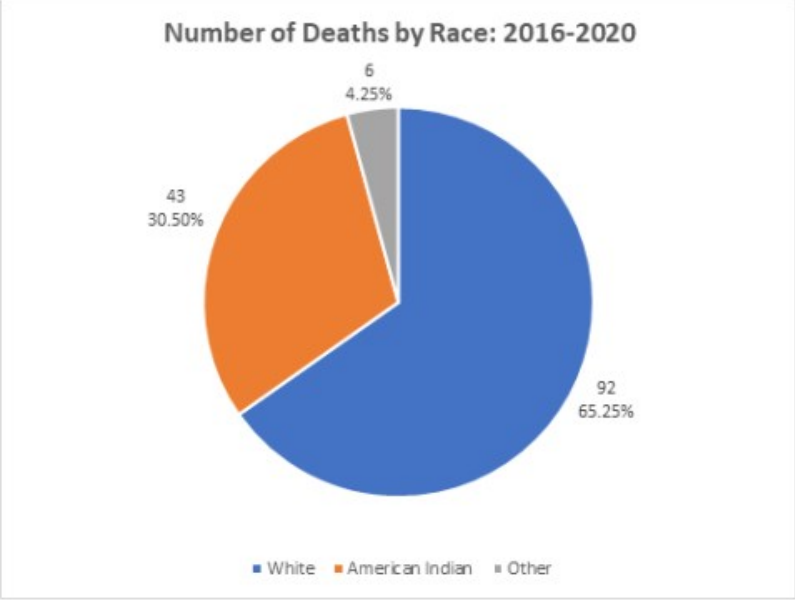
Strategy 5.1: Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media, print, and radio.

The MCH Team continued to work with Hot Pink Media group to disseminate culturally appropriate messages. Social media posts were promoted to a South Dakota specific audience consisting of parents with children under the age of two, grandparents, and childcare providers. See metric table below.

POST IMAGE	TITLE	TYPE (Paid/Organic)	CUMULATIVE REACH	AVERAGE FREQUENCY
	SIDS prevention starts with safe sleep	PAID	12,588	4.2
	11 Key Ways Dads Can Help	PAID	22,525	3.85
	11 Safe Sleep Guidelines	PAID	40,006	2.6
	What Safe Sleep Looks Like (animation)	PAID	27,993	4.36
	Is my Crib Safe?	PAID	38,106	3.4

Data to Action: Based on disparities (in the 2015-2020 Vital Statistics and CDR data) regarding race, the NPM #5 Safe Sleep workgroup promoted a safe sleep message via radio in reservation communities and utilized Native families in Facebook posts (below).

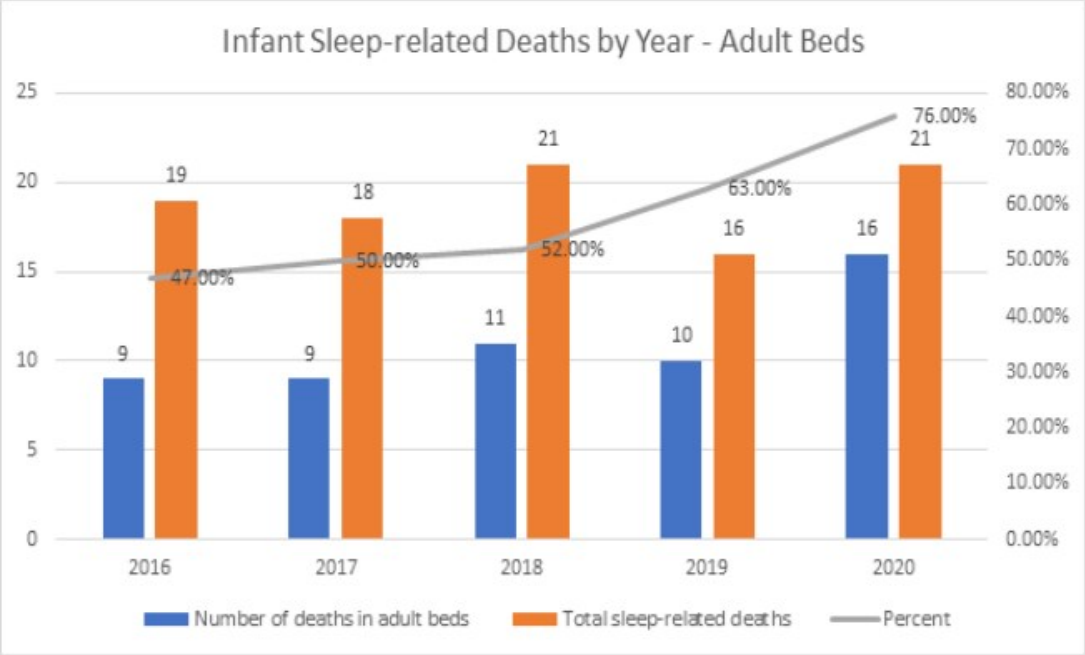

Number of Births by Race: 2016-2020
164
0.28%
8,421
14.35%
8,338
14.21%
41,764
71.16%
White, non-Hispanic
American Indian, non-Hispanic
Other
Unknown


Number of Deaths by Race: 2016-2020
6
4.25%
43
30.50%
92
65.25%
White
American Indian
Other

Radio flights featuring safe sleep messaging were planned and placed during this grant period. A 60-second American Indian voiced spot (below) focused on safe sleep with emphasis on putting babies to sleep on their backs, on a firm surface alone, room sharing but not bed sharing, and safe cribs. This ad points listeners to the For Baby's Sake website. For Baby's Sake | Healthier moms + Healthier babies (forbabysakesd.com)

(Lakota Phrase) "BEBELA WA IYUNKA" or "ABU… ABU.. ABU" or combine phrases
(Repeat in English): SHHHHH! BABY'S ASLEEP.
IT SEEMS SIMPLE, BUT WE KNOW THERE'S MORE TO KEEPING BABY SAFE.
BEFORE YOU LAY YOUR BABY DOWN TO SLEEP, BE SURE TO FOLLOW THESE SAFE SLEEP GUIDELINES –
FIRST, BABIES SLEEP SAFEST ON THEIR BACKS, ON A FIRM SURFACE, WITHOUT PILLOWS, BLANKETS, BUMPER PADS, OR TOYS.
NEXT, BABIES SHOULD ALWAYS SLEEP ALONE, NEVER SHARING ANY SLEEP SURFACE WITH AN ADULT, ANOTHER CHILD, OR PET. ***ROOM*** *SHARING IS OKAY,* ***BED*** *SHARING IS* ***NOT****.*
COUCHES, CHAIRS, INFANT SEATS OR SWINGS ARE NOT SAFE PLACES FOR BABY TO SLEEP. EVERY SLEEP TIME COUNTS.
AND, FINALLY, BABIES NEED A SAFE CRIB. IF YOU HAVE QUESTIONS ABOUT WHERE YOUR BABY SHOULD SLEEP, OR CAN'T AFFORD A SAFE CRIB - WE CAN HELP.
(Lakota Phrase) "ENAH EEWAH CHEE CHEE YE" (Mommy I need your help)
HELP YOUR BABY SLEEP SOUNDLY AND SAFELY.
FIND OUT MORE AT FOR BABY'S SAKE S-D DOT COM.

Data to Action: SD CDR data shows increase in percentage of infant deaths occurring in an adult bed. (NCFRP Case Reporting System)



This increase (in the percent of infants sleeping in an adult bed) prompted the creation of this ad for Black Hills Parent magazine.

Strategy 5.2: Collaborate with diverse community partners to provide CDR and disseminate findings to all South Dakotans.

MCH continues to support the work of 2 Regional CDR teams (East River and West River) and a Statewide Preventable Death Committee. DOH's goal was to have both teams utilizing the same process for reviewing cases. To accomplish this, staff from the National Center for Fatality Review and Prevention provided training, *Steps to an Effective Review,* for the West River team (East River team was already using the process that we wanted to emulate). All West River team members scored above an 80% on a posttest demonstrating knowledge of the new death review process. This ESM was then revised and a training on upstream root causes of infant death was added to the list of activities for the coming year.

In addition to this training, the State CDR coordinator began participating in a Health Equity Learning Collaborative

through the NCFRP. Topics included:

- Equity focused tools and strategies for victim/family blaming
- Upstream cases of child death
- So many prevention recommendations, yet so few resources

Infant death review data in the form of an 8 1/2" x 11" glossy handout is used to promote safe sleep practices statewide. The handout, *Safe Sleep Practices Can Save Lives,* was updated in English and Spanish (to promote health equity) for continued use in discharge packets at the 3 largest birthing hospitals: Sanford Sioux Falls, Avera McKennan, and Monument Health Rapid City. It is also given to new parents at the IHS hospital in Pine Ridge. Three hundred copies were distributed to participants (added to informational packets) at Lach's Legacy *Run for Their Lives* walk/run fundraisers in May and June of 2021. Lach's Legacy hosts these events yearly in Harrisburg and Spearfish to promote SIDS awareness and educate families on safe sleep practices. The *Safe Sleep Practices Can Save Lives* handout is also utilized as a teaching tool by field staff within the Office of Child and Family Services (OCFS) who serve low-income families in 74 Community Health Offices across the state.

The State CDR Coordinator and one of the Pediatricians from the East River CDR team were scheduled to present CDR data at the Medical Examiner's law enforcement/coroner's training (*Infant Death Scene Investigations*) at the end of this grant year but it was canceled due to a spike in COVID cases.

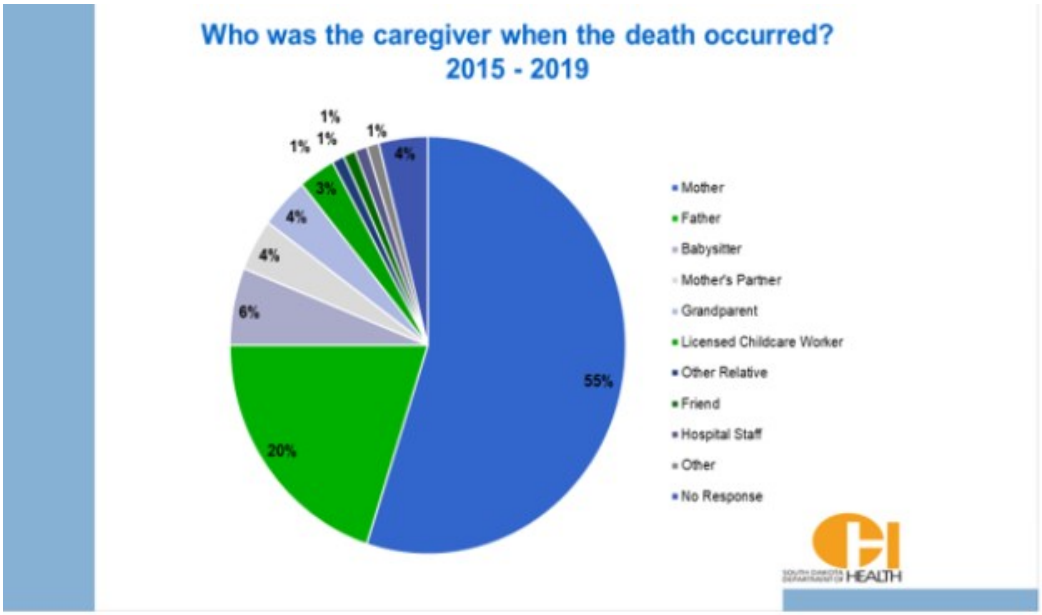
An Infant Mortality Report (2016-2020) and Infant Mortality data dashboard were added to the DOH website and include data from SD CDR.

2016-2020: Full Report | 1 pager

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

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

The MCH Safe Sleep workgroup is made up of multi-sector organizations including birthing hospital administrators, a Neonatal Clinical Nurse Specialist, DSS Childcare Licensing, Extension Services, a family advocate who runs a non-profit in the fight against SIDS, and a tribal representative active in native safe sleep research. Together this workgroup reviews current data and determines evidence-based strategies to decrease infant mortality. The pie graph below is one of the data points that was used to pivot away from focusing on licensed daycares and redirect activities to moms and dads. The current ESM, *% of daycares who respond to survey and indicate that they follow safe sleep guidelines* was abandoned for this reason. Licensed daycares continue to receive safe sleep education, training, and technical assistance in developing safe sleep policies.
Data to Action: The pie graph below (SD CDR data) shows that almost 80% of infant deaths occurred when the infant was in the care of mom, dad, or mom's partner. The Safe Sleep (NPM #5) workgroup decided to target safe sleep education to these caregivers by partnering with the National Cribs for Kids program and all SD birthing hospitals to promote safe sleep certification within their system. The certification ensures that all families hear the safe sleep message before leaving the hospital after birth.



The NPM #5 workgroup decided to partner with Cribs for Kids to promote bronze level safe sleep certification in all 21 birthing hospitals in the state. Workgroup members affiliated with hospital systems became champions within their hospital and its affiliates. By the end of this grant year, champions had been named for 8 of the 21 birthing hospitals and information on the certification process was provided. Bette Schumacher, CNS Sanford Neonatal has taken the lead for the 6 Sanford birthing hospitals and Kerri Bjornson, Neonatal CNP is leading the Monument Health Systems efforts (2 birthing hospitals).

Family Advocate: Brianne Edwards, Lach's Legacy

The Safe Sleep workgroup added a new member this grant year who has experienced infant loss. Brianne Edwards and her husband founded Lach's Legacy after losing their baby boy in 2008 to SIDS. Their website, www.lachslegacy.org states "Since 2008 we have been working to give comfort to families when it is needed most, education to those who can potentially reduce a child's risk of sudden death, and hope for an answer where there currently is no explanation." Their non-profit offers comfort to grieving families through a care package of items that can give a starting point to the long road of healing. Lach's Legacy has partnered with law enforcement across the state to provide information about their care packages via a 3x5 informational card to hand to a parent that has just experienced the loss of their baby. Law enforcement agencies perform all death scene investigations and family interviews when a baby dies unexpectedly in SD. The cards were provided to the Division of Criminal Investigation (DCI) witness specialists, DCI agents, county sheriffs, and police chiefs across the state. Brianne is also a member of the West River CDR team where she steers discussions away from family blaming to focusing on upstream factors. Bri is currently working on a book for bereaved parents titled *A Thousand Pounds* about her own experience of loss and learning to live under the weight of unbearable grief.

Bright Start/Community Health Safe Sleep CQI project: The MCH Infant Domain Lead and Community Health Nurses (CHNs) from across the state collaborated with DOH's Bright Start visiting nurse program on their 18-month safe sleep CQI project. The SMART Aim for the project: By December 2021, improve from 81% to 83% the percentage of Rapid City Bright Start and WIC infants under the age of 6 months who are always put to sleep on their backs without bed-sharing or soft bedding.

Over the course of the project, WIC, Baby Care and Bright Start staff collected data on Safe Sleep. One significant improvement was that all staff began asking the same 3 Safe Sleep questions so there was consistent data across programs for infants under the age of 6 months who are always put to sleep on their backs without bed-sharing or soft bedding. During this time, the clients who answered "Always, Never, Never" to the questions ranged from 73-

88% with a median of 79%. One note on the baseline data for this project is that home visiting staff were concerned with the high percentage of “Always, Never, Never” answers at the start of the project since the visits were virtual or over-the-phone due to COVID: concern that this may have affected the validity of the answers since the nurses were not in-person with the clients.

Data collection differed among programs (Bright Start Home Visiting, WIC/Baby Care) so the first task was to standardize the safe sleep questions and begin collecting data. The team reviewed safe sleep best practices with the MCH Lead. A fishbone diagram was developed along with strategies for implementation. PDSA were completed with families and Nurse Home Visitors to gather feedback on effectiveness/relatability of safe sleep videos used for family education. Recommended safe sleep video resources were emailed to all CHNs and Bright Start nurses. Team members determined they would provide credible resources (ex. videos, safe sleep environment and baby anatomy fact sheets, culturally relevant) to nurses but leave to nurses’ discretion which resources are provided to each family. The team discussed strategies to assist families who indicate they are not practicing safe sleep guidelines. CQI Nurse Consultant provided technical assistance on the CQI tools and methods during the meetings.

At the conclusion of the project, the team shared two main strategies to continue moving forward. First, the three safe-sleep questions asked of clients enrolled in the evidence-based home visiting program were included in the Office of Child and Family Services new electronic health record (EHR) so data could be collected in the same way across all DOH programs. Second, the team identified a set of evidence-based and relevant resources and training materials to increase consistency in staff and client education on safe sleep principles.

Cribs for Kids (C4K) safe sleep kit distribution: OCFS Community Health offices across the state (74 total) continued to partner with the National C4K program to provide safe sleep kits to families in need of a safe environment for their infant to sleep. In CY 2021, 713 kits were distributed containing a Pack ‘n Play unit. The number is down from last year’s total of 751. The pandemic has made it a challenge to disperse the kits as clients were receiving telephone calls for WIC appointments instead of in-person visits. Safe sleep education was provided over the phone and the families then made arrangements to meet a staff person at the door of the clinic to pick up the kit. Pre-pandemic, Community Health Offices were issuing over 1,000 kits per year.

Strong South Dakota Families mailings: Title V continued its collaboration with the governor’s office by including the *Sleep Baby Safe And Snug* book (Charlie’s Kids Foundation) in the Strong Families packets that are mailed to new parents/caregivers in SD. The packets contain information and resources on a variety of topics. Strong Families South Dakota (sd.gov) Below is the section on safe sleep from the website.

Safe Sleep

Using safe sleep practices will greatly reduce a baby’s risk of SIDS (sudden infant death syndrome) and SUID (sudden unexpected infant death). **Learn guidelines for safe sleep** and other ways to keep your baby safe.

Approximately 300 packets are mailed out every month.

Perinatal/Infant Health - Application Year

In this section, South Dakota (SD) MCH Title V reports on planned activities in the Perinatal/Infant Health Domain for the period October 1, 2022 through September 30, 2023. A notable need identified during SD's five-year comprehensive Needs Assessment was education and programming around infant safe sleep. The 3 multisector teams focused on this goal are the MCH NPM #5 Safe Sleep workgroup, and the East and West River Child Death Review teams. These teams have been focusing on upstream factors that contribute to infant deaths and objective findings that can address root causes of infant mortality.

State Priority: Safe Sleep

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

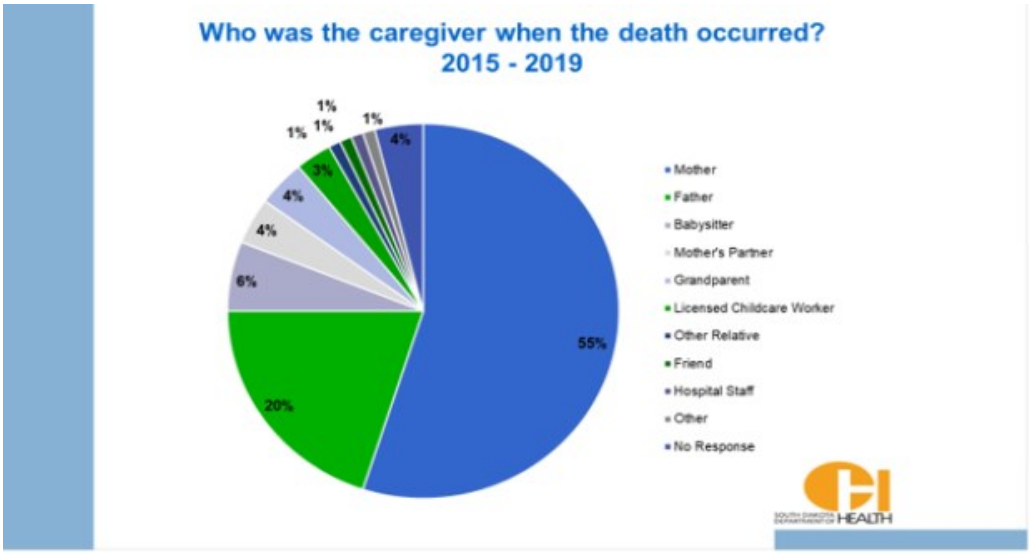
Former ESM 5.1: Percentage of Child Death Review team members who scored above 80% on a post-test (training on root causes of infant mortality).

This ESM was ***met*** in May of 2022 as both CDR teams have now had the *Findings-Recommendations-Action, Making a Difference with CDR Data* training provided by the National Center of Fatality Review and Prevention. All members scored above 80% on the post test.

Former ESM 5.2: Percentage of daycares who respond to survey and indicate that they follow safe sleep guidelines.

This ESM has been ***discontinued*** after reviewing data from Child Death Review:

The pie graph below (SD CDR data) shows that almost 80% of infant deaths occurred when the infant was in the care of mom, dad, or mom's partner vs.3% that were in the care of a licensed childcare provider. The Safe Sleep (NPM #5) workgroup decided to pivot and focus on safe sleep education for parents/caregivers vs. daycares based on this evidence.



ESM 5.3: Percentage of birthing hospitals that receive information on certification process that become safe sleep certified.

This ESM, now **5.1**, will remain active as we continue to promote Cribs for Kids Hospital Safe Sleep bronze level certification for all birthing hospitals in the state. According to the MCH Evidence Center, this ESM is moderate evidence level.

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

2022-2023 Objectives

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

Increase the percent of infants placed to sleep without soft objects or loose bedding from 55.8% in 2020 to 57.2% by 2025 (PRAMS).

Strategies and new Activities

- Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media and print. (we have eliminated *radio* at this time until we are able to study whether radio is indeed the modem to reach our native population.)

Title V has begun working with our own DOH Communications team to post culturally appropriate safe sleep messages on For Baby's Sake and DOH Facebook pages. The MCH team will continue to update the For Baby's Sake website, www.forbabysakesd.com with the newest sleep recommendations by the AAP Safe Sleep Task Force (revisions due to be published in July, 2022). The Infant Domain team lead will update all print materials to include any pertinent AAP revisions. A new safe sleep infographic will be designed which will include state-specific CDR data. This updated infographic will be utilized by birthing hospitals across the state to be disseminated in their family discharge packets (after birth of a baby).

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

Title V will continue to support multisector teams to review infant deaths (post hospitalization after birth) to determine why infants are dying and how we can prevent future deaths. SD CDR plans to work with a team from Johns Hopkins University to translate CDR findings into recommendations.
Plan of action from Johns Hopkins: First, review teams should include **actionable, evidence-informed recommendations** for how to prevent similar deaths in the future. These recommendations should include consideration of the physical environment as a risk factor when appropriate. Support for teams to include recommendations that draw from the best available evidence and consider the physical environment when developing recommendations is needed. Second, models for how to realize those recommendations are needed. To address these needs and better realize the preventive potential of child death review processes the team from Johns Hopkins will undertake the following activities:

1. Review existing child death review teams processes for developing recommendations based on review findings and translating those recommendations into policy, program, system, and/or environmental change.
2. Develop resources to support child death review teams in developing evidence informed recommendations.
3. Develop models, informed by child death review team members and National Center staff, for engaging

stakeholders to realize the recommendations developed through the child death review process.
4. Evaluate the impact of the resources and models on participating teams' recommendations and engagement with the models for translating recommendations into policy, program, systems, or environmental change.
5. Incorporate the resources and models into ChildDASH.

The East River Medical Examiner's annual training on infant death scene investigation and use of SUIDI form was cancelled in October, 2021 due to surging COVID numbers. The statewide CDR coordinator has been invited to present on these topics as well as share state specific data from CDR in fall of 2022.
Another way the MCH team plans to disseminate CDR findings is by speaking to the First 1,000 Days group - Sisseton Wahpeton Oyate and at Sanford's Perinatal/Neonatal conference (March of 2023).

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

Title V will continue to partner with SD birthing hospitals to promote Cribs for Kids BRONZE Level safe sleep certification. The goal is to have 4 new birthing hospitals become certified by the end of FY'23 (one birthing hospital is already GOLD certified). MCH has partners at 2 of the largest birthing centers in the state working on this initiative and plans to develop a new partnership with the Avera hospital network in the coming year.

The NPM #5 workgroup has invited a leader/advocate from the Pine Ridge reservation to serve on the workgroup and share her perspectives on what type of safe sleep messaging would reach the widest native audience. This community leader is also involved with safe sleep research on her reservation and has helped in the development of a native safe sleep curriculum. The MCH team is looking forward to working with the Oglala Sioux Tribe in its efforts to promote/disseminate the curriculum when it is published.

The MCH team will explore a new opportunity to partner with Today's Baby and the SD WIC program. The TodaysBaby™ programs are a collaboration between WIC and research teams (Washington University School of Medicine, Boston University, and University of Virginia) at the community, state, and national levels. Today's Baby programs were developed to complement the education provided by WIC staff by sending participants short videos and text messages directly to their phones.
The aim of the partnership is to improve adherence to breastfeeding and safe sleep recommendations among families of lower socio-economic status.

The MCH Infant Domain coordinator and administrative staff from the SD WIC Program have had an initial meeting with Today's Baby researchers and are looking at steps to move forward in this process.

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

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

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

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

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

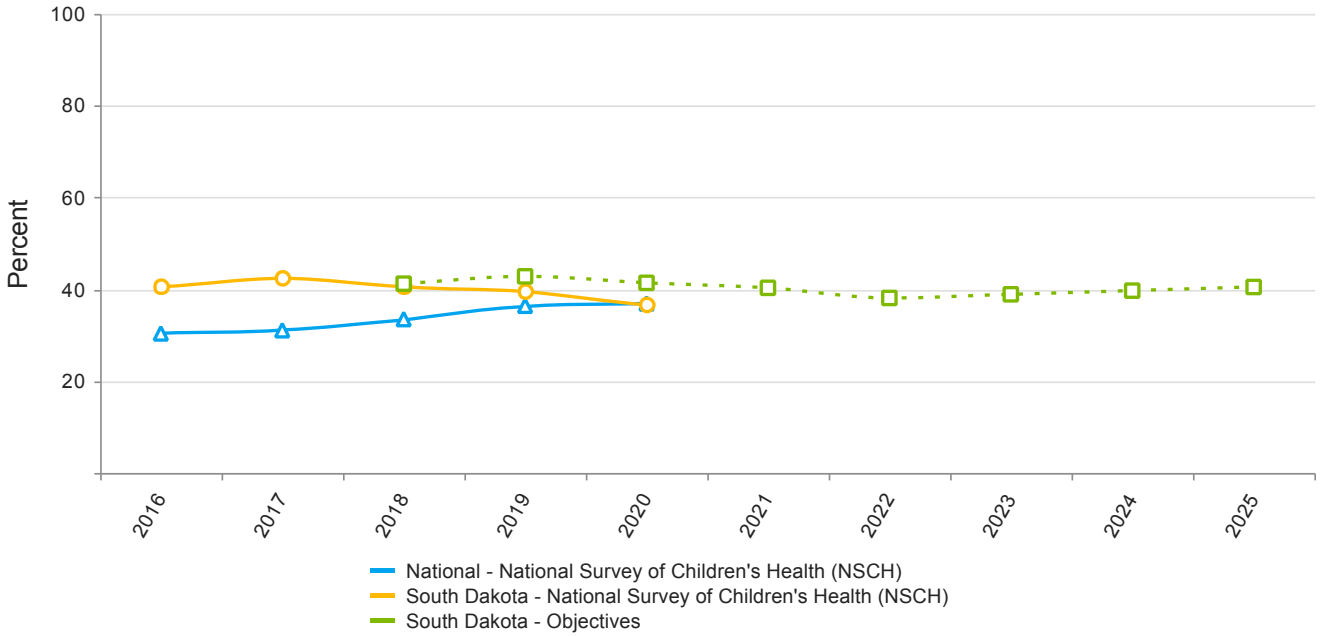
- Continue to promote breastfeeding through social media and provide support for breastfeeding moms through partner agencies, DOH’s Certified Lactation Counselors (CLCs) and WIC’s breastfeeding peer counselors statewide.

- Continue to support the DOH’s efforts to reduce the rates of congenital syphilis and syphilitic stillbirths in SD. In 2021, SD reported 16 congenital cases and 4 syphilitic stillbirths which is a 300% increase from 2020. Disease Intervention Specialists across the state (employed by the DOH) provide case management to all physician-diagnosed and/or suspect cases. The MCH program has placed posts on For Baby’s Sake and DOH Facebook pages (below) and will continue to provide information to our childbearing families via social media in the coming year.

Child Health

National Performance Measures

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



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		41.2	42.8	41.4	40.3
Annual Indicator	40.4	42.4	40.4	39.4	36.5
Numerator	12,135	10,542	8,655	9,910	9,949
Denominator	30,030	24,884	21,429	25,131	27,272
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	38.1	38.9	39.7	40.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator	100	100	100
Numerator	76	76	76
Denominator	76	76	76
Data Source	OCFS Community Health Offices	OCFS Community Health Offices	OCFS Community Health Offices
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

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

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

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (South Dakota) - Child Health - Entry 1	
Priority Need	
Parenting Education and Support	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
Increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year from 22.3% (2019-2020) to 36.5% by 2025 (NSCH)	
Strategies	
6.1: Utilize Community Health offices and Bright Start Home Visiting Program to provide Ages and Stages developmental screen tool to clients.	
6.2: Create new and promote existing parenting resources to support healthy children and families	
6.3: Collaborate with partners to identify gaps in parenting education and support and reduce duplication of efforts	
ESMs	**Status**
ESM 6.1 - % of Community Health Offices that distribute tracking cards	Active
ESM 6.2 - Percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age.	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

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

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

The MCH Program carries out ASQ and ASQ SE developmental screens through the DOH Community Health Offices (including contracted Public Health Alliance sites). Families who visit a community health office are offered a developmental screen when they come to the clinic for WIC services as well as other services. Families are given education from the ASQ screening kits and laminated posters are displayed in the offices promoting developmental screening. In the event of an abnormal screen, additional education is provided, and a family may be referred to their primary care doctor for follow up.

During this reporting period, the community health staff faced the ongoing challenge of carrying out ASQ screens during the Covid 19 pandemic. Developmental screens are typically given when families come into the office for WIC assessments. However, with the federal waiver allowing WIC certifications to be done over the phone, less families were seen in the office and developmental screen rates dropped by approximately 60%. Some offices, particularly those housed in Court Houses, were affected if the courthouse was closed to public traffic. However, community health staff were allowed to meet clients outside and escort them directly to and from the Community Health Office to receive services, but many families opted not to receive in-person services. Some services such as immunizations were offered to families in the parking lot while the child was in their car seat. While other offices did not close to the public, many families chose not to come in due to the risk of contracting illness. In these situations, staff were still able to offer some services virtually and developmental screens were carried out over the phone. Through these efforts, OCFS staff facilitated the completion of 1413 ASQs and ASQ SEs, and completed interventions with 172 infants and children who needed further evaluation for potential developmental delays. The number of infants and children receiving interventions is much higher than last year's reported number due to our contracted Public Health Alliance sites now being included in that count.

The MCH Program also carries out developmental screens through the Bright Start Home Visiting Program. This program utilizes the evidence-based Nurse Family Partnership model and offers services to at-risk pregnant women and parents with young children by partnering families with a registered nurse. The majority of program services are offered during home visits, but families and nurses also meet in other locations if the family prefers. Bright Start is funded in part through the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) federal grant, as well as through a contract with the South Dakota Department of Social Services using Medicaid and TANF Block Grant funding. The Bright Start Home Visiting Manager serves on multiple Title V workgroups and is supervised by the MCH Director.

During this reporting period, 92% of children enrolled in the Bright Start program had a completed ASQ-3 at 18 months.

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

Data Statement:

South Dakota did not reach the 2020 target of 39.9%, with 36.5% of children ages 9-35 months receiving a developmental screening using a parent-completed screening tool in 2019-2020. This is a decrease from 39.4% in 2017-18. In 2019-2020, South Dakota was ranked 26th in the nation in percent of children receiving a developmental screening tool with a national rate of 36.9%.

The full-length South Dakota MCH Annual Data Summary can be found here:
https://doh.sd.gov/documents/MCH/2022_SDMCH_DataSummary.pdf

State Objective:

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

State Objective Data Statement:

The 2019-20 South Dakota rate of 22.3% did not meet the 2020 target of 27.3%. This rate among children from non-metropolitan areas was lower than the overall South Dakota rate of 36.5%. There is a data note for this indicator that the rate should be interpreted with caution because the confidence interval width is greater than 20% points.

The MCH Program has established strategies aimed at improving developmental screening rates through clear and consistent messaging, well-trained staff that provide screenings and education, and identification and remedy of gaps in parenting education and support.

Strategies:

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

- Disseminated a trifold developmental screening tracking card that can be ordered through the DOH central ordering system. Cards are similar to immunization tracking cards and are given to parents for their records.

- Continued to offer online confidential ASQ screening tool at https://doh.sd.gov/family/childhood/child-development.aspx
- Provided Learn the Signs Act Early resources to Community Health staff. Staff were given ordering information and encouraged to order resources including books, checklists, and posters as needed.
- The child domain workgroup continues to meet to provide input and support in carrying out the strategies outlined in the Child action plan. This workgroup has representation from Bright Start Home Visiting, SD Parent Connection, the Department of Education, Sanford Health, Avera Health, and the Department of Social Services (Medicaid). The workgroup is always growing and evolving in membership.
- The Child domain coordinator and MCH Director met with the SD WIC Director and staff to discuss how we can better utilize Learn the Signs Act Early materials in the community health offices. Currently, community health staff utilize posters promoting the CDC Milestone Tracker App and also assist families with downloading the app and going through the app's instructions. Staff are encouraged to utilize other resources including children's books for families of children 1-3 years, developmental checklists, and tip sheets. Discussion was had about increasing the use of the developmental checklists to augment the ASQ and ASQ-SE education currently provided to families who undergo screening in the community health offices.
- The Office of child and Family Services has been working on creating an Electronic Health Record (EHR) to be utilized across programs and within the community health system. The EHR will allow for more seamless tracking of developmental screens and referrals.

6.2. Implement staff training that emphasizes health equity for community health offices that provide ASQ and ASQ SE screenings

- Provided training on administering ASQ and ASQ SE screenings to all new community health and Bright Start Home Visiting staff as part of their orientation. Encouraged staff to use the Brookes Publishing ASQ/ASQ-SE newsletters for continuing education.
- Incorporated training and reminders for Office of Child and Family Services (OCFS) staff to connect families to the CDC Milestone Tracker app. Staff in the community health offices have assisted families in person to download the app and go through instructions for usage, however, the COVID 19 pandemic greatly reduced in person visits in the community health offices for most of this reporting year. Staff were still encouraged to find ways to assist families over the phone with downloading and using the app.

6.3. Identify and address gaps in parenting education through health equity lens and provide parenting support to South Dakota parents

- In 2021, the Bright Start Home Visiting Program restructured and added a Home Visiting Program Manager. The Home Visiting Program Manager supervises the home visiting nurses and reports to the MCH Director, which created a more seamless line of communication between Bright Start Home Visiting and the MCH Program. The MCH and Bright Start Teams met for a two-day meeting in Summer 2021 to discuss our programs, priorities, and collaboration opportunities. This collaboration is important to reduce duplication of or gaps in developmental screenings and referrals for evaluation. The Bright Start nurses work directly with families and bring a family perspective to the work being done in MCH.
- The MCH Program continues to strengthen its partnership with SD Parent Connection. Parent Connection is a strong resource for gaining insight and guidance on current and up and coming needs faced by the families they serve. They are a member of the child domain workgroup and the child domain coordinator often refers families to parent connection for resources.
- The SD DOH facilitates a child interagency workgroup. The workgroup meets quarterly and is attended by leadership from the MCH Program, WIC, Community Health, Bright Start Home Visiting, Department of Social Services including Medicaid, Behavioral Health, and Child Protective Services, and the Department of Education including Birth to 3. The agencies and programs report on current projects, goals, and activities, and opportunities for collaboration are discussed.
- The MCH Program began promoting strongfamiles.sd.gov on the DOH website as a resource for parents. This site was created by the South Dakota Governor's Office and provides information on many local resources for parents, including local parenting education classes. In addition, the MCH Program continues to provide connections to SD Birth to 3, CDC Learn the Signs Act Early, Head Start, and SD Parent Connection on its website.
- The child domain coordinator joined a Medicaid well-child affinity group toward the end of this reporting period. The group will meet for two years and focus on improving well-child visit rates amongst the American Indian/Alaskan Native populations in our state. The child domain coordinator will work with the DSS and DOH communication teams to develop printable materials and social media posts promoting well-child visits to pregnant and postpartum American Indian/Alaskan Native women.

Child Death Review

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

The teams use a common data collection tool (Child Death Review Case Reporting System) so that findings can be reviewed by a state-level advisory group for prevention efforts. The state-wide Preventable Death committee meets bi-annually to review data and make recommendations to help turn tragedies into lessons that can prevent other deaths.

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

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

Child Health - Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Child Health Domain for the period October 1, 2022, through September 30, 2023. In the upcoming year, the Child Domain will continue to focus on parenting education and support and improving developmental screening rates in South Dakota.

Priority Need: Parenting education and support

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

Previous ESM: Percentage of Community Health Offices that distribute trifold developmental screening tracking cards

New ESM 6.1: Percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age.

2022-2023 Objective and Strategies

Objective: Increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year from 22.3% (2019-2020) to 36.5% by 2025 (NSCH)

The MCH Child Domain will continue to see many changes in the upcoming grant year. Many factors contributed to these changes, including an office-wide services assessment that resulted in new and improved processes for service delivery, the expansion of Infant Death Review to include all child deaths up to age 13, and the state legislature's approval to increase funding to expand Bright Start Home Visiting services statewide. The MCH Child domain is always evolving to meet the priority needs of families and adapt to changing circumstances in program structure and data collection.

Proposed Strategies:

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

This is a new strategy for the child domain. The previous strategy, "Develop and equitably disseminate a clear and consistent message to communicate the importance of developmental screening to families and community health providers," has been reworded to more broadly address the work being done and create an evidence-based strategy for basis of measurement of the percentage of Bright Start Home Visiting clients who receive a developmental screen. The Bright Start Program will be expanding statewide in 2022-2023 under the supervision and leadership of the MCH Director and will be adding an epidemiologist to assess the program's impact in many different areas, including developmental screening. A new ESM has been created to measure the percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age. This measure will track the progress of the Bright Start Home Visiting Program in providing developmental screens throughout the expansion process and beyond. The measure will replace the previous ESM, "Percentage of community health offices who distribute trifold developmental screening tracking cards." The former ESM was replaced because it does not measure the number or impact of screens taking place, and all community health offices that provide developmental screening consistently distribute the cards. The new ESM will not change the community health offices' continued efforts to distribute developmental screening tracking cards to families but will provide a more accurate measurement of the work being done around developmental screening.

The community health offices in the state will also continue to provide developmental screening, referrals, and

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

The community health offices and Bright Start Home Visiting program will continue to provide training to staff on developmental screening and early identification as part of their orientation. Staff are specifically trained in providing and scoring ASQ developmental questionnaires. Ongoing training will also be provided, and staff will be encouraged to sign up for Brookes' Newsletters. Staff are also trained in using the CDC Milestone Tracker app, Bright by Text app, and Text4Baby and encouraged to assist families with signing up for these services. In addition to technology resources, community health and Bright Start will also offer hard copy resources, including trifold developmental screening tracking cards, milestone checklists, books, and pamphlets to assist families in planning and tracking their child's development and screening.

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

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

With the expansion of infant death review to include all child deaths up to age 13, the child domain will be putting the data collected from Child Death Review into practice by raising awareness of the leading causes of child injury and death through messaging and educational resources. The DOH Injury Prevention Coordinator will be stepping in to lead the MCH child domain in 2022. The Injury Prevention Coordinator will serve as a vital connection between the MCH Program and public safety, violence prevention, and substance use prevention organizations. They will be a part of Child Death Review committee discussions and will create messaging and resources with an injury prevention focus. They will also continue to monitor progress with developmental screening and provide ongoing training resources to staff. The Injury Prevention Coordinator and current Child domain leader will co-lead the child domain until October 2022, when the injury prevention coordinator will assume leadership.

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

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

The new MCH child domain leader will facilitate the MCH child workgroup with plans to expand the workgroup to include injury prevention partners. The group will continue to have representation from the Department of Education, Department of Social Services, Sanford Health, Avera Health, Bright Start Home Visiting, and South Dakota Parent Connection.

MCH and WIC are currently collaborating to add MCH domain leaders to an internal communication site, Knowledge Base, that will provide a clear pathway for communication and training between MCH domain leaders and community health field staff. The site is currently used by WIC leadership to communicate announcements and

training to community health staff. Each MCH domain leader will have their own space within the site to communicate updates, trainings, requests, and obtain feedback from field staff.

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

Ongoing Efforts Supported by MCH for the Child Domain

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

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

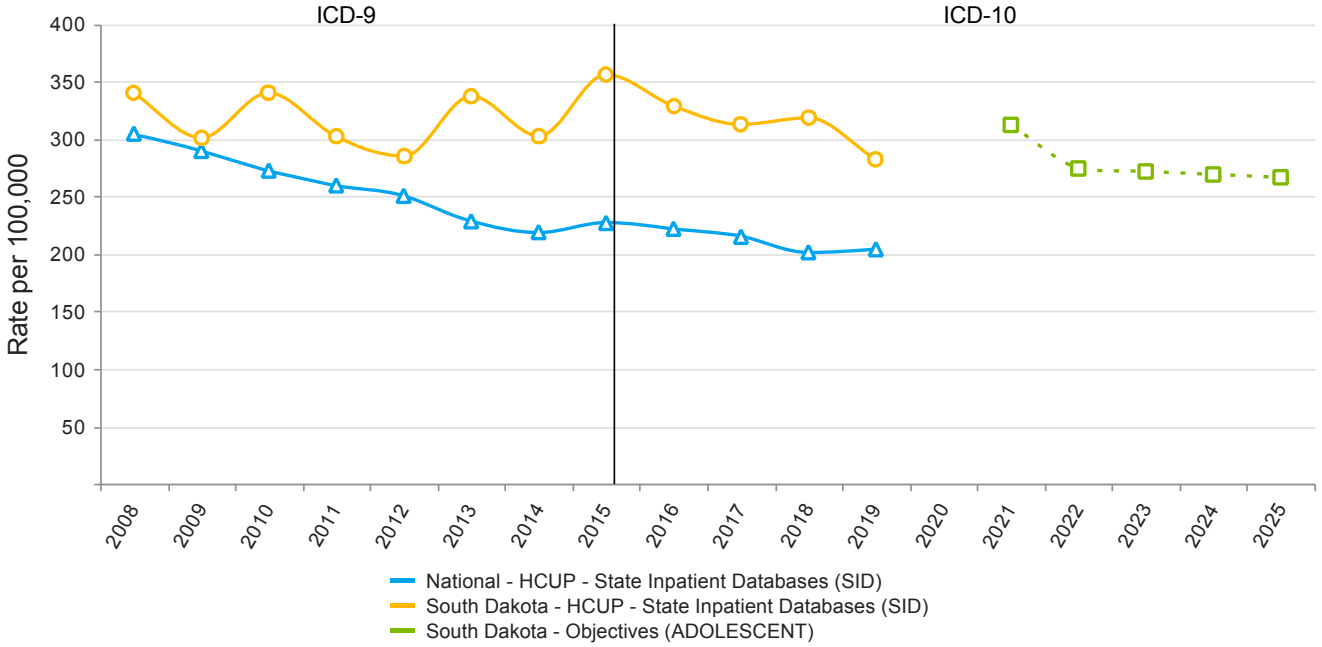
- School Health services, which include basic student health screening, vision screening, scoliosis screening, hearing screening, and health education, are provided at the request of contracting schools. Oral health screening is incorporated with WIC services. Funding supports interpreter services for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

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

Adolescent Health

National Performance Measures

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



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

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

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	274.2	271.7	269.1	266.6

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			60
Annual Indicator			38
Numerator			
Denominator			
Data Source			class training facilitator
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	120.0	180.0	240.0	300.0

State Performance Measures

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 50.9% in 2021 to 55.2% in 2025.

Measure Status:	Active

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

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	52.0	53.1	54.1	55.2

State Action Plan Table

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

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

Priority Need

Healthy Relationships

SPM

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 50.9% in 2021 to 55.2% in 2025.

Objectives

Decrease the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics from 12.5% to 12.1% by 2025 (EHR NetSmart).

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

Strategies

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

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

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

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

Adolescent Health - Annual Report

Adolescent Health: Annual Report

Priorities:

- Suicide Prevention/Mental Health
- Healthy Relationships

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

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

Data Statement:

South Dakota met the target of 282 with a non-fatal injury hospitalization rate of 281.9 per 100,000 adolescents, ages 10 through 19, in 2019. The target was reset at a 10% decrease and the new 2025 target is 253.8 per 100,000 adolescents. The 2018 rate was 318.8 hospitalizations for non-fatal injuries among adolescents, ages 10 through 19. South Dakota ranked 47th in the nation with a significantly higher rate than the U.S. rate of 204.2 per 100,000 adolescents.

State Objective 1:

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

State Objective 1 Data Statement:

South Dakota did not meet the 2020 target rate of 32.5 with an adolescent suicide rate of 34.4 among 15 through 19-year-olds. This is an increase from 33.10 in 2018. South Dakota ranked 48th in the nation with a significantly higher rate than the U.S. rate of 10.8. The change from the base year (2014-2016) is not significant.

State Objective 2:

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

State Objective 2 Data Statement:

The objective was aligned to the South Dakota suicide workgroup's target of 9.0% in 2025. The percentage was based on an average rate of 9.4 from 2011-2019. South Dakota does not have any updated data for this objective, but the 2020 target was 12.0%.

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

- Activity: Provide Youth Mental Health First Aid Training
- Activity: Provide Question Persuade Refer (QPR) trainings for high school staff
- Activity: Provide teen Mental Health First Aid Training

Title V continued to partner with Helpline Center to provide suicide prevention trainings across the state. A new training offered during this reporting period was teen Mental Health First Aid (tMHFA). Teen Mental Health First Aid is a training program for youth by the National Council for Mental Wellbeing in partnership with Born This Way Foundation. Youth are be provided the skills they need to have supportive conversations with their friends and learn how to get help from responsible and trusted adults. TMHFA focuses on youth in grades 10th to 12th or ages 15 to 18 years old. During this reporting period the Helpline Center, Suicide Prevention Director attended a virtual instructor training and provided one teen Mental Health First Aid training to 38 - 10th grade students at Flandreau High School (ESM for NPM 7.2.1).

Additional Suicide Prevention Trainings provided with this partnership:

- Youth Mental Health First Aid Training – 1 training (7 attendees)
- Question Persuade Refer trainings for high school staff – 3 trainings (67 attendees)

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

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

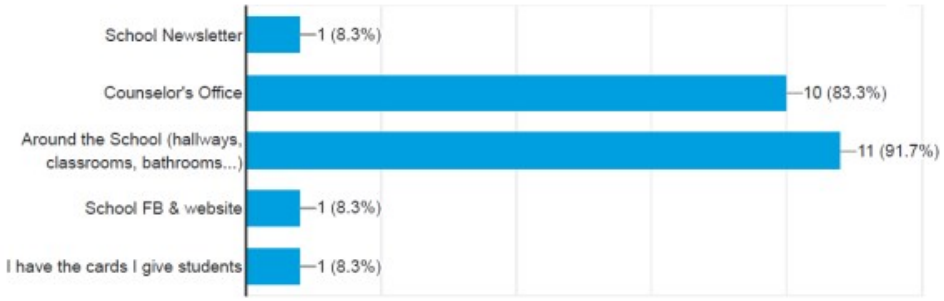
- Number of Text: 141
- Text4Hope Presentations: 19

To understand our current reach with Text4Hope, Title V and the University of South Dakota (USD) developed a short survey for South Dakota high school counselors regarding their school's usage and promotion of Text4Hope. Received 29 responses.

Here are some of the results:

- Is the Text4Hope program a resource that you provide/promote to students at your High School? Yes 48.3%, NO 51.7%

- If you answered yes to the question above, where do you display/share the Text4Hope resources:



- Would you like to request additional materials for use in your school? Yes 79.3%, No 20.7%

With the Text4Hope survey results the Helpline Center was able to send 22 South Dakota schools more information about Text4Hope and set up 10 school presentations. Survey results also highlighted the need for continued promotion.

Additional Text4Hope *NEW* promotions during this reporting period:

- Lutheran Social Services (LSS) added the Text4Hope to their resource card which is passed out at every Healthy Relationship class.
- Miss South Dakota promoted at speaking engagements and on social media
- Developed COR Health + Wellbeing Social Media posts to promote Text4Hope
- Helpline Center promoted Text4Hope on Snapchat
    - Text4Hope Snapchat Ad
        - Duration: 11/11/20 - 12/11/20
        - Impressions: 909,823 (# of times ad was viewed)
        - Swipe Ups: 11,705
        - Swipe Up Rate: 1.29%

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

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

  Positive Youth Development Conference: Title V partnered with LSS to provide the Positive Youth Development Conference. The conference was started to provide an opportunity for those that work with youth and young adults to come together and discuss the latest issues affecting them today. The PYD conference was held online (April 2021) due to safety concern from the pandemic.
  Topics discussed were:

  - Search Institute: 40 Developmental Assets
  - Intentional Relationships
  - Lakota Culture
  - Bullying
  - Human Trafficking

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

  Youth Advisory Council: Title V worked with an MPH Student to develop a youth advisory council plan after receiving additional funding (see the General Department SRAE paragraph below). Title V partnered with LSS of South Dakota to develop a youth advisory council. The first council meeting was December 2020. The council will look at both MCH adolescent priorities - Healthy Relationships and Suicide Prevention/Mental Health. Due to staff turnover and COVID-19, in person meetings were limited.

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

- Activity: Promote suicide prevention and mental health messaging for Cor Health + wellbeing social media

Title V continued to work with Hot Pink marketing agency to develop suicide prevention, mental health posts for Facebook and Instagram.

www.facebook.com/corhealthsd

www.instagram.com/corhealthsd

Since Cor's launch in December 2019, the primary goal has been to provide resources to South Dakota parents and youth (10 to 24 years old). To accomplish this, we've been utilizing Facebook and Instagram carousels to distribute Cor messages on a variety of different subjects such as

mental health, suicide prevention, stress management and injury prevention.

Mental Health: ***Suicide Warning Signs*** carousel (Youth and Parents)

Mental Health > Good to Know: ***Mental Health Screenings*** album (Youth)

During this reporting period the impact of COVID on youth mental health was emerging and experts were warning the toll it was taking. Title V worked with the Hot Pink marketing agency to develop additional messaging focused on mental health related to the COVID-19 pandemic and resources available.

Mental Health: ***COVID/Mental Health - Teens & Stress/Reach Out*** album (Youth)

Feeling overwhelmed? Talk to an adult you trust. Find out more about caring for your mental health: wethinktwice.acf.hhs.gov/mental-health-and-covid-19

Mental Health: ***COVID/How to Help Your Teen Cope*** album (Parents)

The ups and downs of COVID-19 can be especially hard for teens. For ways to help them cope: parentandteen.com/coping-emotions-covid-19/

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

  Title V partnered with USD Center for Disabilities to develop a 4-part Suicide Prevention Video Series. Series focuses on Suicide Prevention, ACEs, Protective Factors, and Mental Health Resources. The video series was developed for parents or those that are working with youth between the ages of 10 to 24 years old. Each part is 5 to 6 minutes long and can be found on the SD DOH website under the youth and young adult section: https://doh.sd.gov/family/Youth/Suicide.aspx. Since the video series was finalized at the end of this reporting period, it will be promoted and disseminated during FY2022 reporting period.

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

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

Adolescent Health Coordinator attended the *Suicide Prevention in Rural Primary Care* two-part webinar series. One take away was that people who die by suicide are likely to have been seen by a Primary Care Provider in the previous month before their death. This is especially true in rural areas where behavioral health resources are fewer and stigma around mental health is greater. The training walked through strategies for primary care providers and provided a step by step Suicide Prevention Toolkit. One activity mentioned was putting materials in office waiting rooms to create an environment that the patient feels comfortable sharing concerns and to share what types of services are available in the community. Title V team began brainstorming ways it could coordinate efforts in the 74 Community Health Clinic/WIC offices across the state. At this same time, the NPM 1 Well Women workgroup was beginning to look at how to initiate depression screening in Community Health offices. The NPM 1 and NPM 7.2 coordinators collaborated to develop two mental health/suicide prevention resources:

1. Suicide Prevention and Mental Health rack card-provides South Dakota resources and mental health/suicide prevention apps.
2. Mental Health poster that could be posted in waiting rooms or exam rooms. (see below)

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

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

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

- Suicide Prevention Director, Helpline Center
- Suicide Prevention Director, Department of Social Services
- Injury Prevention Coordinator, Department of Health
- Director of REACH, Lutheran Social Services
- Pediatric Clinical Nurse Specialist, Sanford Children's Hospital
- Pediatrician/DOH Medical Consultant, Dr. Poppinga
- USD Center for Disabilities, Training Specialist/Adjunct Graduate Faculty

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

Data Statement:

In 2021, South Dakota exceeded the target of 50.2% with 50.9% of 10-19-year-olds reporting they would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do. A new 2025 target has been set at a 10% increase from the previous target. The new 2025 target is 55.2%.

State Objective 1:

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

State Objective 1 Data Statement:

South Dakota met the 2030 target of 12.8% with 12.5% of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics in 2021. A new 2025 target has been set at a 10% decrease from the previous target. The new 2025 target is 11.52%.

State Objective 2:

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

State Objective 2 Data Statement:

South Dakota met the 2020 target of 19.1/1000 with a teen birth rate of 18.7/1000 in 2020. The annual target for 2021 is 18.67/1000. South Dakota ranked 38th in the nation and has a rate that is significantly higher than the U.S. rate of 15.4/1000. The change from the base year (2015) to the current year is significant.

Strategies:

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

- Activity: Provide and promote STI guidelines training to providers serving young people 10 to 24-years-old, including vulnerable/underserved youth.
    - Family Planning conducted a CQI on STD Screening for their clinics, as part of that study a STI training was set up for providers and nurses.

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

General Department SRAE grant: During this reporting period, SD DOH received a new grant, General Department SRAE (Sexual Risk Avoidance Education). This grant will expand the reach of teen pregnancy prevention education to rural areas with high teen birth rates and high STD rates. SRAE funding provides youth with skills on how to voluntarily refrain from non-martial sexual activity. The target population for this programming focuses on Native American youth and vulnerable youth between the ages of 10 to 13 years old living in rural South Dakota.

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

relationship grants and activities.

A new activity was added for the Healthy Relationship priority to develop an evaluation plan for MCH programs and other healthy relationship grants and activities. The Healthy Relationship Evaluation was designed to review program strategies, objectives and indicators; to align youth programming and resource: to improve each individual program and to measure impact on youth and collective effectiveness. Title V will work with the evaluation center, SDSU Population Health to review the MCH healthy relationship priority and five other healthy relationship grants. The five healthy relationship grants are:

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

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

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

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

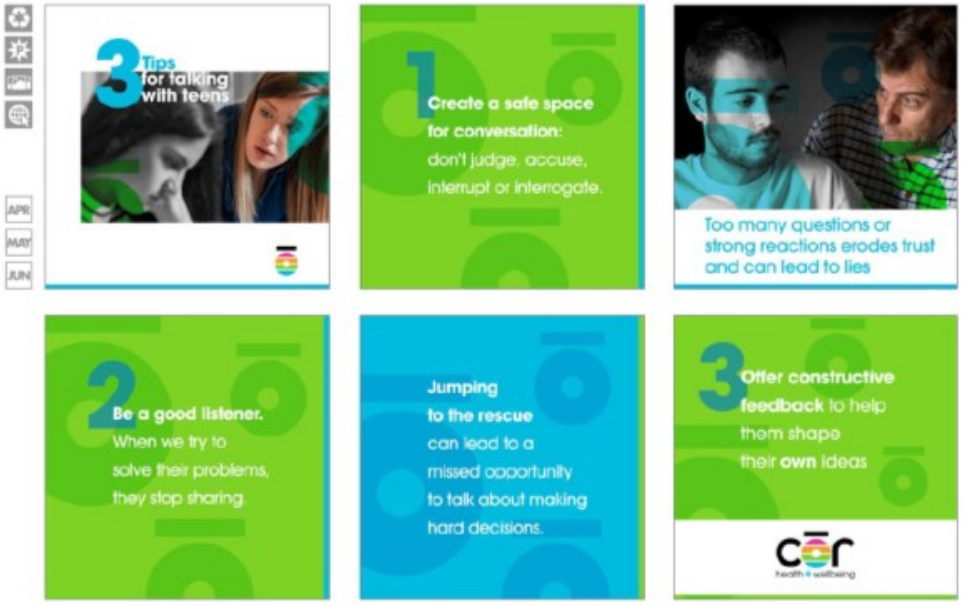
- *NEW* Activity: Develop an assessment tool for Positive Youth Development activities.

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

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

Title V worked with Hot Pink marketing agency to develop 6 carousels for the parent-teen communication campaign. The purpose of the parent-teen communication campaign was to raise awareness among South Dakota parents as to what they can do to promote healthy relationship with their teens, and where to find programs and tools to support ongoing healthy communication. Some key messaging included: *3 ways to ease the tension with your teen; 3 tips to talking with teens' Parent Power!; What you say to your teen matters; 4 ways to ease the tension with your teen, and practice being positive. It Works!*

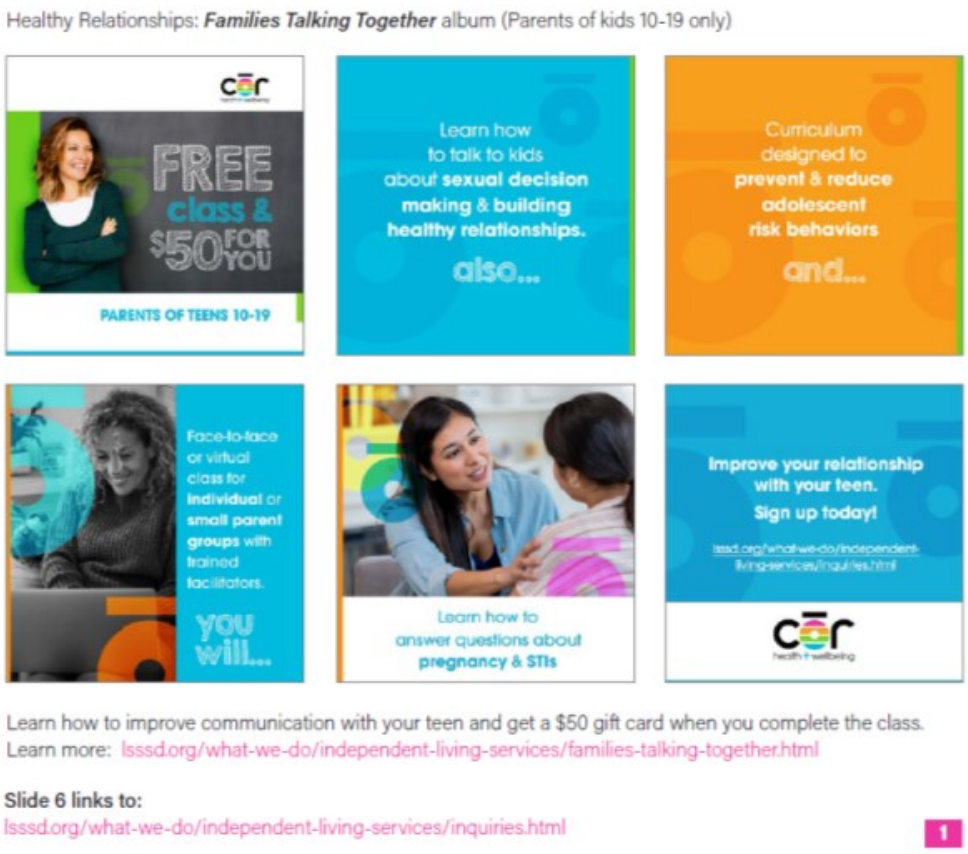
Healthy Relationships: ***3 Tips for Talking with Teens*** album (Parents)



Keep teens safe by setting clear boundaries, promoting open communication, and encouraging them to be their best selves: parentandteen.com/keep-teens-talking-learn-to-listen

Title V collaborated with Federal Youth Services Bureau Personal Responsibility Education Program (PREP) and Lutheran Social Services to develop a social media post to promote the Families Talking Together class. Families Talking Together is a class for parents to reduce adolescent sexual risk behaviors and focuses on parent-adolescent communication; monitoring and supervision; and relationship building activities. Here is the example of the Families

Talking Together carousel:



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

During this report period the STI National Strategic Plan: 2021-2025 was released, the SPM 1 workgroup began looking at this framework to develop new activities to focus on.

There were 3 sections that stood out to the workgroup:

“Awareness education and training are particularly relevant for providers seeing preteen and teen patients. Research suggests that not enough teens get private and confidential time with their providers”

“Among providers caring for preteen and adolescents, strengthening privacy and confidentiality while implementing practices that encourage sexual health assessments and increase risk-avoidance behaviors can further reduce STIs and STI-related stigma and shame.”

“…engagement includes providing a welcoming environment.”

Through these ideas a new activity was implanted to ‘develop youth-friendly services materials for agencies and clinics servicing young people 10 to 24 years old.’

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

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

The MCH SPM #1 workgroup includes the following partners:

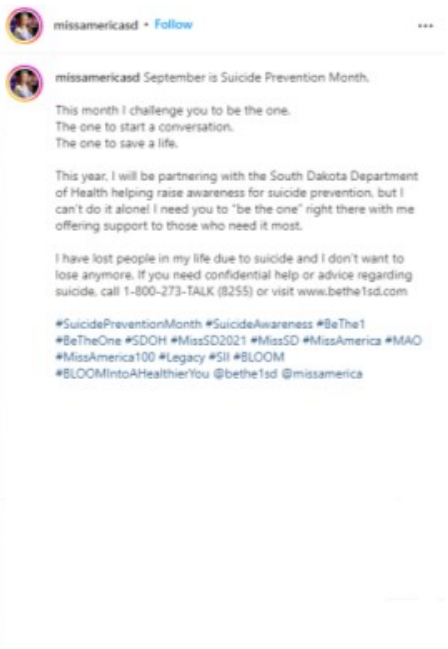
- Director of REACH, Lutheran Social Services
- Pediatrician/Department of Health Medical Consultant, Dr. Poppinga
- Department of Health, Family Planning Manager
- Boys & Girls Club of Watertown, Prevention Specialist
- Department of Health, Sexual Violence Prevention Coordinator

Other Adolescent Health activities during this reporting period:

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

OCFS Community Health Office: Adolescent Health Coordinator continued to collaborate with 74 OCFS Community Health clinics located in 61 of SD's 66 counties that provide public health services to the adolescent population such as contracting with local schools for Community Health Nurses to provide preventive health screening and student health education. Education includes growth and development, injury prevention and suicide prevention for middle and high school students.

Miss America South Dakota: Miss South Dakota Kaitlin O'Neill reached out to Title V to see what resources were available for mental health. Miss SD's social impact initiative was Mental Health and her goal as Miss SD 2021 was to help all individuals no matter the age how to find a healthy balance mentally, physically, and emotionally. She developed a program called BLOOM to help youth and young adults find strategies they can incorporate into their lives and grow towards that balance. Miss SD promoted a variety of different suicide prevention and mental health resources including BeThe1SD and Text4Hope on her social media platforms and at her speaking engagements.


missamericasd • Follow

missamericasd September is Suicide Prevention Month.

This month I challenge you to be the one.
The one to start a conversation.
The one to save a life.

This year, I will be partnering with the South Dakota Department of Health helping raise awareness for suicide prevention, but I can't do it alone! I need you to "be the one" right there with me offering support to those who need it most.

I have lost people in my life due to suicide and I don't want to lose anymore. If you need confidential help or advice regarding suicide, call 1-800-273-TALK (8255) or visit www.bethe1sd.com

#SuicidePreventionMonth #SuicideAwareness #BeThe1 #BeTheOne #SDOH #MissSD2021 #MissSD #MissAmerica #MAO #MissAmerica100 #Legacy #SII #BLOOM #BLOOMIntoAHealthierYou @bethe1sd @missamerica

Adolescent Health – Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Adolescent Health Domain for the period October 1, 2022, through September 30th, 2023. Priority needs identified through the 2020 Needs Assessment process in this domain were: mental health, suicide prevention, and healthy relationships.

PRIORITY: Mental Health/Suicide Prevention

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

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

Objectives

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

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

Proposed Strategies

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

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

Suicide Prevention Trainings: Title V will continue to partner with Helpline Center to provide suicide prevention trainings across the state. Trainings consist of Teen Mental Health First Aid, Youth Mental Health First Aid Training, and Question Persuade Refer.

In the upcoming grant year, Title V plans to work with the School Health Coordinator to expand the reach of Teen Mental Health First Aid and Youth Mental health First Aid trainings. The expansion is provided by to the PHER Workforce Crisis Cooperative Agreement funding. Funding will increase the number of facilitators trained and increase the number Mental Health First Aid trainings provided.

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

There have been multiple requests from partners, teachers, and school professionals to expand and promote Text4Hope to the Middle School age group. During the current FY22 reporting period Title V began discussion on expanding the texting program to this age group. At this time, we have put the expansion on hold as we await the release of the new National Suicide Prevention Lifeline Number 988 phone number and texting number in July (2022). We will continue to promote Text4Hope to High School students for at least one more school year 2022-2023 and decide next steps after the 988 texting number and program has time to be set up.

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

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

voice

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

- Develop an assessment tool for Positive Youth Development activities.

  In the current reporting period, Title V and LSS began looking at how they will evaluate PYD and youth-focused programming. LSS began researching what current tools were developed to measure youth engagement in youth programming activities. In the upcoming grant year, Title V and LSS will continue to develop an assessment tool for PYD activities.

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

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

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

www.facebook.com/corhealthsd

www.instagram.com/corhealthsd

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

Parent Suicide Prevention Training: In the current reporting period, Title V developed a 4-part Suicide Prevention Video Series for parents. Title V and parents disseminated during the 2021/2022 school year through the following communication platforms school newsletters, Cor Health, Dept of Health You tube, and MCH Newsletters. In the upcoming grant year, Title V will continue to promote this training to parents on the SD DOH website - https://doh.sd.gov/family/Youth/Suicide.aspx and develop a post to promote on COR Health platforms.

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

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

PRIORITY: Healthy Relationships

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

Objectives

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

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

Proposed Strategies

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

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

In the current grant year, Title V is working with the Office of Disease Prevention (ODP) STD Coordinator to share awareness on the rise in syphilis cases in South Dakota among youth. ODP provided a 3-part training on syphilis for providers and Title V promotea this training to adolescent providers and teen pregnancy prevention facilitators. In April 2022 ODP presented at the PYD Conference on the latest data on STIs including syphilis and how this might affect our youth. In the upcoming grant year, as syphilis and other STI cases continue to rise in South Dakota, Title V will continue to work with the Office of Disease Prevention to partner on developing and sharing resources for adolescent and those that provide services to youth.

Healthy Relationships Youth Evaluation: In the current reporting period, Title V worked with SDSU Population Health Evaluation to review healthy relationship priorities and also five other healthy relationship grants: Personal Responsibility Education Program (PREP), Title V Sexual Risk Avoidance Education (SRAE), General Departmental Sexual Risk Avoidance Education, Rape Prevention Education, Title X Family Planning Program. In Year 1 of the Healthy Relationship evaluation SDSU developed and reviewed logic models, success stories; and performance measure data.

In the upcoming grant year, the Healthy Relationship Evaluation will continue with the curriculum review and develop new success stories. New special project areas of focus will be social connectedness and looking at the following questions:

- To what extend has connectedness between youth and trusted adults in the communities served been developed?
- How has connectedness at the individual, community and societal levels impacted youths' decision making?

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

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

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

In the upcoming reporting period, the youth advisory council will be active members in the youth-friendly activity and develop materials for agencies and clinics servicing youth. See strategy 1.3.

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

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

- *NEW* Develop youth-friendly service materials for youth, agencies and clinics servicing young people 10 to 24 years old.

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

A new activity for the upcoming grant year will be to develop youth-friendly materials for youth, agencies and clinics serving youth. The World Health Organization describes youth-friendly services as those that are equitable, accessible, acceptable, appropriate, and effective. Title V, Family Planning program, LSS and the youth advisory council have begun collaborating to assess what has already been developed in Youth-friendly materials and develop a plan how this will look for South Dakota.

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

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

Ongoing Efforts Supported by MCH for the Adolescent Domain:

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

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

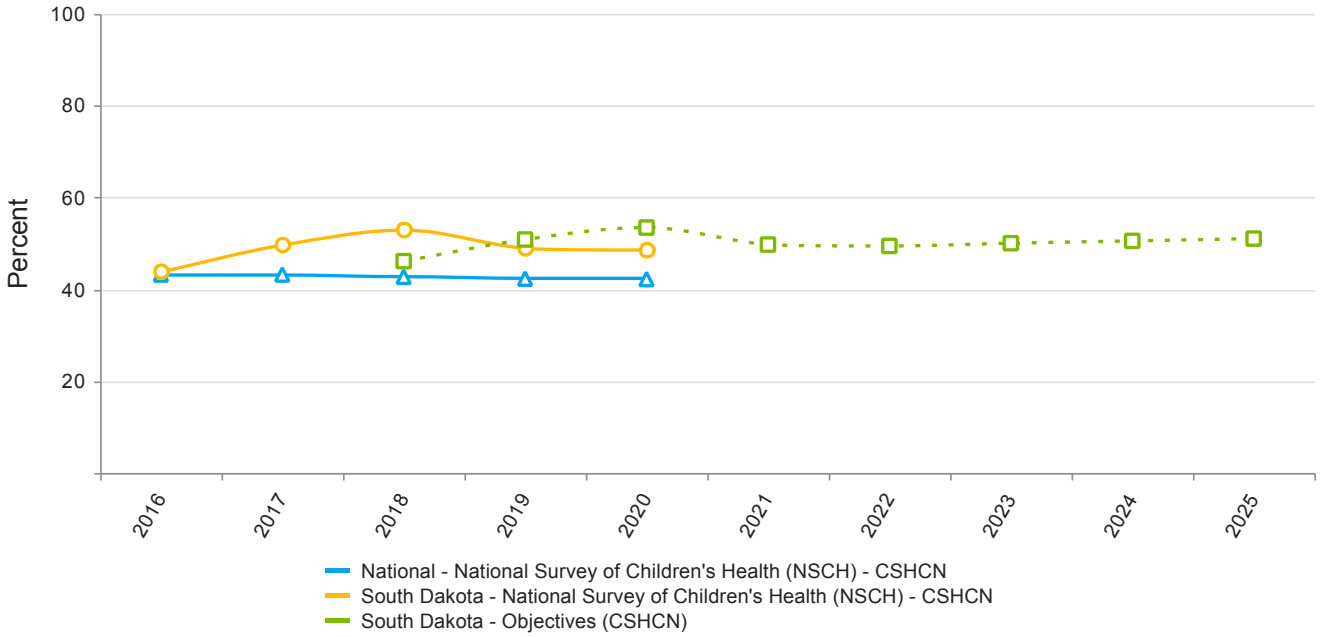
- Continue to collaborate with 74 OCFS Community Health Offices that provide public health services to this Adolescent population such as contracting with local schools to provide preventive health screenings and student health education. Education includes growth and development, injury prevention and suicide prevention for middle and high-schools aged students.

Children with Special Health Care Needs

National Performance Measures

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

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		46.1	50.8	53.4	49.7
Annual Indicator	43.9	49.6	53.0	48.8	48.4
Numerator	14,361	16,789	18,568	17,763	18,368
Denominator	32,704	33,876	35,046	36,404	37,957
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	49.4	50.0	50.5	51.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

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

State Action Plan Table

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

Children with Special Health Care Needs - Annual Report

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

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

Data Statement:

Percent of children with special health care needs having a medical home: South Dakota did not exceed the 2020 target of 49.2% with 48.4% of children with special health care needs having a medical home in 2019-2020. South Dakota ranked 11th in the nation with a U.S. rate of 42.2%. The change from the base year (2016) to this year is not significant.

Percent of children without special health care needs having a medical home: South Dakota did not exceed the 2020 target of 55.7% with 54% of children without special health care needs having a medical home in 2019-2020. In 2019-2020 South Dakota was ranked 11th in the nation with a significantly higher rate than the U.S. rate of 47.9%. The change from the base year (2016) to this year is not significant.

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

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

State Objective 1:

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

State Objective 1 Data Statement:

In 2019-2020 South Dakota exceeded the 2030 target of 19.5% with 20.9% of children with special health care needs receiving care in a well-functioning system. A new annual target was set at 21.1% and a new 2030 target was set at a 10% increase. The new 2030 target is 21.45%. South Dakota was ranked 5th in the nation and is higher than the U.S. rate of 14.4%. The change from the base year (2016) to this year is significant.

Strategies:

11.1. Enhance equitable family access to needed supports and services

The Western half of the state is underserved in the area of pediatric genetics testing and counseling. Through a contracted partnership with Sanford Health, the CYSHCN Program assists with operational costs for the Sanford Children's Specialty Clinic in Sioux Falls, SD to send a geneticist and genetics counselor to Rapid City, SD eight times per year to conduct genetics outreach clinics. In 2021, a total of 54 individuals were served through this partnership.

Families and caregivers often face higher costs when purchasing car seats with the necessary adaptations to safely transport their child/young adult in a vehicle. To assist families with the higher costs, the SD CYSHCN Program, in partnership with the Department of Social Services Child Safety Seat Distribution Program, funded 29 special needs car seats and accessories in 2021. The funds were used to cover the car seat costs for individual families as well as for car seats and accessories that are used as short-term loans by our major health care systems.

Caring for a child with special health care needs can be physically and emotionally demanding for a parent or caregiver. They may need a break to recharge, take care of other family members or tasks, or attend to self-care. In order to provide families and caregivers with much needed rest, the CYSHCN Program, through an interagency agreement, provides financial support to the SD Department of Human Services Respite Care Program. The Respite Care Program authorizes families to receive funding for temporary respite care from a provider of the family's choosing. The program is available to any family regardless of income with a live-in child or adult who has a developmental delay, disability, emotional disturbance, severe and persistent mental illness, chronic medical condition, or a traumatic brain injury. The program served 586 individuals statewide in 2021.

The CYSHCN Program's direct service reimbursement program, Health KiCC, continues to be phased out while still running for the participants enrolled. In 2021, a total of 15 participants remained in the program. The program operates as a secondary payer and covers remaining expenses after insurance payment for clinic and hospital services, laboratory, medications, and medical supplies. The program also reimburses participants for travel expenses incurred. If a participant is uninsured, the program reimburses services at the Medicaid rate.

In 2021 a new page was created on the DOH website listing the programs and services supported by the CYSHCN Program. The page is located at https://doh.sd.gov/family/childhood/CYSHCN.aspx.

The CYSHCN Director has established and maintained a partnership with SD Parent Connection to help better connect families to resources in our state. A Parent Connection representative serves as a family delegate on the NPM 11 workgroup and brings a unique family perspective to the discussion, informing the group on best practices and providing suggestions for improvement. The CYSHCN Director ensures all families who contact the office for resources are aware of SD Parent Connection and provides direct contact information.

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

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

In 2021, the Sanford Patient Navigation Program, in partnership with the CYSHCN Program and South Dakota State University (SDSU) Population Health, completed its first year of implementation. The program consists of a Registered Nurse Patient Navigator housed in the Sanford Children's Hospital in Sioux Falls, SD. The Patient Navigator provided extensive care coordination services to the first cohort of 30 participants. The participants were chosen by Sanford based on criteria provided by the CYSHCN Program. The first cohort criteria included the following:

- The participant must be under 18 years old
- Participant must have a very complex medical condition (3 or more systems involved)
- Participant must have Medicaid or be uninsured

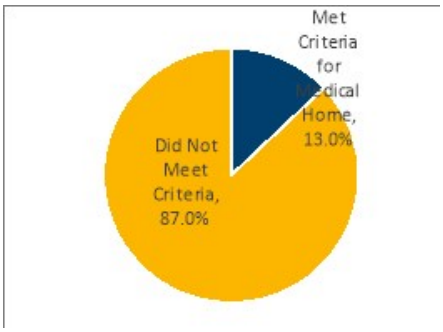
- Preference should be given to participants who live further than 100 miles from Sioux Falls

Participants were given the option to voluntarily participate in the evaluation portion of the program, provided by SDSU. A financial incentive was provided to the families for participation in the evaluation. The evaluation portion consisted of a pre and one year post family survey, an affiliated professional survey, and an ongoing evaluation based on a care coordination management tool used by the Patient Navigator.

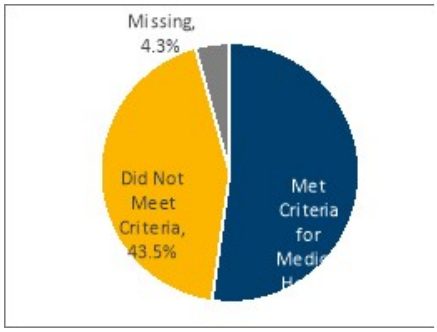
The post survey was completed in the fall of 2021 and had a 79% response rate from the participants. Most notable results included:

- Families meeting criteria for receipt of care in a medical home went from 13% at enrollment to 52.2% at one year.
- Parental awareness of a shared plan of care went from 17% aware of their child's shared plan of care at enrollment to 74% aware at one year.
- Nearly 61% of families reported they have not received the extra help with care coordination they need at enrollment. At one year, no families reported unmet needs with care coordination.

Enrollment

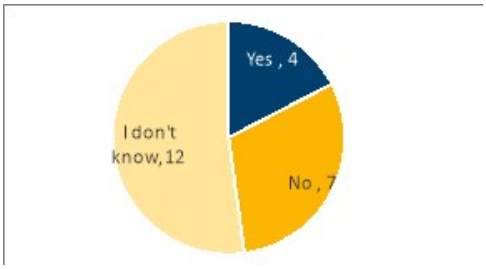


Post-Survey

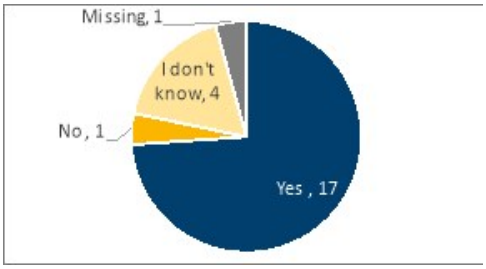


Parental awareness of shared plan of care

Enrollment



Post-survey



Comments from families about the program:

"Amazing, so so grateful!"

"I'm so thankful they have programs like this. It makes parenting a special needs child much less stressful. Great job on helping us out!!"

"Love it!"

"Never get rid of this program!"

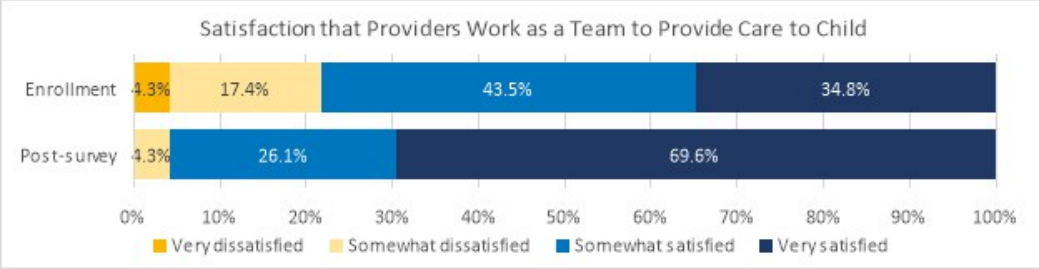
"This program has helped my family so much and I greatly appreciate everything."

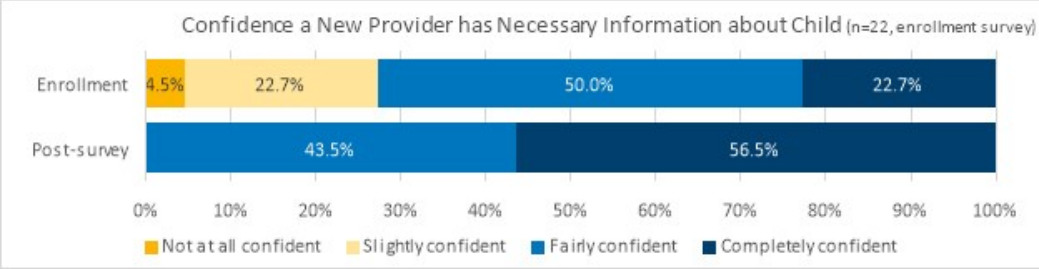
"(Patient Navigator) was amazing and helped us with everything we needed! I had no worries when I called her to help."

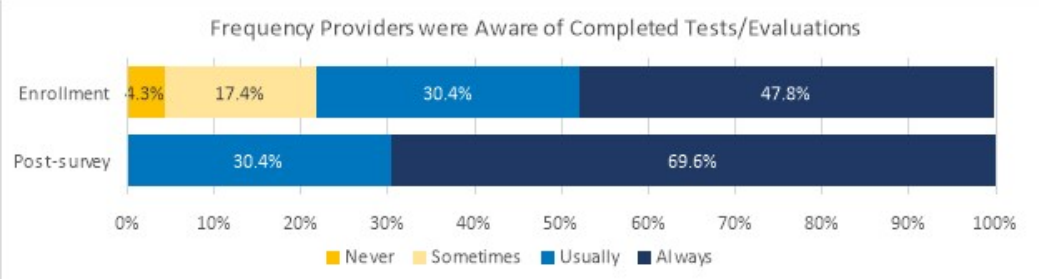
"Very helpful."

We are very happy here and I'm encouraging my family to come here.

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







The full report on post-program outcomes and perceptions of the cohort one families is available in the supporting documents of this application.

Recruitment is currently underway for the second cohort, with modified criteria based on program data and feedback received from the first cohort of families. The first cohort (as well as families who declined to join the first cohort) reported a greater need for these types of services when their children were younger, and the family was early on in their journey to navigate the system.

"*Again, would be a great service for those medically complex kids getting discharged from the NICU, we have a good grasp on my child's issues as we have been doing it for 3+ years now."*

Based on this feedback, cohort 2 will have a higher percentage of children under age 5. In addition, the very complex medical condition requirement was also removed for the second cohort in order to evaluate the effectiveness of the program on different patient populations. Upon reviewing the first cohort demographics, additional income verification measures were added to the selection process as well. In 2022, a certified nurse

practitioner will be added to the program to enhance the services the program offers.

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

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

In 2021, the Newborn Screening Program established the South Dakota Newborn Screening Advisory Committee, consisting of pediatric specialists, laboratory personnel, nurses, pediatricians, families, and community members interested in learning more and providing input on the program. The committee was formed to bring professionals and families together and will convene on an annual basis to receive updates from the newborn screening program, provide program input, and discuss additions of new disorders to the South Dakota panel of disorders.

The first meeting was held in April of 2021 and had a good turnout of both professionals and family and community members. During this meeting, the committee recommended the addition of both Spinal Muscular Atrophy (SMA) and Pompe disease to the South Dakota panel of newborn screening disorders. As of June 28, 2021, all South Dakota newborns are now screened for SMA through Iowa SHL's current SMA screening process. Because the Iowa newborn screening program does not currently screen for Pompe disease, the Iowa SHL does not have the infrastructure in place to screen for Pompe. In response to the RFP released by the SD newborn screening program for laboratory screening services (including Pompe disease screening), the Iowa SHL created a plan and timeline for Pompe disease screening implementation. We are currently in the planning and preparation phase of Pompe disease screening. Full implementation will take place in late summer 2022.

During this grant period, the MCH team continued to partner with SHL for newborn screening testing and destruction of specimen collection cards. The Newborn Screening Program Manager participated in Iowa SHL's monthly partnership calls among the four state newborn screening programs; Alaska, Iowa, North Dakota, and South Dakota. In addition, the NBS Program Manager attended the 2021 Virtual APHL Newborn Screening Symposium.

Some additional data highlights from this reporting year:

- 99.3% (11,838/11,922) of the birth certificates had matching newborn screening laboratory results.
- 413 infants had either presumptive positive or borderline newborn screening results. Of these 413 infants, contact was lost with the parent/guardian of one infant, and one infant's parent/guardian refused to pursue diagnostics.
- SHL reported that 95.9% of newborn screening results for FY21 were provided to SD healthcare providers <= 7 days of age.
- SHL reported that 2.1% of specimens received were deemed unacceptable (poor quality).
- SHL reported that 93.4% of time-critical results were reported within 5 days of birth.
- SHL reported that 100% of non-critical screening results were reported within 7 days of birth.

Children with Special Health Care Needs - Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Children and Youth with Special Health Care Needs (CYSHCN) Domain for the period October 1, 2022 through September 30, 2023. The CYSHCN Domain will continue to focus on improving access to care and services in the upcoming year.

Priority: Access to care and services

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

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

2022-2023 Objective and Strategies

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

Proposed Strategies:

11.1: Enhance equitable family access to needed supports and services

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

- Provide financial support to the DHS respite care program for families of CYSHCN and continue to refer families to the program to enhance equitable access to respite services across the state. This program will be contracting translation services in 2022 to translate all of their materials to Mandarin, Spanish, Amharic, and the Karen language. This is a long-awaited change and will increase family access to these services.
- Provide financial support for operational costs of genetics outreach clinics in Rapid City, SD. This support allows the Sanford Children's Specialty Clinic to send geneticists and genetics counselors to Rapid City, SD for 8 one-day clinics set up throughout the year.
- Partner with DSS to support equitable provision of special needs car seats through the Child Safety Seat Distribution Program. The CYSHCN Program plans to focus on raising public awareness of these services in the upcoming year.
- Explore additional opportunities to link families of CYSHCN to needed resources in our state. The CYSHCN Director will continue to work closely with partners to identify new and existing resources available to families in South Dakota.
- Provide financial support to eligible families of CYSHCN through Health KiCC program while continuing to phase the program and explore alternative resources for remaining participants.

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

- Partner with Sanford Health to provide care coordination services for families of children with complex medical conditions at Sanford Children's Hospital. This program has added a Certified Nurse Practitioner and will be expanding over the next year to include the addition of transition services to assist participants age 18-21 with transitioning to adult care.
- Collect and review data from Sanford Children's Patient Navigation Program to identify needs and health disparities and inform program planning.
- Explore new opportunities for expansion of care coordination services in the state. In 2022, the CYSHCN Program resumed discussions with Avera Health System around opportunities to provide care coordination services to Avera patients. This project was previously discussed with Avera but was placed on hold in 2021

due to the COVID 19 pandemic. Discussions will continue in 2022 with the goal of establishing services in late 2022 or 2023. Many areas of need are being explored, including the areas of mental and behavioral health and suicide prevention. Discussions also include looking into different models of service delivery, including community programs and workers, social services, and the medical community.

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

- Contract with the Iowa State Hygienic Laboratory for the newborn screening and initial follow up of all South Dakota births.
- Partner with Sanford Children's Specialty Clinic to contract medical consultants, genetics counselors, and a follow up nurse to address equitable and appropriate testing, treatment, and follow up for out-of-range results and presumptive positive cases.
- The Newborn Screening Advisory Committee will continue to convene on an annual basis to give families and providers an opportunity to come together, share updates, and obtain feedback.
- The contracted Iowa Health Lab is working on infrastructure to screen for Pompe disease. Full implementation of Pompe screening is expected to take place in late summer 2022.

Additional Efforts Supported by MCH for the CYSHCN Domain

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

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

- The CYSHCN Director currently facilitates the MCH workgroup specific to NPM 6 – parent completed developmental screenings. The CYSHCN program supports the cost of early identification and referral of children with possible developmental delays via the purchase of Ages & Stages Developmental Screening instruments and staff time to refer families for further evaluation if a concern is identified on the screening. The NPM 6 workgroup will be under new leadership in late 2022 as the DOH Injury Prevention Coordinator steps in to lead the child domain. The CYSHCN Director will orientate the injury prevention coordinator to the child domain.

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

Collective, which meets quarterly and brings professionals, families, and individuals with intellectual and developmental disabilities together.

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

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

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

Cross-Cutting/Systems Building

State Performance Measures

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

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			4
Annual Indicator			3
Numerator			
Denominator			
Data Source			Count of projects
Data Source Year			2021
Provisional or Final ?			Final

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

Measure Status:		Active	
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	56.0	57.8	59.6

State Action Plan Table

State Action Plan Table (South Dakota) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Data Sharing and Collaboration

SPM

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

Objectives

Increase the extent to which data equity principles have been implemented in SD MCH data projects from 54.2% in 2021 to 59.6% in 2025.

Strategies

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

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

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

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

Cross-Cutting/Systems Builiding - Annual Report

Priority: Data sharing and collaboration

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

2021-2025 Objectives and Strategies:

Objective:

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

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

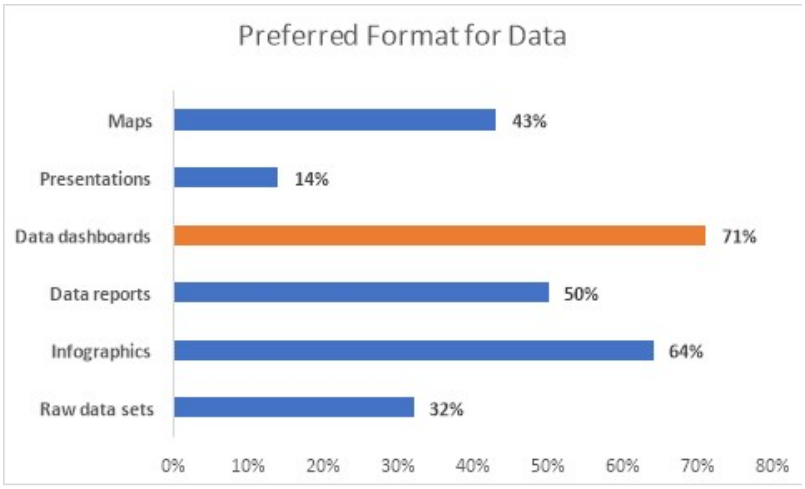
Data Statement

During the reporting period, three new MCH data sharing projects were accomplished. This included the MCH newsletter, the Medicaid/DOH collaboration on maternal morbidity and mortality, and the 2019 SD PRAMS report. These projects are discussed in greater detail throughout this report. The MCH team also formed two new partnerships for data collaboration, which included Medicaid and the South Dakota Maternal Mortality Review Committee (MMRC). The MMRC consists of many new, multi-disciplinary partners but are just counted as one partner for the purpose of this objective. These are also explained in further detail in this report.

Proposed strategies:

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

- MCH Data Use Survey
  The MCH data survey was sent out in the April 2021 MCH newsletter. It was also sent out to MCH domain leaders so that their workgroup members could distribute it to additional partners. Thirty-two partners responded to the survey. Overall, partners wanted more data at a county and local level, and wanted data shared through dashboards.



  Partners indicated that evaluation of a program was the most common reason they used SDDOH data, followed closely by applying for grants and supporting a new program. This and other information from the survey will be used to inform work for the next year. This activity was removed from this year's action plan since it was completed.

- Data dashboard with MCH data
  The MCH epi and OCFS data analyst took a Tableau training so they would have the skills needed to create a data dashboard. An infant mortality dashboard was created for the SDDOH website https://doh.sd.gov/statistics/infant-mortality/.

  The MCH epi applied to host an MCH epi intern for the summer of 2021 and was matched with a Masters of

Epidemiology student from Emory. The project focused on creating a plan for officewide data reporting and visualization that includes overarching MCH outcomes and program specific data. The intern researched the outcomes (e.g. reduce obesity, reduce youth suicide, and increase breastfeeding rates) to find the best data sources and indicators for each outcome. The intern also decided how to report that data (e.g. at state or county level, by race/ethnicity, by other demographic characteristics, etc.). The intern also created a health equity principles in data visualization checklist for staff and started on a data dashboard with SD PRAMS data. The MCH data staff along with a WIC data specialist used the indicator spreadsheet to start building an internal data dashboard for staff to use.

- MCH Newsletter The MCH newsletters were sent out quarterly to over 200 MCH partners. The newsletter included a "Data Bytes" section that highlighted MCH data and new reports.

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

- Updated Infant mortality report The MCH Epidemiologist, OCFS data analyst, and infant domain leader reviewed other states' child death review/infant mortality reports to brainstorm what a new South Dakota report could look like. They preferred Louisiana's Child Death Review report and were able to meet with two of the staff who had worked on this report. The Louisiana staff answered questions the South Dakota staff had around data reporting and gave helpful tips about how to visualize the data and include special sections such as considerations for CYSHCN, health disparities, and data to action. The MCH epidemiologist began work on the infant mortality report that will include vital statistics data, data from Child Death Review, and PRAMS data. The goal was to complete the report by the end of 2021.

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

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

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

- SD Maternal Mortality Review Committee A new maternal mortality abstractor began with South Dakota in April 2021. SD DOH was able to sign data sharing agreements with the three major health systems in the state. The abstractor has access to these records along with information from the health information exchange (HIE), vital records, WIC, and Medicaid. The new abstractor signed up with the MMRIA platform and started abstracting cases. The maternal mortality abstractor, MCH Epi and MCH/Title V Director all participated in the MMRIA user meeting held in April. The team held their first SD MMRC meeting in July 2021. It was a virtual orientation meeting and covered the purpose, scope, and mission of the group, along with current maternal mortality data and plans for future meetings. The first case review meeting will be held in-person in October 2021.

New Efforts:

- Maternal and Child Health Policy Innovations
  South Dakota was selected to participate in the National Academy for State Health Policy Maternal and Child Health Policy Innovations Program. A group of 8 states will work over the next two years to build state capacity to address maternal mortality for Medicaid-eligible pregnant and parenting women. The MCH Epi is a member of the South Dakota team to provide data support. The epi started working with an ArcGIS consultant to map all 2020 Medicaid births and the travel times between their place of residence and the facility where they delivered. This will help inform a policy proposal for pregnancy as a qualifying condition for a medical home.

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

- Nutrition Education Marketing Plan for WIC
  Each year the SD WIC program drafts and follows a Nutrition Education Marketing Plan (NEMP) that is utilized in the community health offices across the state. It consists of a needs assessment, goal setting, and evaluation for those providing WIC services. As recommendations from the OCFS services assessment were finalized, the MCH epi started revising this plan so that it is an office wide plan for implementing WIC goals and MCH goals through the community health offices. One shared goal across the state will focus on infant mortality and will align with the work being done in NPM 5. It will be changed from a yearly plan to a 3-year plan, allowing for more time to carry out activities and evaluate the plans. Another goal is that OCFS priorities will continue to align across programs and staff will see how their work contributes to outcomes across the office, including within the MCH program. The internal data dashboard being created aligns with these goals and will inform priority setting and strategy creation.

- South Dakota Preventable Death Committee
  SD DOH formed a multi-disciplinary group with both state government partners and other statewide agencies to look at preventable deaths across the lifespan. This group looks at infant, child, and maternal deaths, along with those deaths identified through SD National Violent Death Reporting System. The goal is to identify common causes or risks for death across age groups to inform prevention efforts with partners. The MCH Epidemiologist reported on maternal death data and MMRC updates to this group.

- Equity in SD MCH data
  This year the MCH data sharing and collaboration workgroup discussed ways to measure their work. Out of this conversation came the idea that their focus is around equity in data sharing and collaboration. The workgroup decided on a set of 6 guiding principles for equity in data. The AMCHP epi intern also produced a equity in data visualization checklist to staff in carrying out these principles. The State Epidemiologist reviewed this checklist and is interested in using it across the SDDOH. The workgroup will begin to measure its work to the extent to which data equity principles have been implemented in SD MCH data projects using a scoring rubric created by the MCH epidemiologist.

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

- PRAMS: MCH continued to conduct CDC Pregnancy Risk Assessment Monitoring System (PRAMS) through a contract with South Dakota State University. 2019 PRAMS data was weighted and sent to South Dakota. SD PRAMS produced multiple reports from this data including the following:
  - 2019 Data summary report by maternal race, August 2021
  - 2019 Data summary report by WIC participation, September 2021
  - 2017-2019 Data summary report among WIC participants by public health service region, September 2021
  - 2019 Data report and summary report for American Indian mothers by reservation counties, PRAMS data report booklet, September 2021
  - 2019 Opioid Supplement Summary, August 2021
  - 2019 Disability Supplement Summary, August 2021

Challenges and Emerging Issues:

- Data sharing and collaboration has proven a difficult area to measure. During this reporting period, much research, thought, and discussion took place with the workgroup members to come up with a way to measure this work. All the SPM's strategies focused on equity in data, so it seemed fitting that the group tried to measure if this was occurring. The group agreed on six equity in data principles:
    - Partner with communities
    - Address the root causes of inequity
    - Report disaggregated data
    - Honor indigenous data sovereignty
    - Move beyond maps and numbers
    - Build alliances with other government agencies to advance equity

The scoring rubric for these 6 principles is as follows:

- 0=principle has not been implemented
- 1=there has been discussion around this principle but no action
- 2=there has been some action around this principle
- 3=considerable and consistent action has been made in this area

The full tool can be found in the supporting documents.

Cross-Cutting/Systems Building - Application Year

Priority: Data sharing and collaboration

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

2021-2025 Objectives and Strategies:

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

The objective was changed in 2021 from measuring the number of new data projects and data partners to measuring how data equity principles are applied in MCH data projects. This came after much discussion between the MCH epidemiologist and other data partners on the SPM 2 workgroup. It was identified that at the heart of data sharing and collaboration strategies was an emphasis on health equity. Data and data visualization can advance equity and it is a topic that has meaning to the group as we look for ways to improve data sharing and collaboration with groups such as South Dakota Native American Tribes. In FY22, the workgroup began using the SD equity in data tool to score MCH data projects. This gave the baseline percentage of 54.2%. The tool is included in the supporting documents. After the shift in focus and measurement was determined, SPM 2 was discontinued after FY21 and implementation of SPM 3 went into effect in FY22.

Proposed strategies:

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

- Data dashboard with MCH data
  The Office of Child and Family Services internal data dashboard was completed in February 2022. This dashboard will be used to carry out the Strategic Community Outreach and Outcomes Plan (SCOOP), a county level needs assessment and action planning process for all community health offices in South Dakota. During the next reporting period, the MCH epi team will continue to make updates to the dashboard. The SPM 3 workgroup will brainstorm how access to this dashboard could be granted to the public or how it could be used as a model for a public facing MCH dashboard.

- MCH Data Publications
  The MCH newsletter continues to be sent out with a “Data Bytes” section focused on new MCH data. The MCH epidemiologist will continue to submit MCH data such as new PRAMS reports to the SD Department of Health (SDDOH) Newsletter and SDDOH Public Health Bulletin. The SPM 3 workgroup will determine if there are other publications that could be used to disseminate MCH data.

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

- South Dakota Maternal Mortality Report
  The first full year of SD MMRC meetings and data collection will conclude in October 2022 and then the MCH epidemiologist plans to create a report with this information, including contributing factors and recommendations for prevention that can be shared with statewide partners.

- Update MCH data briefs
  The OCFS data team is taking a training through Depict Data Studio on dashboard design. The team will use this knowledge to create static data dashboards with FAD data and other sources for each MCH workgroup. These dashboards could also be shared with partners. The team is also thinking about static dashboards that could be made for the OCFS electronic health record reporting, OCFS quality improvement projects, and reporting county level data to communities. The MCH epidemiologist is also working with an MPH student on a Women’s Health Report card that will be finished during the next reporting period. It will highlight a variety of women’s health indicators.

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

- Death Review Social Determinants of Health Data
  The OCFS data team has been reviewing variables from Child Death Review, Maternal Mortality Review, and SD-Violent Death Reporting System to understand the data that can potentially be collected for social determinants of health. The team has created a crosswalk of these factors and is analyzing the data to understand the completeness of the data and barriers to collecting this information. In the next reporting period, the team hopes to share a report with the South Dakota Preventable Death Committee so that the group can share this with statewide partners and work on prevention strategies with these social and

environmental factors.

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

- ASTHO Data Linkage Project
  SD DOH was recently awarded funding and accepted into the ASTHO PRAMS data linkage community cohort. DOH will be linking SD PRAMS to Medicaid claims data to continue work around maternal morbidity, mortality, and a potential pregnancy medical home. The MCH epi leads this team. The group is interested to learn more about the intersection of substance misuse and mental health disorders; access to preconception, prenatal, and postpartum care; access to SUD treatment; and postpartum birth control for the Medicaid population.

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

Over the past reporting period, the SPM 2 (now SPM 3) workgroup decided to be more intentional about data collaboration and sharing with Tribal partners cross South Dakota. A new strategy was added to address this need.

- Sharing PRAMS data
  We will work on engagement with tribal leaders to learn their preferred method of sharing county level data from Tribal land (i.e. PRAMS tribal reports). We will work through existing partnerships and outreach through our health equity coordinator who has frequent meetings with the Tribal Health Directors.
- Tribal data to action
  We will work with Great Plains Tribal Leaders Health Board to understand what tools the Tribes need to put data into action and how we can partner with them in their efforts.

Completed Efforts:

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

Infant mortality report

The Maternal Child Health Epidemiologist completed the South Dakota Infant Mortality and Prevention report in December 2021. This activity has been removed from the state action plan and replaced with a South Dakota Maternal Mortality Report for the next reporting period.

Launch of the SD-MMRC

The SD MMRC held their first review of maternal mortality cases in October 2021. The group continues to meet, collect data, and discuss prevention strategies. This activity has been removed from the state action plan and an activity for the production of a SD Maternal Mortality report has been added under strategy 2.2.

Collaboration with DSS to analyze Medicaid data on maternal mortality and morbidity:

This project was supported with technical assistance from the Medicaid Innovation Accelerator Program. Although this analysis was completed and removed from the state action plan, DOH and Medicaid are still working together on several data related initiatives outlined elsewhere in this application.

New Efforts:

- Maternal and Child Health Policy Innovations

South Dakota was selected to participate in the National Academy for State Health Policy Maternal and Child Health Policy Innovations Program. A group of 8 states will work over the next two years to build state capacity to address maternal mortality for Medicaid-eligible pregnant and parenting women. The MCH Epi is a member of the South Dakota team to provide data support. The epi worked with an ArcGIS consultant to map all 2020 Medicaid births and the travel times between their place of residence and the facility where they delivered. The epi will continue to provide data support to this project as needed to inform a policy proposal for pregnancy as a qualifying condition for a medical home.

- Office of Child and Family Services Assessment of Services
  The Office of Child and Family Services underwent a multi-year services assessment with Health Management Associates (HMA) in 2020-2021 to understand how to make services more accessible to clients, sustainable, and equitable for South Dakotans. Workgroups were formed around organizational structure, external partnerships, program data, financial data, CQI and evaluation, digital services delivery, and communications. The MCH epi leads the combined data/evaluation/CQI workgroup. The group has four main strategies to focus on: 1) Maximize the use of new and current tools to collect and report critical program and officewide data; 2) Create dashboards and reports of critical data and information to share more broadly with staff so it is actionable, relevant, and usable for internal and external partners; 3) Identify specific staff with CQI and evaluation responsibilities; 4) Develop a data collection and analysis infrastructure for client satisfaction and program outcomes. The group will continue to work on these strategies (many which align with this SPM 3 workgroup) over the next reporting period.

- SCOOP
  The MCH Epidemiologist revised WIC's Nutrition Education Marketing Plan to be an office wide action plan that still fulfills WIC requirements. The Strategic Community Outreach and Outcomes Plan (SCOOP) focuses on four main goal areas of breastfeeding, nutrition, outreach, infant mortality, and there is an option for a fifth health outcome of interest. During the next reporting period, community health clinics from across the state will finalize their SCOOP plans and the OCFS data team will review and assist with evaluation plans. The new plans will be implemented in 2023.

- MCH interns:
  The MCH Director and MCH epidemiologist will be advising three MCH student interns this summer. One intern is through the GSEP and the other two through the MCH/Title V program. These interns will support the SCOOP process, specifically in the priority of outreach and evaluation. They will complete numerous projects include qualitative analyses, surveys, literature reviews, process evaluation, tool kits, and training tools.

- OCFS Electronic Health Record
  The Office of Child and Family Services launched a new electronic health record in January 2022. The Health Informatics Analyst was a new position created by OCFS and hired in August 2021. This position will oversee the EHR development and launch, deliver technical assistance to staff, create and run reports, and analyze data coming from the EHR. This EHR will have data from family planning, nurse visiting, and community health services. During the next reporting period the OCFS data team will begin to analyze new data from these programs and services and link risk factors to outcomes.

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

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

III.F. Public Input

The Department of Health (DOH) made the FY 2023 MCH block grant priorities and action plans available for public review and comment via the DOH website and an email blast to our full stakeholder listserv. MCH Team members were asked to share with any additional partners that would be involved in MCH activities and initiatives, and stakeholders were asked to share the notice widely among the populations they serve. The public comment posting can be found here:

https://doh.sd.gov/documents/MCH/2022/FY23_MCHGrant_PublicCommentNotice.pdf

The DOH received one comment and a couple requests for the full application once it is completed and printed.

The comment came from Unite Us, a technology company that builds coordinated care networks of health and social service providers. Unite Us is a new commenter for South Dakota. The comment's primary statement reads:

"*Overall, Unite Us agrees with the areas of priority needs and the measures selected to evaluate those areas. We recommend that OCFS emphasize addressing SDoH (*social determinants of health*) that influence maternal and child health and create collaborative partnerships with CBOs, government agencies, hospitals and health systems, health plans, and the safety-net systems within their MCH Block Grant Submission."*

The MCH Director responded directly to the comment and requests for the printed application and encouraged their ongoing input and participation in planning and implementation efforts. The MCH Team meets regularly to discuss methods of improving communication with partners and the public to foster a greater understanding of Title V activities and collaborations as well as to further promote community involvement in these activities.

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

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

III.G. Technical Assistance

Technical Assistance

In the last year, the MCH domain leaders, WIC central office staff and MCH Director and CYSHCN Director have participated in a variety of trainings and technical assistance offered through the MCHB Workforce Development Center. Specifically, the virtual skills trainings on health equity and family engagement; Building Expertise in Administration and Management and AMCHP Leadership Lab training for the MCH and CYSHCN Directors. In the coming year, more training on systems of care development, community and family engagement and evidenced-based practice are all areas of need for continued development by MCH staff and partners. Specifically, the SD MCH program would like to request TA assistance to attend a Wilder Collaboration Index workshop focused on different aspects of collaboration in order to effectively assess how our multi-sector workgroups are doing in this area.

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

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

Supporting Document #01 - CMC Navigation Program_Family Post Survey Report Cohort I (002).pdf

Supporting Document #02 - InfantMortality_1pager_2021final.pdf

Supporting Document #03 - SDDOH_MentalHealth_SuicidePrevention_RackCard (1).pdf

Supporting Document #04 - Equity in data principles.pdf

Supporting Document #05 - SCOOP guidance document final.pdf

VI. Organizational Chart

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

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: South Dakota

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,458,310	
A. Preventive and Primary Care for Children	$ 744,727	(30.2%)
B. Children with Special Health Care Needs	$ 773,226	(31.4%)
C. Title V Administrative Costs	$ 95,250	(3.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,613,203	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,735,315	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 93,379	
5. OTHER FUNDS (Item 18e of SF-424)	$ 114,005	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 988,392	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,931,091	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 5,389,401	
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)	$ 20,150,177	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 25,539,578	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,096
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 81,923
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 17,201,110
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 252,707
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 187,739
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 190,698
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 888,929
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,104,904
Department of Justice > Office of Violence Against Women > DOJ Sexual Assault Training	$ 147,071

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,194,925 (FY 21 Federal Award: $ 2,205,134)		$ 1,396,200	
A. Preventive and Primary Care for Children	$ 719,740	(32.8%)	$ 503,566	(36%)
B. Children with Special Health Care Needs	$ 692,180	(31.5%)	$ 438,810	(31.4%)
C. Title V Administrative Costs	$ 75,000	(3.4%)	$ 34,451	(2.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,486,920		$ 976,827	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 514,881		$ 1,557,960	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 40,940		$ 88,093	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,100,000		$ 932,445	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,655,821		$ 2,578,498	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 3,850,746		$ 3,974,698	
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)	$ 21,996,626		$ 19,771,485	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 25,847,372		$ 23,746,183	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 88,700	$ 80,003
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 149,723	$ 186,228
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 213,314	$ 183,339
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 261,690	$ 246,785
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 245,053	$ 93,576
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,150,952	$ 868,095
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 110,048	$ 92,867
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 999,404	$ 1,079,008
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 18,730,977	$ 16,797,959
Department of Justice > Office of Violence Against Women > DOJ Sexual Assault Training	$ 46,765	$ 143,625

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This is due to many staff responding to the COVID 19 pandemic and coding that time to COVID funding. In addition, many families opted to hold off on receiving services in our clinics due to the risk of infection, resulting in less staff time coding to MCH funds.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This is due to many staff responding to the COVID 19 pandemic and coding that time to COVID funding. In addition, many families opted to hold off on receiving services in our clinics due to the risk of infection, resulting in less staff time coding to MCH funds.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This is due to many staff responding to the COVID 19 pandemic and coding that time to COVID funding. In addition, many families opted to hold off on receiving services in our clinics due to the risk of infection, resulting in less staff time coding to MCH funds.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This is due to many staff responding to the COVID 19 pandemic and coding that time to COVID funding. In addition, many families opted to hold off on receiving services in our clinics due to the risk of infection, resulting in less staff time coding to MCH funds.	
5.	**Field Name:**	**3. STATE MCH FUNDS**

	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This is due to many staff responding to the COVID 19 pandemic and coding that time to COVID funding. In addition, many families opted to hold off on receiving services in our clinics due to the risk of infection, resulting in less staff time coding to MCH funds.	
6.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This is due to many staff responding to the COVID 19 pandemic and coding that time to COVID funding. In addition, many families opted to hold off on receiving services in our clinics due to the risk of infection, resulting in less staff time coding to MCH funds.	
7.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This is due to many staff responding to the COVID 19 pandemic and coding that time to COVID funding. In addition, many families opted to hold off on receiving services in our clinics due to the risk of infection, resulting in less staff time coding to MCH funds.	

Data Alerts: None

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

State: South Dakota

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 462,766	$ 238,377
2. Infants < 1 year	$ 382,341	$ 149,831
3. Children 1 through 21 Years	$ 744,727	$ 503,566
4. CSHCN	$ 773,226	$ 438,810
5. All Others	$ 0	$ 31,165
Federal Total of Individuals Served	$ 2,363,060	$ 1,361,749

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 782,140	$ 874,855
2. Infants < 1 year	$ 780,360	$ 770,525
3. Children 1 through 21 Years	$ 962,685	$ 583,179
4. CSHCN	$ 319,000	$ 326,416
5. All Others	$ 86,906	$ 23,523
Non-Federal Total of Individuals Served	$ 2,931,091	$ 2,578,498
Federal State MCH Block Grant Partnership Total	$ 5,294,151	$ 3,940,247

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: South Dakota

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 59,704	$ 33,909
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	$ 59,704	$ 33,909
2. Enabling Services	$ 1,287,057	$ 730,985
3. Public Health Services and Systems	$ 1,111,549	$ 631,306
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		$ 18,505
Physician/Office Services		$ 3,924
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 7,946
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 400
Laboratory Services		$ 3,100
Other		
Targeted Case Management		$ 34
Direct Services Line 4 Expended Total		$ 33,909
Federal Total	$ 2,458,310	$ 1,396,200

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 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	$ 1,012,870	$ 955,538
3. Public Health Services and Systems	$ 1,720,337	$ 1,622,960
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 2,733,207	$ 2,578,498

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

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

State: South Dakota

Total Births by Occurrence: 11,922 **Data Source Year: 2021**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	11,838 (99.3%)	412	16	16 (100.0%)

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

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Infant Hearing Screening	11,040 (92.6%)	377	33	11 (33.3%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

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

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Infant Hearing Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**

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

Data Alerts: None

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

State: South Dakota

Annual Report Year 2021

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

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,949	29.0	0.0	68.0	3.0	0.0
2. Infants < 1 Year of Age	4,506	29.0	0.0	68.0	3.0	0.0
3. Children 1 through 21 Years of Age	7,379	25.0	0.0	69.0	5.0	1.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	685	49.0	0.0	49.0	2.0	0.0
4. Others	4,878	8.0	0.0	84.0	0.0	8.0
Total	18,712					

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

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	10,960	Yes	10,960	51.0	5,590	1,949
2. Infants < 1 Year of Age	11,620	Yes	11,620	100.0	11,620	4,506
3. Children 1 through 21 Years of Age	254,685	Yes	254,685	77.0	196,107	7,379
3a. Children with Special Health Care Needs 0 through 21 years of age^	47,436	Yes	47,436	74.0	35,103	685
4. Others	626,222	Yes	626,222	71.0	444,618	4,878

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2021**
	Field Note: Prenatal Health Review clients + MCH case managed clients + post-partum visits to women not risk assessed during pregnancy = 1236 Cribs for Kids Safe Sleep kits distributed (with education provided) = 713 1236 + 713 = 1949	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	Field Note: 412 infants receiving follow up after a positive newborn screen + 119 infants vaccinated in Community Health offices and PHA sites (number increased from last year due to addition of PHA site data) + 713 Cribs for Kids safe sleep kits distributed (with education provided)+ 3262 infants enrolled in WIC whose parents received safe sleep education = 4506	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: 3287 individuals vaccinated in community health and PHA offices* + 2641 suicide hotline calls + 1413 ASQ and ASQ SE screenings at community health and PHA sites (all screenings billed to MCH except those billed to Medicaid)** + 38 attendees to Teen Mental Health Class = 7379 *First year PHA sites included in this count; count is significantly lower than previous years due to fewer people seen during the COVID pandemic **First year combined community health office and PHA site count; count is significantly lower than previous years due to fewer people seen during the COVID pandemic	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: 15 Health KiCC clients served + 586 clients served through respite program + 55 individuals served in Sanford Patient Navigation Program + 29 special needs car seats purchased	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**
	Field Note: Adults vaccinated at Community Health and PHA offices	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**

Field Note:
3622 Strong Families Envelopes + 5a count 1949 = 5571

Not included in count due to possible duplication is 17,272 views on ForBabySake (FBS) website, FBS Paid Facebook/Instagram: Reach - 179,099
FBS Paid Snapchat: Reach - 135,155
FBS Paid YouTube: Full Video Views - 53,988

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**

Field Note:
Newborn screening is a service available to 100% of infants born in South Dakota. During annual report year 2021, 11,838 infants were screened out of 11,922 total births.

Total count from 5a is 4506 and is not included due to duplication

3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
19,958 student contact at schools + immunizations from Immunization Program 174,533 + 54 individuals served through Sanford genetics outreach + 5a suicide hotline count 2641 = 197,186

Not included due to duplication: 5A individuals vaccinated in community health and PHA offices, 352 hits on well visit promotion with Medicaid and third party payers
Also not included: hotline youth mental health and QPR (suicide prevention) trainings to teachers and agencies that provide service to children: 3 QPR trainings (67 total attendees); 1 mental health first aid training with 7 attendees

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
NSCH data shows 17.8% of SD children are CYSHCN
Form 5b 3A count: 197,186

197,186 x .178 = 35,099/47436 = 74%

5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**

Field Note:
reached within Immunization program = 443, 046
Numerator includes both men and women

*Due to data limitations, family planning data not included in this year's count

Data Alerts:

1.	Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note.

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

State: South Dakota

Annual Report Year 2021

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	11,101	7,896	378	686	1,484	202	9	417	29
Title V Served	3,889	1,885	192	471	948	145	9	239	0
Eligible for Title XIX	3,858	1,631	202	268	1,631	96	29	0	1
2. Total Infants in State	11,810	8,396	340	859	1,261	245	8	701	0
Title V Served	11,810	8,396	340	859	1,261	245	8	701	0
Eligible for Title XIX	4,721	2,152	311	300	1,804	110	44	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

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

State: South Dakota

A. State MCH Toll-Free Telephone Lines	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 305-3064	(800) 305-3064
2. State MCH Toll-Free "Hotline" Name	Bright Start	Bright Start
3. Name of Contact Person for State MCH "Hotline"	Jennifer Folliard	Jennifer Folliard
4. Contact Person's Telephone Number	(605) 367-5374	(605) 367-5374
5. Number of Calls Received on the State MCH "Hotline"		845

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names	National Suicide Prevention Lifeline; Text4Hope	National Suicide Prevention Lifeline; Text4Hope
2. Number of Calls on Other Toll-Free "Hotlines"		2,641
3. State Title V Program Website Address	doh.sd.gov/family	doh.sd.gov/family
4. Number of Hits to the State Title V Program Website		105,085
5. State Title V Social Media Websites	See note 1b for list	See note 1a for list
6. Number of Hits to the State Title V Program Social Media Websites		918,491

Form Notes for Form 7:

This is the first year South Dakota has separated out the social media platforms from the other websites. With the exception of YouTube, our social media platforms are not measured by the number of page hits or views, but by the number of individuals reached through paid promotion of posts. The total "hits" reported in Form 7.B.6 looks much higher than last year due to the new measurement. Previously, we counted page views of non-social media pages and left the social media reach out of the count.

1a. Social Media usage in Annual Report Year 2021:

www.Facebook.com/ForBabySakeSD 179,099 reached
https://www.facebook.com/SouthDakotaWIC/ 199,449 reached
www.instagram.com/corhealthsd 41,600 reached
www.facebook.com/corhealthsd 309,200 reached
For Baby Sake Paid Snapchat: Reach - 135,155
For Baby Sake YouTube https://www.youtube.com/watch?v=V17i0Kvn2sI: Full Video Views - 53,988

Total reached/viewed: 918,491

1b. Social Media for Application Year 2023:
www.Facebook.com/ForBabySakeSD
https://www.facebook.com/SouthDakotaWIC/
www.instagram.com/corhealthsd
www.facebook.com/corhealthsd
For Baby Sake Snapchat
For Baby Sake Youtube

Additional websites/pages used by Title V and WIC in annual report year 2021 (not included in Form 7.B.6 count):

http://doh.sd.gov/family/wic 1389 views
http://doh.sd.gov/family/pregnancy/family-planning.aspx 1463 views
www.SDWIC.org 166,774 views
https://doh.sd.gov/statistics/infant-mortality/ 888 views
https://doh.sd.gov/family/pregnancy/perinatal.aspx 660 views
https://doh.sd.gov/statistics/maternalmortality.aspx? 914 views
https://doh.sd.gov/family/Youth/ 1609 views
https://doh.sd.gov/statistics/prams.aspx? 811 views
www.ForBabySakeSD.com 17,272 views

Form 8
State MCH and CSHCN Directors Contact Information

State: South Dakota

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

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

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

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: South Dakota

Application Year 2023

No.	Priority Need
1.	Mental Health/Substance Misuse
2.	Safe Sleep
3.	Parenting Education and Support
4.	Mental Health/Suicide Prevention
5.	Access to Care and Services
6.	Healthy Relationships
7.	Data Sharing and Collaboration

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

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

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

Form 10
National Outcome Measures (NOMs)

State: South Dakota

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

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	77.9 %	0.4 %	8,475	10,873
2019	77.7 %	0.4 %	8,816	11,341
2018	77.5 %	0.4 %	9,118	11,769
2017	76.0 %	0.4 %	9,103	11,978
2016	76.8 %	0.4 %	9,326	12,149
2015	76.6 %	0.4 %	9,301	12,144
2014	76.4 %	0.4 %	9,248	12,103
2013	72.3 %	0.4 %	8,693	12,021
2012	70.6 %	0.4 %	8,367	11,843
2011	69.9 %	0.4 %	8,120	11,622
2010	71.2 %	0.4 %	8,255	11,596
2009	67.3 %	0.4 %	7,919	11,760

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	52.5	7.0	57	10,854
2018	57.1	7.2	64	11,207
2017	47.0	6.5	53	11,286
2016	40.4	6.0	46	11,399
2015	39.4	6.9	33	8,385
2014	47.7	6.6	53	11,122
2013	45.5	6.5	50	10,987
2012	33.1	5.5	36	10,873
2011	35.4	5.8	38	10,743
2010	40.7	6.2	43	10,555
2009	56.5	7.3	61	10,796
2008	40.8	6.2	44	10,780

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2020	18.7	5.7	11	58,711
2015_2019	16.6	5.3	10	60,087
2014_2018	16.4	5.2	10	60,921

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.9 %	0.2 %	753	10,955
2019	7.0 %	0.2 %	802	11,444
2018	6.6 %	0.2 %	789	11,886
2017	6.9 %	0.2 %	835	12,126
2016	6.8 %	0.2 %	830	12,275
2015	6.1 %	0.2 %	754	12,328
2014	6.5 %	0.2 %	804	12,280
2013	6.3 %	0.2 %	766	12,237
2012	6.2 %	0.2 %	748	12,098
2011	6.3 %	0.2 %	744	11,839
2010	6.8 %	0.2 %	806	11,801
2009	5.8 %	0.2 %	696	11,929

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	9.4 %	0.3 %	1,030	10,945
2019	9.6 %	0.3 %	1,093	11,444
2018	9.4 %	0.3 %	1,122	11,882
2017	9.3 %	0.3 %	1,125	12,121
2016	9.0 %	0.3 %	1,098	12,268
2015	8.5 %	0.3 %	1,053	12,325
2014	8.5 %	0.3 %	1,040	12,268
2013	8.1 %	0.3 %	993	12,221
2012	7.8 %	0.2 %	946	12,084
2011	7.9 %	0.3 %	940	11,832
2010	8.6 %	0.3 %	1,013	11,788
2009	7.9 %	0.3 %	944	11,912

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	28.3 %	0.4 %	3,100	10,945
2019	27.8 %	0.4 %	3,177	11,444
2018	25.6 %	0.4 %	3,046	11,882
2017	25.3 %	0.4 %	3,063	12,121
2016	24.6 %	0.4 %	3,023	12,268
2015	23.7 %	0.4 %	2,917	12,325
2014	24.0 %	0.4 %	2,948	12,268
2013	22.9 %	0.4 %	2,795	12,221
2012	22.3 %	0.4 %	2,696	12,084
2011	23.5 %	0.4 %	2,781	11,832
2010	24.7 %	0.4 %	2,906	11,788
2009	26.1 %	0.4 %	3,106	11,912

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 6 - Notes:

None

Data Alerts: None

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

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020/Q3-2021/Q2	2.0 %			
2019/Q4-2020/Q3	3.0 %			
2019/Q1-2019/Q4	3.0 %			
2018/Q4-2019/Q3	3.0 %			
2018/Q3-2019/Q2	3.0 %			
2018/Q2-2019/Q1	3.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	3.0 %			
2016/Q4-2017/Q3	3.0 %			
2016/Q3-2017/Q2	3.0 %			
2016/Q2-2017/Q1	3.0 %			
2016/Q1-2016/Q4	3.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	6.2	0.7	71	11,478
2018	4.6	0.6	55	11,919
2017	7.8	0.8	95	12,177
2016	5.7	0.7	70	12,319
2015	6.8	0.7	84	12,374
2014	6.3	0.7	78	12,326
2013	6.4	0.7	79	12,292
2012	8.8	0.9	107	12,147
2011	6.3	0.7	75	11,882
2010	8.4	0.9	100	11,864
2009	5.8	0.7	69	11,962

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	7.0	0.8	80	11,449
2018	5.9	0.7	70	11,893
2017	7.7	0.8	94	12,134
2016	4.9	0.6	60	12,275
2015	7.3	0.8	90	12,336
2014	5.7	0.7	70	12,283
2013	6.5	0.7	79	12,248
2012	8.3	0.8	101	12,104
2011	6.1	0.7	72	11,846
2010	7.1	0.8	84	11,811
2009	6.7	0.8	80	11,934

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.1	0.6	47	11,449
2018	2.9	0.5	35	11,893
2017	5.5	0.7	67	12,134
2016	2.5	0.5	31	12,275
2015	4.8	0.6	59	12,336
2014	3.3	0.5	41	12,283
2013	3.9	0.6	48	12,248
2012	5.5	0.7	67	12,104
2011	3.6	0.6	43	11,846
2010	4.8	0.6	57	11,811
2009	3.8	0.6	45	11,934

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	2.9	0.5	33	11,449
2018	2.9	0.5	35	11,893
2017	2.2	0.4	27	12,134
2016	2.4	0.4	29	12,275
2015	2.5	0.5	31	12,336
2014	2.4	0.4	29	12,283
2013	2.5	0.5	31	12,248
2012	2.8	0.5	34	12,104
2011	2.4	0.5	29	11,846
2010	2.3	0.4	27	11,811
2009	2.9	0.5	35	11,934

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	148.5 ϟ	36.0 ϟ	17 ϟ	11,449 ϟ
2018	92.5 ϟ	27.9 ϟ	11 ϟ	11,893 ϟ
2017	255.5	45.9	31	12,134
2016	97.8 ϟ	28.2 ϟ	12 ϟ	12,275 ϟ
2015	178.3	38.1	22	12,336
2014	138.4 ϟ	33.6 ϟ	17 ϟ	12,283 ϟ
2013	212.3	41.7	26	12,248
2012	214.8	42.2	26	12,104
2011	168.8	37.8	20	11,846
2010	211.7	42.4	25	11,811
2009	167.6	37.5	20	11,934

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	139.8	35.0	16	11,449
2018	168.2	37.6	20	11,893
2017	115.4	30.9	14	12,134
2016	122.2	31.6	15	12,275
2015	218.9	42.2	27	12,336
2014	114.0	30.5	14	12,283
2013	130.6	32.7	16	12,248
2012	90.9	27.4	11	12,104
2011	92.9	28.0	11	11,846
2010	118.5	31.7	14	11,811
2009	134.1	33.5	16	11,934

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	13.3 %	1.3 %	1,380	10,345
2019	10.8 %	1.1 %	1,156	10,715
2018	8.2 %	1.0 %	913	11,086
2017	8.3 %	1.0 %	919	11,073

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 10 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	1.6	0.4	17	10,798
2018	1.4	0.4	15	11,024
2017	1.7	0.4	19	11,354
2016	1.8	0.4	21	11,528
2015	1.6	0.4	14	8,555
2014	1.6	0.4	18	11,255
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	1.3	0.4	14	10,849
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR
2008	NR	NR	NR	NR

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 11 - Notes:

None

Data Alerts: None

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

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

NOM 12 - Notes:

None

Data Alerts: None

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

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

NOM 13 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	8.2 %	1.1 %	16,357	199,763
2018_2019	8.6 %	1.2 %	16,737	195,087
2017_2018	8.4 %	1.3 %	16,330	193,439
2016_2017	8.7 %	1.2 %	16,828	193,935
2016	9.6 %	1.4 %	18,332	191,693

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	19.1	4.2	21	110,041
2019	22.7	4.5	25	110,116
2018	20.8	4.3	23	110,785
2017	29.1	5.2	32	109,874
2016	29.2	5.2	32	109,629
2015	24.7	4.8	27	109,091
2014	26.7	5.0	29	108,445
2013	25.1	4.8	27	107,646
2012	31.3	5.4	33	105,530
2011	21.1	4.5	22	104,150
2010	20.3	4.4	21	103,502
2009	24.6	4.9	25	101,525

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	42.5	6.0	51	120,111
2019	52.3	6.7	62	118,466
2018	54.8	6.8	65	118,556
2017	51.7	6.7	60	115,978
2016	63.7	7.5	73	114,680
2015	56.6	7.1	64	113,106
2014	37.0	5.7	42	113,630
2013	44.5	6.3	50	112,318
2012	44.0	6.3	49	111,395
2011	43.7	6.3	49	112,012
2010	56.5	7.1	63	111,588
2009	65.2	7.6	73	111,893

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2018_2020	23.0	3.6	40	174,234
2017_2019	26.7	3.9	46	172,083
2016_2018	29.8	4.2	51	171,187
2015_2017	24.1	3.8	41	170,094
2014_2016	23.4	3.7	40	171,242
2013_2015	14.5	2.9	25	171,823
2012_2014	19.1	3.3	33	172,681
2011_2013	17.4	3.2	30	172,774
2010_2012	24.3	3.8	42	172,983
2009_2011	29.3	4.1	51	173,766
2008_2010	33.2	4.4	58	174,643
2007_2009	35.1	4.5	62	176,399

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	34.4	4.5	60	174,234
2017_2019	33.1	4.4	57	172,083
2016_2018	29.2	4.1	50	171,187
2015_2017	30.0	4.2	51	170,094
2014_2016	28.0	4.1	48	171,242
2013_2015	29.1	4.1	50	171,823
2012_2014	22.6	3.6	39	172,681
2011_2013	22.0	3.6	38	172,774
2010_2012	20.8	3.5	36	172,983
2009_2011	24.2	3.7	42	173,766
2008_2010	28.6	4.1	50	174,643
2007_2009	24.9	3.8	44	176,399

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	17.8 %	1.4 %	37,957	213,159
2018_2019	17.2 %	1.5 %	36,404	211,616
2017_2018	16.6 %	1.5 %	35,046	211,653
2016_2017	16.1 %	1.3 %	33,876	210,513
2016	15.7 %	1.4 %	32,704	208,339

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	20.9 %	3.5 %	7,950	37,957
2018_2019	15.7 %	3.3 %	5,705	36,404
2017_2018	16.3 %	3.9 %	5,708	35,046
2016_2017	15.6 %	3.8 %	5,296	33,876
2016	9.6 %	1.9 %	3,144	32,704

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	2.4 %	0.8 %	4,183	173,989
2018_2019	2.2 %	0.8 %	3,863	172,694
2017_2018	1.3 %	0.4 %	2,259	173,786
2016_2017	1.5 %	0.5 %	2,649	171,841
2016	2.0 %	0.8 %	3,263	166,826

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	8.4 %	1.0 %	14,432	172,440
2018_2019	7.0 %	1.0 %	11,981	170,586
2017_2018	6.5 %	1.1 %	11,164	172,611
2016_2017	6.5 %	1.0 %	10,997	170,388
2016	7.0 %	0.9 %	11,719	166,311

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	55.8 %	5.4 %	13,171	23,621
2018_2019	58.3 %	6.2 %	11,586	19,858
2017_2018	66.8 %	6.6 %	12,005	17,965
2016_2017	60.9 %	5.9 %	10,629	17,449
2016	51.8 %	7.0 %	8,075	15,596

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	92.0 %	1.0 %	195,399	212,305
2018_2019	91.6 %	1.1 %	192,700	210,359
2017_2018	93.7 %	1.0 %	197,336	210,705
2016_2017	93.7 %	0.9 %	196,224	209,466
2016	92.7 %	1.1 %	191,296	206,419

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	16.0 %	0.5 %	1,004	6,269
2016	17.1 %	0.5 %	1,156	6,771
2014	17.1 %	0.5 %	884	5,179
2012	14.8 %	0.4 %	1,190	8,020
2010	17.3 %	0.4 %	1,363	7,884
2008	16.1 %	0.4 %	1,121	6,946

Legends:

Indicator has a denominator <50 and is not reportable

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	14.1 %	0.9 %	5,256	37,324
2015	14.7 %	1.3 %	5,550	37,746
2013	11.9 %	1.1 %	4,509	37,874
2011	9.8 %	1.0 %	3,812	38,957
2009	9.5 %	1.0 %	3,662	38,353
2007	9.0 %	1.2 %	3,680	40,789
2005	10.4 %	1.1 %	4,285	41,028

Legends:

Indicator has an unweighted denominator <100 and is not reportable

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	15.2 %	2.1 %	13,488	88,834
2018_2019	11.7 %	2.0 %	10,480	89,317
2017_2018	11.9 %	2.3 %	10,969	91,796
2016_2017	13.6 %	2.3 %	11,680	86,126
2016	13.0 %	2.2 %	10,488	80,613

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	5.7 %	0.9 %	12,368	215,236
2018	5.2 %	0.7 %	11,133	214,180
2017	6.1 %	1.0 %	12,936	212,391
2016	4.3 %	0.8 %	9,120	213,902
2015	7.4 %	1.3 %	15,401	209,556
2014	7.3 %	1.2 %	15,285	209,494
2013	7.3 %	1.0 %	14,974	205,982
2012	3.9 %	0.8 %	7,869	204,137
2011	5.7 %	0.8 %	11,454	202,877
2010	7.1 %	1.2 %	14,562	204,414
2009	6.7 %	0.9 %	13,342	199,435

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	69.7 %	3.5 %	9,000	12,000
2016	68.9 %	3.8 %	9,000	12,000
2015	72.2 %	3.9 %	9,000	13,000
2014	73.4 %	3.3 %	9,000	13,000
2013	64.7 %	4.1 %	8,000	13,000
2012	73.6 %	4.2 %	9,000	12,000
2011	68.7 %	4.8 %	8,000	12,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	64.4 %	2.4 %	131,809	204,673
2019_2020	70.3 %	1.9 %	145,068	206,356
2018_2019	67.2 %	2.2 %	136,681	203,394
2017_2018	64.4 %	2.0 %	128,145	198,957
2016_2017	63.2 %	2.4 %	125,737	199,014
2015_2016	70.8 %	2.0 %	139,014	196,236
2014_2015	64.4 %	2.4 %	124,290	192,937
2013_2014	68.5 %	2.1 %	131,211	191,596
2012_2013	73.2 %	3.3 %	140,455	192,009
2011_2012	58.2 %	2.6 %	107,634	184,949
2010_2011	53.7 %	4.6 %	100,976	188,037
2009_2010	56.5 %	2.6 %	95,462	168,959

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	84.5 %	2.2 %	50,137	59,310
2019	73.6 %	3.0 %	43,186	58,689
2018	68.7 %	2.9 %	39,413	57,365
2017	63.2 %	3.2 %	35,462	56,124
2016	55.9 %	3.4 %	30,966	55,423
2015	46.0 %	3.2 %	25,628	55,733

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	91.5 %	2.0 %	54,257	59,310
2019	90.0 %	2.1 %	52,846	58,689
2018	86.6 %	2.2 %	49,689	57,365
2017	79.5 %	2.8 %	44,628	56,124
2016	79.4 %	2.9 %	43,986	55,423
2015	72.4 %	2.9 %	40,325	55,733
2014	75.0 %	3.0 %	41,570	55,439
2013	70.0 %	3.3 %	38,650	55,198
2012	65.9 %	3.3 %	35,845	54,368
2011	54.4 %	5.2 %	29,467	54,183
2010	52.5 %	3.2 %	29,225	55,702
2009	39.6 %	3.4 %	22,002	55,527

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	94.2 %	1.5 %	55,888	59,310
2019	86.2 %	2.4 %	50,619	58,689
2018	85.3 %	2.2 %	48,920	57,365
2017	74.5 %	2.9 %	41,838	56,124
2016	65.7 %	3.2 %	36,400	55,423
2015	55.5 %	3.2 %	30,918	55,733
2014	57.0 %	3.4 %	31,618	55,439
2013	51.7 %	3.4 %	28,523	55,198
2012	40.0 %	3.5 %	21,743	54,368
2011	37.4 %	4.8 %	20,280	54,183
2010	30.9 %	3.0 %	17,198	55,702
2009	24.9 %	2.9 %	13,838	55,527

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	18.7	0.8	533	28,486
2019	19.2	0.8	536	27,955
2018	20.4	0.9	565	27,707
2017	22.6	0.9	614	27,226
2016	25.1	1.0	681	27,149
2015	26.5	1.0	720	27,214
2014	26.7	1.0	735	27,483
2013	29.4	1.0	812	27,650
2012	33.5	1.1	929	27,747
2011	34.3	1.1	964	28,066
2010	34.8	1.1	975	28,045
2009	38.7	1.2	1,092	28,228

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 23 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	12.6 %	1.2 %	1,299	10,272
2019	12.6 %	1.1 %	1,338	10,618
2018	13.0 %	1.2 %	1,435	11,037
2017	14.3 %	1.2 %	1,604	11,203

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	2.9 %	0.7 %	6,164	212,838
2018_2019	2.4 %	0.7 %	5,106	211,616
2017_2018	2.9 %	0.7 %	6,216	211,542
2016_2017	3.1 %	0.7 %	6,559	210,083
2016	2.3 %	0.7 %	4,772	207,703

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: South Dakota

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

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				79.6	73.1
Annual Indicator			77.6	70.4	77.3
Numerator			110,174	101,908	110,595
Denominator			141,888	144,765	143,127
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

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

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	78.9	79.7	80.5	81.3

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	88.9	92.4	89.3	89.1	87
Annual Indicator	91.7				
Numerator	10,013				
Denominator	10,922				
Data Source	SD PRAMS Like Survey				
Data Source Year	2016				
Provisional or Final ?	Final				

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	88.0	88.1	88.2	88.3

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			39.2	41.8	41.5
Annual Indicator	26				
Numerator	2,821				
Denominator	10,844				
Data Source	SD PRAMS Like Survey				
Data Source Year	2016				
Provisional or Final ?	Final				

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	41.2	41.8	42.4	42.9

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			48.4	48.4	52.9
Annual Indicator	44.7				
Numerator	4,681				
Denominator	10,472				
Data Source	SD PRAMS Like Survey				
Data Source Year	2016				
Provisional or Final ?	Final				

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	56.1	56.2	56.4	56.5

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		41.2	42.8	41.4	40.3
Annual Indicator	40.4	42.4	40.4	39.4	36.5
Numerator	12,135	10,542	8,655	9,910	9,949
Denominator	30,030	24,884	21,429	25,131	27,272
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	38.1	38.9	39.7	40.5

Field Level Notes for Form 10 NPMs:

None

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

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

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	274.2	271.7	269.1	266.6

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		46.1	50.8	53.4	49.7
Annual Indicator	43.9	49.6	53.0	48.8	48.4
Numerator	14,361	16,789	18,568	17,763	18,368
Denominator	32,704	33,876	35,046	36,404	37,957
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	49.4	50.0	50.5	51.0

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: South Dakota

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 50.9% in 2021 to 55.2% in 2025.

Measure Status:	Active

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

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	52.0	53.1	54.1	55.2

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			4
Annual Indicator			3
Numerator			
Denominator			
Data Source			Count of projects
Data Source Year			2021
Provisional or Final ?			Final

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	56.0	57.8	59.6

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: South Dakota

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator			0
Numerator			0
Denominator			100
Data Source			DOH EMR
Data Source Year			2020
Provisional or Final ?			Provisional

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator			0
Numerator			0
Denominator			100
Data Source			2021
Data Source Year			DOH EMR
Provisional or Final ?			Provisional

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

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - # of messages posted promoting well women care

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	13.0	14.0	15.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator			100
Numerator			10
Denominator			10
Data Source			Post test results
Data Source Year			2021
Provisional or Final ?			Provisional

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Inactive - Recent data shows 80% of infants died in SD while under a parent's care. 3% in daycare. For this reason, this measure has been discontinued.

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator			0
Numerator			0
Denominator			100
Data Source			Survey distributed to daycares
Data Source Year			2021
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			100
Annual Indicator	100	100	100
Numerator	76	76	76
Denominator	76	76	76
Data Source	OCFS Community Health Offices	OCFS Community Health Offices	OCFS Community Health Offices
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			60
Annual Indicator			38
Numerator			
Denominator			
Data Source			class training facilitator
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	120.0	180.0	240.0	300.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

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

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

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: South Dakota

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 50.9% in 2021 to 55.2% in 2025.
Population Domain(s) – Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Improve young peoples' (10 to 24 years) relationships by increasing education and support, STI prevention, and pregnancy prevention.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of individuals answering “very true” to the entry survey question: “I would talk to a trusted adult (for example, a family member, teacher, counselor, coach, etc.) if someone I am dating or going out with makes me uncomfortable, hurts me, or.....</td></tr>
<tr><td>Denominator:</td><td>total # of individuals who completed the above question on the entry survey</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>SRAE and PREP entry survey</td></tr>
<tr><td>Significance:</td><td>Relationships are an important part of adolescent development. Adolescence is a time for young people to explore and develop relationships by connecting with peers, parents, teachers, or a romantic partner. These relationships might be healthy or unhealthy, and can be emotional, physical, or sexual. A comprehensive approach of covering education and support for healthy relationships, STI prevention, and teen pregnancy prevention is key to achieving healthy relationships in adolescence.</td></tr>
</table>

SPM 2 - The extent to which data equity principles have been implemented in SD MCH data projects
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Inactive - Replaced
Goal:	Increased data sharing and collaboration
Definition:	**Unit Type:** Count **Unit Number:** 7 **Numerator:** Number of data sharing projects **Denominator:**
Data Sources and Data Issues:	Count of the number of new data sharing projects completed by the DOH and partners on this SPM
Significance:	Data sharing and collaboration are evidence-based strategies for improving health equity. Disaggregated data that is available to communities can lead to a better understanding of local conditions and help monitor progress toward achieving health equity. Linking data sets and sharing resources across sectors will lead to a more robust understanding of the health of South Dakotans. Data sharing and collaboration were common themes during the needs assessment process across all population domains, thus making it ideal for the cross-cutting state performance measure.

SPM 3 - Percent of data equity principles implemented in South Dakota MCH projects
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Understand our strengths and weaknesses in collecting, analyzing, and sharing data equitably. This measurement promotes communication about equity principles among the workgroup members with the goal of improving our data sharing and collaboration.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Combined score of each principle for all data projects using the SD data equity tool **Denominator:** highest possible score of each principle for all data projects using the SD data equity tool
Data Sources and Data Issues:	South Dakota data equity tool
Significance:	Data can be a powerful, evidence-based approach to addressing health equity. Disaggregated data and data on social determinants of health can help identify and understand health inequities. Using community-based participatory research or qualitative methods lifts community voices and supplements quantitative data. Working across sectors to link and analyze data creates more robust data sets and parallel approaches to reporting. In South Dakota, honoring Indigenous data sovereignty is an especially important data principle to advance equity in data sharing and collaboration. This measure not only helps the group identify weaknesses in this area but offers an avenue to communicate about the ways that Indigenous data sovereignty can be observed in future data projects. South Dakota Maternal Child Health strives for meaningful partnership with American Indian Tribes and wants to honor their perspective on the ways in which data should be analyzed and interpreted to represent their communities.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: South Dakota

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: South Dakota

ESM 1.1 - % of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Address mental health in women by measuring the percentage of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening</td></tr>
<tr><td>Denominator:</td><td># of positive PHQ 2 generated from the WIC assessment</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>code added to the state's Time Keeping System for a PHQ 9 screening</td></tr>
<tr><td>Significance:</td><td>A Pregnancy and Postpartum WIC Assessment provides a critical opportunity to identify mental health needs and improve subsequent maternal and infant outcomes by providing appropriate referrals to address mental health issues.</td></tr>
</table>

ESM 1.2 - % of WIC clients whose PHQ 9 score met criteria for a referral and were referred
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Address mental health in women by measuring the percentage of WIC clients whose PHQ 9 score met criteria for a referral and were referred
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of WIC clients whose PHQ 9 score met criteria for a referral and were referred **Denominator:** # of WIC clients whose PHQ 9 score met criteria for a referral
Data Sources and Data Issues:	Statistics kept by Community Health Offices
Significance:	A Pregnancy and Postpartum WIC Assessment provides a critical opportunity to identify mental health needs and improve subsequent maternal and infant outcomes by providing appropriate referrals to address mental health issues.

ESM 1.3 - # of messages posted promoting well women care
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>This measure is tracking the number of our posts on social media to childbearing people in SD that seek well care.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of social media posts to childbearing people in SD that seek well care</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>South Dakota media services data from Facebook, Instagram, and snapchat.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The evidence for this strategy falls under “Community, other media, population-based systems”.

There is moderate evidence to support this strategy to be effective.

The use of media to facilitate and support healthy behaviors is found throughout the literature. Anderson et al (2009) developed and broadcast a mass media campaign that targeted women 40-69 across all socioeconomic groups. Cervical screening increased 27% during the campaign over a 52-week period. Other studies have looked at the influence of social media on the ability to increase knowledge and change behavior. A study by Bonnevie et al (2020) used a pre- and post- campaign surveys to measure the impact of flu vaccination rates using social media influencers. The 117 influencers generated over 69,000 engagements showing significant increases in positivity about the flu vaccine. Another study aimed to describe the use of social media by young adults aged 18-24 years to motivate and engage with health information. Participants completed profiling surveys and web-based registration to be part of the study. They completed discussion forums on a web-based community. They found that young adults used Facebook, You Tube, and Instagram for health and wellness information. Twitter, Tumblr, and Snapchat were rarely used for health information (Lim, Molenaar, Brennan, Reid & McCaffrey, 2022).

Anderson JO, Mullins RM, Siahpush M, Spittal MJ, Wakefield M. (2009). Mass media campaign improves cervical screening across all socio-economic groups. Health Educ Res: 24(5):867-75. https://www.ncbi.nlm.nih.gov/pubmed/19342422

Bonnevie E, Rosenberg SD, Kummeth C, Goldbarg J, Wartella E, Smyser J (2020) Using social media influencers to increase knowledge and positive attitudes toward the flu vaccine. PLoS ONE 15(10): e0240828. https://doi.org/10.1371/journal. pone.0240828

Lim, M., Molenaar, A., Brennan, L., Reid, M., and McCaffrey, T. (2022). Young adults’ use of different social media platforms for</td></tr>
<tr><td>Significance:</td><td>Social media provides an outlet to reach a broader audience to disseminate health related information. Messages posted related to well woman promotes communication by informing women of childbearing age the importance of preventative care for overall health.</td></tr>
</table>

ESM 1.4 - % of women with positive depression screen who are referred to their PCP within OCFS field offices
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	This measure will determine if our process for screening is effective in identifying women with symptoms of depression and getting them referred to their PCP.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** number of women with a positive screen who were referred to PCP **Denominator:** total number of women with a positive PHQ-9
Data Sources and Data Issues:	Netsmart EHR screens and documented referrals
Evidence-based/informed strategy:	The evidence for this strategy falls under emerging evidence. The Association of Maternal & Child Programs (AMCHP) supports strategies to build capacity to support pregnant people and women of reproductive age with mental health and substance use disorders (https://amchp.org/mental-health-sud/). It aligns with Innovation Hub's Perinatal Depression Screening and Referral Project example in Connecticut (https://amchp.org/wp-content/uploads/2021/05/Perinatal-Depression-Screening-Referral_2015.pdf). The Agency for Healthcare Research and Quality states on their fact sheet for depression screening that screening pregnant women for depression enables health professionals to initiate services that can prevent later problems for both the mother and baby. (https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/depression.html) Further support comes from the American College of Obstetricians and Gynecologists (ACOG) in their ACOG committee opinion: Screening for Perinatal Depression (ACOG, No. 757, 2018) and Optimizing postpartum care (ACOG No. 736, 2018). It is recommended that "obstetric care providers complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive visit for each patient", (ACOG, No. 757,2018). Postpartum support international (PSI) recommends universal screening for the presence of prenatal or postpartum mood and anxiety disorders, using an evidence-based tool (https://www.postpartum.net/professionals/screening/). The US Preventative Services Task Force (USPSTF) recommendation statement (2016) calls for screening for depression in the general adult population, including pregnant and postpartum women. Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018: 131: e140-50 Post-Partum Support International (PSI) https://www.postpartum.net/professional
Significance:	Screening women for depression during routine, prenatal, and postpartum WIC visits allows health professionals to refer and initiate services with a primary care provider. This screening to initiate primary care can prevent later problems for mom and baby.

ESM 5.1 - % of Child Death Review (CDR) team members who scored above 80% on a post-test
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Determine the effectiveness of training provided to CDR team members by measuring the % of team members who scored above 80% on a training post-test.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of CDR team members who scored above 80% on a post-test **Denominator:** # of CDR team members who took post-test
Data Sources and Data Issues:	Manual tally of post-test scores
Significance:	By measuring the effectiveness of training on upstream root causes of infant death, we have more confidence in a review team's ability to recommend ways to prevent deaths from occurring instead of responding to the deaths.

ESM 5.2 - % of daycares who respond to survey and indicate that they follow safe sleep guidelines
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Inactive - Recent data shows 80% of infants died in SD while under a parent's care. 3% in daycare. For this reason, this measure has been discontinued.</td></tr>
<tr><td>Goal:</td><td>Collaborate with diverse, multi-sector organizations/agencies to promote safe sleep by providing safe sleep materials to daycares and measuring the % of daycares who respond to a survey and indicate they follow safe sleep guidelines</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of daycares who respond to survey and indicate they follow safe sleep guidelines</td></tr>
<tr><td>Denominator:</td><td># of daycares who respond to survey</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Survey distributed to daycares</td></tr>
<tr><td>Significance:</td><td>Through this measure we can determine whether the training/education provided to daycares across the state was effective in increasing a provider’s confidence in following safe sleep guidelines within their home or a daycare center.</td></tr>
</table>

ESM 5.3 - % of birthing hospitals that receive information on certification process that become safe sleep certified NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the % of birthing hospitals that become safe sleep certified after receiving information on the certification process
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of birthing hospitals in SD that receive information on Cribs for Kids safe sleep certification process that become safe sleep certified **Denominator:** # of birthing hospitals in SD that receive information on Cribs for Kids safe sleep certification process
Data Sources and Data Issues:	Manual count of SD birthing hospitals that become safe sleep certified after receiving information on Cribs for Kids safe sleep certification process.
Evidence-based/informed strategy:	The evidence for this strategy falls under “Caregiver+Provider+Hospital without Quality Improvement (Moderate Evidence) “appear to be effective as the majority of the studies had favorable results” in the National Performance Measure 5 Safe Sleep Evidence Review from the Women’s and Children’s Health Policy Center at John Hopkins University (2017). NICHQ’s study states “Statewide implementation of hospital policy intervention to increase knowledge among health care professionals has resulted in significant reductions in infants found in unsafe sleep situations while in the hospital. (Infant Safe Sleep Interventions, 1990 -2015: A Review. J community Health. 2016) Cribs for Kids National Safe Sleep Hospital Certification Program includes: • Developing safe sleep policy statement incorporating the AAP’s Infant Safe Sleep guidelines • Training staff on safe sleep guidelines, hospital safe sleep policy, and the importance of modeling safe sleep for parents • Educating parents on the importance of safe sleep practices and implementing these practices in the hospital setting.
Significance:	This measure is significant because it demonstrates that hospital systems (who become safe sleep certified) have met Cribs for Kids standards of providing evidence based strategies in their policies, in safe sleep training for staff and with their education provided to new families.

ESM 6.1 - % of Community Health Offices that distribute tracking cards
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Provide parenting education on developmental screening by providing trifold developmental screening tracking cards at Community Health Offices
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of Community Health Offices that distribute tracking cards **Denominator:** # of Community Health Offices
Data Sources and Data Issues:	Reporting from Community Health Offices
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. There are many electronic options available for parents and caregivers to track a child's development, however, not every family has access to the required technology to utilize these apps. It is important that community health offices continue to distribute developmental screening tracking cards and other hard copy resources to ensure all populations have an effective means to track the development of the children in their care.

ESM 6.2 - Percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Track the percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age to measure the impact of the program on improving developmental screening rates.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of children served in Bright Start Home Visiting aged 18 months that have received a developmental screen</td></tr>
<tr><td>Denominator:</td><td>Total # of children aged 18 months that have been served by Bright Start Home Visiting</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Bright Start Home Visiting program data records</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>There is moderate and growing evidence that using home visiting sessions to encourage parents to use the Ages and Stages tool may increase developmental screening rates. Green et al. looked at whether home visiting services were effective for families with different social, demographic, and other differing characteristics by conducting a randomized study of the Healthy Families Oregon home visiting program. The study was carried out through a telephone survey with a randomly selected group of mothers to assess the program’s early outcomes at children’s 1-year birthday. Out of 803 randomly selected mothers, 402 were assigned to receive the Healthy Families Oregon program. Results found that mothers assigned to the Healthy Families program read more frequently to their young children and provided more developmentally supportive activities. Children of these mothers were more likely to have received developmental screenings and were somewhat less likely to have been identified as having a developmental challenge.

Green B, Tarte JM, Harrison PM, Nygren M, Sanders M. Results from a randomized trial of the Healthy Families Oregon accredited statewide program: early program impacts on parenting. Child Youth Serv Rev. 2014; 44:288-298.

https://www.sciencedirect.com/science/article/pii/S0190740914002175</td></tr>
<tr><td>Significance:</td><td>Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. As the Home Visiting program expands, it provides an opportunity to improve the state's developmental screening rates.</td></tr>
</table>

ESM 7.2.1 - # of students trained in teen Mental Health First Aid
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	Address suicide prevention and mental health in adolescents by promoting evidence-based programs and practices that increase protection from suicide risk
Definition:	**Unit Type:** Count **Unit Number:** 300 **Numerator:** # of students trained in teen Mental Health First Aid **Denominator:**
Data Sources and Data Issues:	# of class participants reported by training facilitator to have completed the teen mental health first aid curriculum
Significance:	New evidence-based curriculum for youth that teaches high school students how to identify, understand and respond to signs and symptoms of mental health or substance abuse. Education is important in this area because during Adolescence 1 in 5 youth has had a serious mental health disorder at some point in their life and 50% of all mental illnesses begins by age 14 and 75% by the mid-20s(Mental Health First Aid). This training gives students the skills to have supportive conversations with their friends and get a responsible and trusted adult to take over as necessary.

ESM 11.1 - % of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Improve access to care and services for CYSHCN by measuring the effectiveness of the Sanford Care Coordination Program.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services **Denominator:** # of families enrolled in care coordination services
Data Sources and Data Issues:	pre-care coordination and post-care coordination surveys of clients provided by South Dakota State University Population Health
Significance:	The AAP specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. By measuring the effectiveness of the Sanford Care Coordination Program, the CYSHCN program can tailor services provided to close gaps in care and increase the percentage of families that experience an improvement in obtaining needed referrals to care and/or services. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

Form 11
Other State Data

State: South Dakota

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: South Dakota

Annual Report Year 2021

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Monthly	1		
2) Vital Records Death	Yes	Yes	Monthly	1	Yes	• Infant Birth
3) Medicaid	Yes	No	Annually	12	No	
4) WIC	Yes	Yes	More often than monthly	6	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	6	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	6	Yes	
7) Hospital Discharge	Yes	Yes	Semi-Annually	6	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	12	Yes	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) Pregnancy Mortality Surveillance System	Yes	Yes	Annually	36	Yes	
10) Fatality Review Case Reporting System	Yes	Yes	More often than monthly	0	No	
11) OCFS Electronic Health Record	Yes	Yes	More often than monthly	0	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None