Maternal and Child Health Services Title V Block Grant

South Dakota

FY 2017 Application/ FY 2015 Annual Report

Created on 10/3/2016 at 12:35 PM

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I. General Requirements

I.A. Letter of Transmittal

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SOUTH DAKOTA DEPARTMENT OF HEALTH
Office of the Secretary

June 30, 2016

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 2017 South Dakota Maternal and Child Health Block Grant application and annual report. Should you have any questions concerning this application, please contact Scarlett Bierne at 605.773.4439.

Sincerely,

Linda Ahrendt
Administrator
Office of Child and Family Services

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

In January 2016 the DOH released its 2015-2020 Strategic Plan which provides a road map for the future and helps staff work together to achieve meaningful outcomes. The strategic plan includes the DOH vision (Healthy People, Healthy Communities, Healthy South Dakota), mission (promote, protect and improve the health of every South Dakotan) and guiding principles (serve with integrity and respect, eliminate health disparities, demonstrate leadership and accountability, focus on prevention and outcomes, leverage partnerships, and promote innovation). Each objective has key strategies to help guide activities along with 27 key performance indicators to allow the DOH to monitor progress. See http://doh.sd.gov/strategicplan/ for more information.

The MCH program integrated the newly revised MCH State Action Plan with the DOH Strategic Plan to link DOH and programmatic goals/strategies. The MCH plan's guiding principles are: (1) enhance internal and external partnerships to address MCH priorities; (2) utilize DOH communications and social media platforms to enhance education and awareness; (3) maintain DOH infrastructure/workforce to provide education and outreach to clients and providers; and (4) maintain data and epidemiology support to assist with collection and analysis of data.

Goal 1 – IMPROVE THE QUALITY, ACCESSIBILITY, AND EFFECTIVE USE OF HEALTHCARE

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

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

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

- Outreach/collaborate with insurance providers to promote adolescent well visits and reminder strategies
- Provide resources for providers on Bright Futures guidelines and the value of provider one-on-one time with adolescents
- Implementation of 6th grade vaccination requirements

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

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

Key Performance Indicators:

1. Increase the percent of 18-24 year old women with a past year preventive medical visit from 66.4% to 69.5% by 2020. *BRFSS*
2. Increase the number of adolescents (13-18 years old) that enroll in the SD QuitLine from 45 to 50 by 2020. *SD QuitLine*
3. Increase the immunization rate for the >1 dose of meningococcal vaccine for adolescents 13-17 years of age from the baseline of 57% to 80% by 2020. *NIS*
4. Increase the percentage of CYSHCN who report receiving care in a well-functioning system from 17.6% to 18.6% by 2020. *NSCSHCN –National Survey of CSHCN*

Goal 2 – SUPPORT LIFE-LONG HEALTH FOR ALL SOUTH DAKOTANS

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

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

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

- Convene a partner team to look at developmental screening and referrals
- Facilitate the completion of developmental screenings and anticipatory guidance for clients served

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

- Identify a team of internal/external partners for which motor vehicle safety is already part of their mission
- Integrate injury prevention education, motor vehicle safety, and prevention of drug and alcohol use into broader child health promotion efforts by DOH
- Explore a collaborative communication platform for adolescent health information

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

- Provide oral health information to new mothers through the Bright Start Welcome Box
- Facilitate access to oral health services through partnerships with SD's parenting training center, other state agencies, and service providers
- Conduct Oral Health Basic Screening Survey of 3rd graders

NPM 14: Percent of women who smoke in the last three months of pregnancy

- Maintain DOH infrastructure/workforce in order to provide education and outreach to clients and make SD QuitLine referrals as appropriate
- Include smoking cessation and promote tobacco free environment messages in social media and other communications across the DOH

SPM 2: Percentage of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile

(overweight or obese)

- Engage and support collaboration among State agencies and community partners around nutrition/physical activity
- Integrate nutrition/physical activity education into broader health promotion efforts
- Identify ways to raise awareness of importance of nutrition/physical activity at a young age

SPM 3: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent

- Implement strategies to increase awareness on importance of preconception/inter-conception and postpartum health in social media and other communications
- Outreach to insurance providers to promote early and adequate access to prenatal care

Key Performance Indicators:

1. Increase the percent of infants from other races (not White or AI) placed to sleep on their backs from 77.0% to 80.9% by 2020. *SD PRAMS*
2. Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool from 23.5% to 24.9% by 2020. *National Children's Health Survey*
3. Decrease the percentage of high school students who report in the past 30 days they rode with a driver who had been drinking alcohol from 20.1% to 19.2% by 2020. *YRBS*
4. Increase the percentage of 6 to 9 year old children who received a dental sealant on at least one permanent molar from 57% to 59.9% by 2020. *Oral Health Basic Screening Survey*
5. Reduce the percentage of pregnant females that smoke from 14.8% to 8.1%. *DOH Vital Records*
6. Reduce the percentage of children, 5-6 years old with a BMI at or above the 85th percentile (overweight or obese) from 26.6% to 25.2%by 2020. *DOH School Height and Weight Survey*
7. Increase the percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent from 79.2% to 87.1% by 2020. *SD PRAMS*

Goal 3 – PREPARE FOR, RESPOND TO, AND PREVENT PUBLIC HEALTH THREATS

DOH Objective A: Prevent and control infectious disease

- Improve South Dakota's age-appropriate immunization rate
- Provide support and education on emerging public health threats

Key Performance Indicators:

1. Increase the percent of children aged 19-35 months who receive recommended vaccinations from 76.3% to 80% by 2020. *NIS*

Goal 4 – DEVELOP AND STRENGTHEN STRATEGIC PARTNERSHIPS TO IMPROVE PUBLIC HEALTH

SPM 1: Reduce suicide attempts by adolescents

- Identify and partner with organizations for which suicide prevention is already a mission and highlight their efforts as examples others could follow
- Integrate suicide prevention education into broader adolescent health promotion efforts within DOH

Key Performance Indicators:

1. Reduce suicide attempts by adolescents from 8.9% to 8.0% by 2020. *YRBS*
2. Reduce the suicide age-adjusted death rate for South Dakota from 17.1 per 100,000 to 12.6 per 100,000 by

2020. *DOH Vital Records*

Goal 5 – MAXIMIZE THE EFFECTIVENESS AND STRENGTHEN THE INFRASTRUCTURE OF THE DEPARTMENT OF HEALTH

DOH Objective B: Promote a culture of organizational excellence

- Enhance maternal child health messaging
- Maintain DOH infrastructure/workforce to provide education and outreach to clients and providers
- Provide professional development and resources to employees

Key Performance Indicators:

1. Increase the number of Certified Lactation Consultants from 3 to 60 by 2020. *DOH*

The MCH Program realigned the MCH Team into two workgroups: (1) Child/Adolescent Health and CYSHCN and (2) Women/Maternal Health and Perinatal Infant Health. The workgroups meet regularly to monitor and update MCH data measures, expand internal/external partnerships and provide oversight of the MCH state plan objectives/strategies. The workgroups meet jointly group once a month with the MCH Evaluation team (EA Martin) to discuss and share data, assess evaluation needs, and provide data focused training in order to increase the use of data across programs.

ACCOMPLISHMENTS & STRATEGIES:

The larger MCH workgroup met and identified nine Evidence Based Strategy Measures and four State Performance Measures to focus on for FY 17. In addition, the office created a Child and Family Services Interagency Workgroup and it meets quarterly and focuses on children ages 0-5 years to improve service, promote collaborative programming, reduce duplication of resources, and support strategic plans. The workgroup includes the DOH, DOE (Birth to Three, Head Start), DSS (Childcare Services, Economic Assistance, Substance Abuse/Behavioral Health), and DHS (Developmental Disabilities).

The sections below highlight selected accomplishments for the previous year along with a brief description of strategies for the coming year.

Domain: Women/Maternal Health

The priority need is promoting preconception and inter-conception health. Overarching objectives/strategies are aimed at increased awareness of overall preventive medical care and risk factors that affect maternal and child wellness. The DOH will engage other agencies and providers to identify and implement strategies to increase awareness of and promote annual preventive medical visits including preconception/inter-conception and postpartum care.

Domain: Perinatal/Infant Health

The priority need is the reduction of infant mortality. Overarching objectives/strategies are aimed at increased awareness of safe sleep practices as well as other factors that affect infant mortality. The DOH will engage other agencies and providers to identify and implement strategies to increase awareness of the importance of safe sleep practices.

Domain: Child Health

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

identification of concerns and risk factors that affect positive child and youth development. The DOH will engage other agencies and providers to identify and implement strategies to increase awareness of the importance of early childhood screening and referral for services.

Domain: Adolescent Health

The priority need is to improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN; and promote positive child and youth development to reduce morbidity and mortality. Overarching objectives/strategies are aimed at preventing adolescent injuries, suicides, and motor vehicle deaths through awareness of importance of preventive service visits and healthy life styles choices. The DOH will engage other agencies and providers to identify and implement strategies to increase awareness of and promote motor vehicle safety education, including prevention efforts focused on drug and alcohol use and texting while driving.

Domain: Children and Youth with Special Health Care Needs

The priority need is to improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN. Overarching objectives/strategies are aimed at the early identification and treatment of newborns with metabolic disorders and increasing the number of children with and without special health care needs having a medical home. The DOH will provide information and education on the Medical Home Model to primary care providers, pediatric specialists, and community providers.

Domain: Cross-cutting/Life Course

The priority needs are promoting oral health for all populations; promote positive child and youth development to reduce morbidity and mortality; and improve state and local surveillance, data collection, and evaluation capacity. Overarching objectives/strategies are aimed at increased awareness of importance of oral health across the life span; dangers of tobacco use; and importance of data to support program efforts. The DOH will begin to engage other agencies and providers to include oral health and tobacco prevention/cessation messaging as a component of all of media platforms.

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

II. Components of the Application/Annual Report

II.A. Overview of the State

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

According to 2014 population estimates from the US Census Bureau, 24.7% of the state's population are children (under the age of 18) while 7.1% are age 4 or younger. Just over 37% percent (37.3%) of the state's female population is considered to be of childbearing age (age 15 through 44). In 2014, there were 12,636 resident pregnancies (20 of those were to women not in the 15-44 year age range). Pregnancies were estimated by totaling resident pregnancies producing at least one live birth, fetal deaths and abortions.

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

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

Access to primary care providers is limited in the state. As of March 2013, there were 849 active primary care physicians licensed to practice in South Dakota (family practice – 381; internal medicine – 236; pediatrics – 120; OB/GYN – 93; general practice – 43) and 514 physician assistants. As of December 31, 2014, there were 651 actively licensed nurse practitioners and 32 actively licensed nurse midwives in South Dakota. About two-thirds of the state is designated by the federal government as a Health Professional Shortage Area (HPSA).

Another factor to consider is transportation to access services. For some, this means traveling great distances (over 50 miles) to see a primary care provider and even further to see a specialist. The majority of specialists and children's hospitals are located on the eastern side of the state. This adds additional travel and expense for families of children in the central and western regions of the state. On Indian reservations, this problem is further complicated

by the lack of a reliable transportation system. The DOH CSHS program does reimburse travel expenses incurred when traveling for specialty care for eligible CYSHCNs.

South Dakota has 49 general community hospitals, of which 38 are critical access hospitals (CAHs). There are five federally qualified health centers (FQHCs) with 33 delivery sites and 59 rural health clinics. There are five Indian Health Services (IHS) hospitals in South Dakota, of which only two provide routine obstetrical services. Recruitment and retention of primary care providers is a significant challenge for the Aberdeen Area IHS on South Dakota reservations. Housing and schools are problems South Dakota reservations face when recruiting healthcare providers. In addition, many providers do not want to go to South Dakota IHS facilities because the service area does not provide a full range of health care services (i.e., surgery, obstetrics, etc.) and providers do not want to lose competencies.

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

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

In January 2016, the DOH released its 2015-2020 Strategic Plan. The strategic plan provides a road map for the future of the DOH and helps staff work together as a department to achieve meaningful outcomes. The plan is not designed to be a compilation of all DOH programs and services but instead helps the DOH identify new things to be accomplished as well as reflect key strategic initiatives the DOH is doing today and will continue in the future. The DOH strategic planning workgroup included both central and field office staff and both administrators and program staff. An internal SWOT analysis was sent to all DOH employees to get input regarding strengths, weaknesses, opportunities, and threats of the department. In addition, an external SWOT was sent to partners (i.e., healthcare providers, health organizations/ associations, legislators, IHS/tribal representatives, medical/nursing schools, philanthropic foundations, other state agencies) to get input regarding the strengths, weaknesses, opportunities, and threats of South Dakota’s public health system.

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

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

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

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

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

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

Each objective has key strategies to help guide DOH activities. There are also 27 key performance indicators that will be tracked to allow the DOH to monitor progress towards these goals. A copy of the strategic plan is provided as an attachment and more information about the plan can be found at http://doh.sd.gov/strategicplan/.

During the 2016 legislative session there were several bills which passed that impact the MCH population in South Dakota.

- SB 28 added vaccination against meningitis to the list of immunizations required for school entry. Meningococcal vaccination will be required for entry into sixth grade. The DOH recently updated its administrative rules and starting with the 2016 school year, both Tdap (Tetanus, Diphtheria, Pertussis) and MCV 4 (Meningococcal ACYW) will be required for entry into sixth grade. Vaccine requirements for kindergarten entry have been in place for many years but this will be the first such requirement for middle school entry in South Dakota.
- SB 129 requires teachers, school administrators, and other education professionals to receive a minimum of one hour of suicide awareness and prevention training. The South Dakota Board of Education will identify evidence-based resources that will fulfill the suicide awareness and prevention training requirements and make a list of those resources available to school districts.
- HB 1104 allows a dentist to perform an "oral health review" as an alternative to a comprehensive exam when supervising a dental hygienist working under collaborative supervision. This will increase access to preventive

dental services – particularly for the state's more underserved, vulnerable populations.
- HB 1110 created a prenatal care program in DSS to provide medical care for unborn children whose mothers are ineligible for Medicaid coverage based on their citizenship status.

In May 2011, Governor Daugaard announced the appointment of the Governor's Task Force on Infant Mortality to study the state's infant mortality rate and how to reduce it. Task force members were a diverse group from rural and urban areas across the state representing physicians (including family practice, neonatology, and perinatology), nurse midwives, hospitals, rural clinics, social work, the University of South Dakota (USD) School of Medicine (SOM), IHS, Great Plains Tribal Chairmen's Health Board (GPTCHB), DOH, DSS, and Department of Tribal Relations (DTR). First Lady Linda Daugaard served as the task force chair. The Task Force developed six recommendations and accompanying strategies to reduce the state's infant mortality rate. Because South Dakota has a disproportionate number of its infants dying in the postneonatal period, many of the recommendations and strategies of the Task Force focused on providing a safe, healthy environment for the baby once home from the hospital. Recommendations include: (1) improve access to early, comprehensive prenatal care; (2) promote awareness and implementation of safe sleep practices; (3) develop community-based systems of support for families; (4) conduct statewide education campaigns to reduce infant mortality; (5) develop resources for health professionals specific to infant mortality prevention; and (6) improve data collection and analysis. The recommendations and accompanying strategies of the Task Force were intended as a starting point for action by state government, health care providers, hospitals, tribes, parents, communities, and others to reduce infant mortality and improve infant health in South Dakota. A copy of the final report can be found at http://doh.sd.gov/infant-mortality/.

While the Task Force was appointed for a one-year period and completed its work with the submission of the final report in December 2012, the DOH continues to work with task force members and other partners to implement task force recommendations. In July 2014, a team from South Dakota participated in a National Institute for Children's Health Quality (NICHQ)-sponsored Collaborative for Improvement and Innovation Network (CoIIN) meeting. South Dakota selected the following strategic priorities to address for the CoIIN initiative: (1) increase prenatal and maternal care; (2) improve family capacity to protect and promote their own health (specifically addressing tobacco use/secondhand smoke); (3) increased rates of breastfeeding; and (4) decreasing early elective deliveries (EEDs).

The For Baby's Sake website and media platform (http://forbabysakesd.com/) has safe sleep as the primary message directed at the general public, childcare and healthcare providers. The DOH emphasizes the new safe sleep guidelines by weighting this message with additional radio, Facebook and magazine advertising. With South Dakota's persistent problem with infant mortality, the DOH knows that applying safe sleep practices will positively affect the rates of death after the first 30 days of life until 1 year. The campaign objectives are to: (1) raise awareness that infant mortality is indeed a problem; (2) provide information and resources for women of childbearing age and caretakers of all ages; and (3) motivate South Dakotans to change old habits and adopt new practices specifically with regard to safe sleep.

The DOH is improving data collection through the support of statewide infant death review and the funding of a statewide PRAMS based survey. The department continues to promote infant mortality prevention messaging through social media platforms and statewide media campaigns. Culturally appropriate messaging has been developed for outlets serving Native American populations. The Cribs for Kids program in place since 2012 has expanded to additional tribal reservations. First Lady Linda Daugaard continues to champion infant mortality prevention efforts, and in 2015 obtained pledges from all 24 birthing hospitals in South Dakota to reduce early elective deliveries.

The Primary Care Task Force Oversight Committee was established in 2013 to monitor implementation of the

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

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

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

II.B. Five Year Needs Assessment Summary

Needs Assessment Update (as submitted with the FY 2017 Application/FY 2015 Annual Report)

PROCESS UPDATES

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

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

ESMs

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

SPMs

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

TITLE V PROGRAM CAPACITY UPDATES

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

As of September 2015 when SCID was implemented, South Dakota now screens for 29 disorders either pursuant to

statute or administrative rule.

AGENCY CAPACITY UPDATES

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

MCH WORKFORCE DEVELOPMENT AND CAPACITY UPDATES

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

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

PARTNERSHIPS, COLLABORATION, AND COORDINATION UPDATES

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

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

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

Tribes/Tribal Organizations - During the past year Home Visiting program staff collaborated with the Maine MIECHV program to share tribal outreach strategies and tribal government systems in order to enhance the DOH's ability to provide tribal outreach in SD.

The Home Visiting program is implemented in three of the nine reservations in SD reservation areas so cultural competence is very important to working with native clients/community partners. The two home visitors on the Pine Ridge team are Lakota and members of the Oglala Sioux Tribe and the site coordinator has lived within 30 miles of the reservation for 20 years. The Pine Ridge Reservation site is currently a part of a Tribal Formative project that is guided by staff at the Prevention Resource Center (PRC) at the University of Colorado, which serves as the research arm of NFP. This formative work involves two innovations to the traditional NFP model: (1) admitting non-first time (multiparous) women who are less than 28 weeks gestation; (2) assessing and amending the Visit to Visit Guidelines and other service delivery methods to meet the needs of the local American Indian/Alaska Native population. South Dakota chose to have Pine Ridge participate in this Formative Project due to the extremely high needs of the Oglala-Lakota people, and also to increase the potentially eligible caseload by including multiparous women as clients.

In Sisseton, the Home Visitation program has linked with GPTCHB on ECCS grant activities. The Nurse Home Visitor and Rural Team Site Coordinator are members of the First 1000 Days Interagency Committee formed to carry out the next steps from the Community GONA (Gathering of Native Americans) and the ECCS project on mitigating toxic stress in childhood. The First 1000 Days group supports the work plan of the ECCS project, and has completed a wide variety of activities including community presentations on ACES, planning for the first MCH Resiliency Conference, focus groups for the development of marketing materials, and a community resource directory.

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

new version of the Delta Dental Mobile Program. That aspect of the program includes seven dental hygienists and three community health workers who provide reservation-based services including teeth cleanings, dental sealants and fluoride applications as well as oral health education and care coordination. In 2015, the community-based staff served nearly 4,400 children ages 0 through the 8th grade. In total, Delta Dental's clinical services program served nearly 7,300 patients in 2015.

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

II.B.1. Process

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

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

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

Improve the Health Behaviors of South Dakotans to Reduce Chronic Disease

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

Strengthen the Healthcare Delivery System in South Dakota

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

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

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

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

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

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

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

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

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

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

Women/Maternal Health

South Dakota's data shows:

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

for both White and Native Americans.

- 68% of women had a past year preventive visit. Even with ACA, it is still a challenge for women to get an annual medical visit. This challenge is made worse by the fact that two-thirds of the state is considered a HPSA and the distance some women have to travel to receive care.

Conclusions:

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

Perinatal/Infant Health

South Dakota's data shows:

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

Conclusions:

Existing Programs/Strategies	Concerns:
- Family Planning - Bright Start Home Visiting Program - Baby Care Program - March of Dimes public education/awareness - WIC - South Dakota QuitLine - *For Baby's Sake* campaign/education - Cribs for Kids	- Cultural disparities - Limited NICU providers - Access to care and prenatal visits - Shortage of primary care providers - Geography and distance to providers - Hearing screening and lost to documentation rates - Continuity of care - Limited data on oral health during pregnancy

- COIIN - Statewide Infant Death Review - State Early Intervention program - Breastfeeding peer counselors for WIC clients - Newborn Metabolic Screening Program - Will soon have PRAMS data	- Maternal alcohol and tobacco use - Maternal mental health - Cultural beliefs (Safe Sleep)

Child Health

South Dakota's data shows:

- Percent of children (1-17) who have decayed teeth or cavities (19.0% in 2007) is below US Healthy People 2020 target.
- Ranked 40th in children receiving a developmental screening (43.7% 2009-10).
- Ranked 48th nationally in child mortality (ages 1-9) with a rate of 25.2 per 100,000.
- Low percent of 19-35 month olds with complete vaccine series (74.5% in 2012).
- Type of insurance coverage seems to affect immunization rates.
- High percentage of 2-5 year olds with a high BMI (33.2% in 2012).
- Rate of injury-related hospitalizations (both fatal and non-fatal) is high among 9-19 year olds.

Conclusions:

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

Adolescent Health

South Dakota's data shows:

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

Conclusions:

Existing Programs/Strategies	Concerns:
- Abstinence education program	- Title V is not the lead agency in regards to many of the

- Family Planning - OFCH offices - Rape Prevention Education program - Contract with HelpLine Center - Suicide Prevention Advisory Committee - Volunteers of America - Office of Highway Safety programs - Immunization program and awareness efforts - Office of Disease Prevention (ODP)	adolescent health initiates (i.e., suicide, mental health, traffic safety) - Young driving age in South Dakota - Lack of parent education on need for immunization at this age - Attempted suicide rates - Sexually transmitted infection (STI) rates - Electronic cigarettes - Substance abuse - Emancipated minors – adolescents living on their own - Tribal collaboration

Children and Youth with Special Health Care Needs

South Dakota's data shows:

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

Conclusions:

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

Cross-cutting or Life Course

South Dakota's data shows:

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

Conclusions:

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

- Healthy SD	- Oral health and lack of Medicaid providers

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

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

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

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

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

II.B.2.b Title V Program Capacity

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

The DOH is an executive-level department with the Secretary of Health appointed by, and reporting to, the Governor. The mission of the DOH is to promote, protect, and improve the health and well-being of all South Dakotans. The DOH is charged with the protection of the public health by appropriate measures set forth and authorized by state law. South Dakota Codified Law (SDCL) 34-1-21 designates the DOH as the sole state agency to receive, administer, and disburse federal Title V monies and authorizes the DOH to adopt rules to administer the Title V program relating to MCH and CSHS services. Administrative Rules of South Dakota (ARSD) 44:06 provides guidance on the delivery of services to CYSHCN and outlines general operation of the program, eligibility requirements, providers, family financial participation, claims, and scope of benefits. SDCL 34-24-18 requires all infants born in South Dakota to be screened for phenylketonuria (PKU), hypothyroidism, and galactosemia and provides rulemaking authority for the DOH to require additional screening for other metabolic, inherited and genetic disorders. ARSD 44:19 contains the rules regulating metabolic screening including screening for biotinidase deficiency, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders fatty acid oxidation disorders, organic acid disorders, and cystic fibrosis. The DOH is currently updating ARSD 44:19 to include screening for Severe Combined Immunodeficiency (SCID) with an anticipated effective date of August 9, 2015.

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

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

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

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

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

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

The Perinatal program provides direction and technical assistance for primary and preventive care for women and infants including risk assessment and care coordination of pregnant women, perinatal education,

prenatal/Bright Start home visits, and education on safe sleep.

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

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

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

The Child/Adolescent Health program collaborates on a variety of activities designed to promote health, prevent disease and reduce morbidity and mortality among children and adolescents including abstinence, school health guidance, drug/alcohol prevention, rape prevention, and intentional/unintentional injury prevention.

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

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

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

The All Women Count! (AWC) Breast and Cervical Cancer Control program coordinates statewide activities to promote early detection of breast and cervical cancer. Mammograms, Pap smears and related exams are

available at no cost to eligible women at many physician offices, mammography units, family planning clinics, and other clinics throughout the state. AWC serves women (30-64 years of age for pap smears, 50-64 for mammograms) who are without insurance to pay for screening exams or who have insurance but cannot pay the deductible or co-payment.

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

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

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

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

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

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

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

OFFICE OF DISEASE PREVENTION (ODP) – ODP coordinates infectious disease prevention and control programs. Within ODP, the Immunization Program provides vaccines for VFC-eligible children in South Dakota to prevent such childhood diseases as measles, mumps, rubella, varicella, HiB, hepatitis B, and bacterial meningitis. The program also provides recommendations and education on adult immunizations such as influenza, pneumonia and tetanus. The Immunization program provides vaccine materials, training, and support to

both public and private immunization providers in the state and works in partnership with local and statewide coalitions. The South Dakota Immunization Information System (SDIIS) is a computerized software system that allows healthcare providers to share immunization records.

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

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

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

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

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

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

- Linda Ahrendt, OCDPHP Administrator
- Sue Alverson, State Nutritionist

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

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

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

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

Other MCH Investments

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

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

The Maternal, Infant and Early Childhood Home Visiting (MIECHV)-funded Home Visiting program in South Dakota, Bright Start, is a partner in serving the MCH population of the state. The Nurse Family Partnership model

has a strong emphasis on prenatal care, breastfeeding, immunizations, smoking cessation, infant safe sleep, developmental screening, oral health and nutrition. Trained nurse home visitors address these and other issues with pregnant women, infants and children until age two in identified high risk counties. In addition to the direct service work, Bright Start is committed to building a system of strong data collection and an Early Childhood Comprehensive System (ECCS) in the counties served.

Other Federal Investments

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

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

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

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

Other HRSA Programs

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

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

Other DOH Programs

The DOH receives $5 million annually from the cigarette tax for tobacco prevention and control efforts. Funds are used to support cessation and statewide programming, community and school programming, and counter marketing, surveillance/evaluation, and administration. South Dakota offers QuitLine services including coaching, free tobacco cessation products, and three lifetime opportunities for tobacco users to use the QuitLine. South Dakota provides either Chantix or Zyban or patches or gum for QuitLine participants regardless of income. Since

January 2002, the SD QuitLine has assisted over 81,351 South Dakotans in their efforts to quit. The SD QuitLine has the most successful quit rate in the country at 43% (next closest is 28.7%).

Other Government Agencies

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

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

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

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

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

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

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

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

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

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

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

DHS administers the state's Respite Care Program. The program is jointly funded with state general funds, MCH block grant funds, and some DHS federal grant funds. MCH block grant funds are used to provide services for children on the program diagnosed with chronic medical conditions. CSHS program staff assist families with referral to the Respite Care Program. The program has an advisory group with representation from various state programs serving families who have children with special needs including special education, child protection, developmental disabilities, mental health, and CYSHCN. Parents are also represented on this group.

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

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

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

Tribes/Tribal Organizations

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

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

Health Professional Education Programs/Universities

The DOH has a long-standing collaborative relationship with the Center for Disabilities within the USD SOM Department of Pediatrics. The South Dakota Leadership Education Excellence in Caring for Children with Neurodevelopmental and Related Disorders (LEND) is a program of the Center for Disabilities that works to improve the health status of infants, children, and adolescents with neurodevelopmental and related disabilities. The LEND program provides one year of specialized training focusing on the interdisciplinary training of professionals for leadership roles in the provision of health and related services to infants, children and adolescents with neurodevelopmental and related disabilities and their families. The program augments graduate studies in the disciplines of audiology, health administration, medicine, nursing, nutrition, speech-language pathology, occupational/physical therapy, pediatric dentistry, psychology, and public health social work. In addition to LEND, MCH and the Center for Disabilities collaborate on a number of training and other interagency projects. The Center for Disabilities Autism Spectrum Disorders Program provided “Autism Spectrum Disorders in Public Health Settings” training to all OFCH staff including how to talk to parents when there are concerns.

Family/Community Partnerships

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

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

In addition to the activities referenced above, MCH staff also serve on a variety of workgroups and advisory boards including Highway Safety Workgroup, Oral Health Advisory Board, Healthy SD Workgroup, State

Diabetes Coalition, Parent Connection Family to Family Advisory Council, Early Intervention Coordinating Council, and Developmental Disabilities Council, and South Dakota Youth Suicide Prevention Project Advisory Committee.

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

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

II.C. State Selected Priorities

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

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

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

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

- Promote preconception/inter-conception health
- Reduce infant mortality

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

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

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

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

Priority and Population Domain	**2011-2015 MCH Priorities**	**2016-2020 MCH Priorities**
Maternal/Women Health – NPM 1 Percent of women with a past year preventive medical visit		
Reduce unintended pregnancies	X	
Improve pregnancy outcomes	X	
Promote preconception/inter-conception health		X
Perinatal Health – NPM 5 Percent of infants placed to sleep on their backs		
Reduce infant mortality	X	X
Child's Health – NPM 6 Percent of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool		
Promote positive child and youth development to reduce morbidity and mortality (intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization)		X
Improve early identification and referral of developmental delays		X
Reduce morbidity and mortality among children and adolescents	X	
Reduce childhood obesity	X	
Adolescent Health – NPM 7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 and NPM 10 Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year		
Promote positive child and youth development to reduce		X

morbidity and mortality (intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization)		
Reduce morbidity and mortality among children and adolescents	X	
Improve adolescent health and reduce risk-taking behaviors	X	
CYSHCN – NPM 11 Percent of children with and without special health care needs having a medical home		
Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN		X
Improve the health of, and services for, CYSHCN through comprehensive services and support	X	
Cross-cutting/Life Course – NPM 13 A) Percent of women who have a dental visit during pregnancy and B) percent of infants and children, 1 to 17, who had a preventive dental visit in the past year and NPM 14 A) Percent of women who smoke during pregnancy and B) percent of children who live in a household where someone smokes		
Improve state and local surveillance, data collection, and evaluation capacity	X	X
Promote oral health for all populations		X
Improve and assure appropriate access to services that are focused on families, women, infants, children, adolescents and CYSHCN	X	

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

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

- SPM 1 - Percent of suicide attempts by adolescents 12 through 17 years of age
- SPM 2 - Percentage of children, ages 2-5, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)
- SPM 3 - Percent of women (15-44 years of age) with a live birth whose observed to expected prenatal visits are greater than or equal to 80%
- SPM 4 - MCH data is analyzed and disseminated

UPDATE

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

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

As a result, the MCH team selected four SPMs.

- SPM 1: Percent of suicide attempts by adolescents ages 12 through 17
- SPM 2: Percentage of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)
- SPM 3: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent
- SPM 4: MCH data is analyzed and disseminated

II.F. Five Year State Action Plan

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

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

Promote preconception/inter-conception health

NPM

Percent of women with a past year preventive medical visit

Objectives

By June 30, 2020, increase the percent of 18-24 year old women with a past year preventive medical visit from 66.4% to 69.7%.

Strategies

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

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

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

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

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

ESMs

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

NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

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

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

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

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

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

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

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

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

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

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

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

State Action Plan Table - Women/Maternal Health - Entry 2

Priority Need

Promote preconception/inter-conception health

SPM

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

Objectives

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

Strategies

Convene a DOH-wide team to address early and adequate prenatal care

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

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

Make resources available to women and providers

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

Measures

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	70.7	71.3	71.8	72.4	73	73.6

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	69.5 %	2.3 %	97,430	140,254
2013	68.4 %	2.2 %	94,349	137,883
2012	68.9 %	1.9 %	92,628	134,431
2011	64.5 %	2.4 %	85,260	132,208
2010	71.1 %	2.4 %	94,741	133,263
2009	74.5 %	2.0 %	100,984	135,490

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	6.0	7.0	8.0	9.0

Women/Maternal Health - Plan for the Application Year

The priority need identified for this population domain is promoting preconception and inter-conception health. The overarching objectives and strategies are aimed at increased awareness of overall preventive medical care and risk factors that affect maternal and child wellness.

In order to address the ESM chosen for this measure (ESM 1.1: Number of partners who collaborate to promote well women visits), the DOH will begin to engage other agencies and providers to identify and implement strategies to increase awareness of and promote annual preventive medical visits including preconception/inter-conception and postpartum care. Some additional activities that will be implemented for this domain include:

- Through programs such as Family Planning, WIC, Baby Care, and the Tobacco Control Program provide patient education on preconception and inter-conception and postpartum health to all consumers accessing services.
- Collaborate with other agencies and offices with similar missions to increase awareness/education.
- Provide non-NFP Bright Start Home Visiting Program in service areas targeting populations at highest risk of adverse pregnancy outcomes.
- Collaborate with SDSU/EA Martin to develop and disseminate key findings of the PRAMS survey through data briefs and infographics.
- Air culturally appropriate radio media targeting Native American population areas.
- Starting summer of 2016, pregnant women enrolling in the QuitLine will be able to receive additional support through the QuitLine Postpartum Protocol.
- Promote the completion of the PROF online QuitLine training module to healthcare professionals who serve pregnant women and new mothers.
- Update tobacco policies at WIC offices to align with the SD TCP healthcare model policy.
- Provide counseling, education, medical and contraceptive services to women at risk for unintended pregnancies.

The SPM chosen for this domain is SPM 3: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent.

Women/Maternal Health - Annual Report

Unintended pregnancy resulting in live birth or abortion

- Prorated 2014 South Dakota birth certificate data based on the 2009 Perinatal Health Risk Assessment Survey data and 2014 South Dakota abortion data reflected 34.6% of pregnancies were unintended vs. 34.8% in 2013.
- Provided family planning services to 5,882 clients in CY15. Of these clients, 4,222 were women over the age of 19 and 1,295 were adolescents aged 19 and under. Of the total clients 4,464 were at or below 150 percent of poverty.
- Provided community education regarding reproductive health/family planning to 5,580 adults during CY15.
- Provided counseling, education, medical, and contraceptive services to women at risk of unintended

pregnancy.
- Provided community education to individuals and groups regarding reproductive health/family planning topics.
- Analysis of the effectiveness of the current program activities and strategies include an analysis of factors contributing to progress made. SDFP services are confidential for all clients and are provided to all clients based on a fee scale basis. No client can be denied services related to inability to pay for services.
- All family planning services are covered by ACA and clients can go to any provider for these services rather than having to utilize a SDFP clinic.

Pregnancy weight gain

- 2015 South Dakota birth certificate data reflects 28.1% of singleton birth mothers achieved a recommended weight gain vs. 28.4% in 2014.
- Supported the ForBabySakeSD website, Facebook page, and TV/radio/print media awareness campaigns.
- Contracted with SDSU/EA Martin to manage the distribution, collection, and analysis of population-based survey using PRAMS model/methodology.
- Supported/facilitated ongoing distribution of *I Didn't Know My Weight Matters* prenatal education resources to health care professionals.
- Provided education to women of childbearing age through OCFS programs and delegate family planning agencies regarding healthy weight, nutrition, preconception health, pregnancy planning and awareness, and the importance of early and regular prenatal care.
- Educated pregnant women on WIC, Baby Care, and Bright Start on healthy diet and appropriate weight gain during pregnancy, and risks associated with less than or more than recommended prenatal weight gain.
- Partnered with DSS Medicaid to assess all pregnant women for risks with the potential to adversely affect pregnancy outcome including pre-pregnancy BMI, and provided case management for women at risk.
- Promoted monthly contacts with pregnant women on WIC to provide nursing assessments, monitor weight and other health indicators, provide education, and facilitate early referrals.
- Provided NFP Bright Start Home Visiting Program in service areas targeting populations at highest risk of adverse pregnancy outcomes.

Women who smoked during last three months of pregnancy

- 2015 South Dakota birth certificate data reflects 9.5% of women smoked during the last three months of pregnancy vs. 10.2% in 2014.
- Assessed pregnant women served in OCFS offices statewide for tobacco use and readiness to quit, provided education on benefits to mother and baby of being tobacco free.
- Provided OCFS health professionals and front line staff with Quit Line 101 training with emphasis on services to pregnant/post-partum women. Trainings included information on QuitLine services and referral options.
- Provided incentives to pregnant women who successfully completed the QuitLine and quit tobacco use.
- Ran TV ads targeting pregnant women and the dangers of secondhand smoke and a CDC "Tips from Former Smokers" commercial focusing on smoking during pregnancy.
- Developed and aired a 'how-to-use" the QuitLine TV ad on broadcast and social media platforms.
- Made available a QuitLine Facebook page to pregnant women with a push to call button which allows users to have the QuitLine call them for services that help them quit. Participants enter basic contact information in order to receive a call from a Quit Coach within one business day to begin enrollment.
- Provided QuitLine services to pregnant women at no cost. All pregnant women must get a doctor's prescription before getting NRT or cessation medication. Pregnant women are also able to enroll with greater frequency than the general public.
- Partnered with the Teddy Bear Den in Sioux Falls to promote tobacco cessation. Volunteers at the Teddy Bear Den were educated on how the QuitLine works and how to help pregnant women with the initial call to the

QuitLine. The Teddy Bear Den is an incentive program for pregnant women to promote healthy lifestyles, prenatal visits, and well-baby checkups.
- Utilized the ForBabySakeSD website and Facebook pages to promote the Infant Mortality Task Force priority of educating women on benefits of being tobacco free.
- Provided training about the QuitLine to the WIC program.

Infants born to pregnant women receiving prenatal care beginning in the first trimester

- 2015 South Dakota birth certificate data reflects 71.5% of infants were born to women receiving prenatal care beginning in the first trimester. Trimester of prenatal care was determined using date last normal menses began and date of first prenatal care visit.
- Supported ForBabySakeSD website, Facebook page, TV and radio media campaign educating women on early signs of pregnancy and the importance of early and adequate prenatal care.
- Provided education to women of childbearing age at OCFS and delegate family planning sites regarding preconception health, pregnancy planning/spacing, awareness of pregnancy, and importance of early/regular prenatal care.
- Partnered with Medicaid to market OCFS services to Medicaid eligible women and facilitated early access/referral for prenatal care.
- Contracted with SDSU/EA Martin to manage distribution, collection, and analysis of population-based survey using PRAMS model/methodology.
- Assessed local plans expanding services to pregnant women at OCFS offices to foster earlier access to services, increase participation, and improve quality of care.
- Monitored strategies for assuring monthly contact with all pregnant women on OCFS caseloads to facilitate/monitor access to prenatal care, monitor health, provide ongoing education, and facilitate referrals.
- Collaborated with GPTEC and tribal health representatives to share data and foster working relationships.
- Collected and disseminated data regarding rates of early and adequate prenatal care to stakeholders including medical associations, South Dakota Perinatal Association, and other MCH partners.
- Partnered with Teddy Bear Den incentive program in Sioux Falls encouraging participants to seek early and regular prenatal care.
- Aired culturally appropriate radio media targeting Native American population areas.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

Reduce infant mortality

NPM

Percent of infants placed to sleep on their backs

Objectives

By June 30, 2020, increase the percent of infants from other races (not White or Native American) placed to sleep on their backs from 77% to 80.9%

By June 30, 2020, decrease the percent of adults who co-sleep with their child as determined in the 2016 SD PRAMS-like survey. Target for 2020 will be based on achieving a 10% reduction in this rate by 2026.

Strategies

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

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

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

Implement strategies to increase awareness of the importance of safe sleep practices targeted to Native Americans, dads, and grandparents

Collaborate with community partners to facilitate infant death review

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

ESMs

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

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

NOMs

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

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

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

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	88.2	88.9	89.6	90.3	91.1	91.8

FAD not available for this measure.

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	107,100.0	109,200.0	111,300.0	113,400.0	115,500.0

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	32.2	33.8	35.4	37.1	38.9

Perinatal/Infant Health - Plan for the Application Year

The priority need identified for this population domain is the reduction of infant mortality. The overarching objectives and strategies are aimed at increased awareness of safe sleep practices as well as other factors that affect infant

mortality.

The ESMs chosen for this measure include: (a) ESM 5.1: Number of page engagements to the For Baby's Sake Facebook page and (b) ESM 5.2: Percent of infant deaths reviewed for which a SUIDI reporting form was received. In order to address these ESMs, the DOH will begin to engage other agencies and providers to identify and implement strategies to increase awareness of the importance of safe sleep practices. Some additional activities that will be implemented for this domain include:

- Starting summer of 2016, pregnant women enrolling in the QuitLine will be able to receive additional support through the QuitLine Postpartum Protocol.
- Breastfeeding Peer Counseling (BFPC) phone and statewide e-mail service is currently being reviewed within a possible pilot anticipated for the fall of 2016. The goal would be to encourage breastfeeding using BFPC to improve overall rates for breastfeeding in an effort to reduce BMI rates for children 2-5 years of age.
- Breastfeeding-friendly business pilot was completed and will be expanded statewide. Business owners are encouraged to make the Breastfeeding-Friendly Business Pledge at: www.healthySD.gov/Breastfeeding. This will provide a positive environment where mothers can enjoy a welcoming attitude from staff, management and other patrons while breastfeeding.
- Train 50+ OCFS health professionals, many of whom are Clinic Breastfeeding Coordinators, as Certified Lactation Counselors (CLCs).
- Collaborate with other agencies and offices with similar missions to increase awareness/education of safe sleep practices.
- Continue partnership with USD Nursing Program to implement HRSA EHDI Grant including establishment of the EHDI Advisory Board Committee.

Perinatal/Infant Health - Annual Report

Newborn hearing screening prior to hospital discharge

- 97.6% of all infants born in South Dakota received a hearing screening prior to hospital discharge in 2015. There are no legislative mandates regarding performance or reporting of infant hearing screening. The linkage capability to the Electronic Vital Records and Screening System (EVRSS) provides individualized, unduplicated data through the 1-3-6 EHDI process.
- Linked hearing screenings results, audiological evaluation reports and early intervention data to EVRSS system provides the infrastructure to ensure all babies born in South Dakota receive appropriate EHDI services.
- Notified physicians of missed/not passed hearing screening results for infants 30 days of age.
- Utilized the Data Surveillance Specialist to increase EHDI awareness and reporting by the physicians to the newborn hearing screening program.
- Faxed monthly EVRSS reports of transferred, missed, and not passed hearing screenings to all birthing hospitals.
- Participated on the Heartland Regional Genetics and Newborn Screening Collaborative EHDI workgroup.
- Challenges include significant program effort required to obtain EHDI data post hospitalization. Early intervention enrollment and eligibility data is only obtained through a parent consent process that is facilitated by audiologists.
- Targeted program activities to reduce lost to follow-up rates. The EHDI team meets monthly to review the monitoring capabilities of screening, diagnostic and early intervention components of EVRSS. EVRSS demographic data is being reviewed to identify and target areas with EHDI service disparities.
- Worked with USD to establish an EHDI Advisory Committee.

- Submitted EHDI data for the Hearing Screening and Follow-up Survey (HSFS).

Infants exposed to second hand smoke

- 26.2% of infants were exposed to secondhand smoke (2011-2015 BRFSS data).
- Ran TV ads targeting pregnant women and the dangers of secondhand smoke and a CDC “Tips from Former Smokers” commercial focusing on smoking during pregnancy. Additional reach to pregnant women, including Native American population, was posted on the SD QuitLine and Find Your Power SD Facebook pages.
- Provided cessation services via the QuitLine at no cost to the caller.
- Expanded QuitLine Service to pregnant women that include an additional coaching call as well as incentive item for completing the program.
- Provided tobacco prevention/cessation materials in Bright Start Welcome Boxes to new moms to reinforce the message of not smoking during pregnancy and preventing secondhand smoke exposure for infants and young children.
- Collaborated with the Teddy Bear Den to assess tobacco use among pregnant moms, provide tobacco cessation educational materials, and refer to the QuitLine.
- Partnered with GPTCHB to provide training and funding to implement the newly developed Tribal Tobacco Policy Toolkits to Indian reservations in South Dakota. GPTCHB provided onsite training to Sisseton-Wahpeton Oyate and Oglala Sioux Tribes. In addition health care providers and tobacco control staff from tribes were provided with 5As and basic cessation training.
- Provided tobacco prevention education materials, commercial tobacco cessation information and technical assistance to healthcare providers.
- Collaborated with March of Dimes, Perinatal Association, American Cancer Society, and CHAD to educate professionals about the risks associated with smoking during pregnancy.
- Risk assessed pregnant clients and provided tobacco cessation/referral services to clients.
- Supported ForBabySake website, Facebook page, and TV/radio media campaign.
- Regularly posted to QuitLine, Rethink It, and Find Your Power Facebook pages.

Women who smoked in the last three months of pregnancy

- 2015 South Dakota birth certificate data reflect 9.5% of women smoked in the last three months of pregnancy vs. 10.2% in 2014.
- Assessed pregnant women served in OCFS offices each month for tobacco use and readiness to quit and provided education on benefits to mother and baby of being tobacco-free.
- Provided OCFS health professionals and front line staff with Quit Line 101 training with emphasis on services to pregnant/post-partum women. Trainings included information on QuitLine services and referral options.
- Provided incentives to pregnant women who successfully completed the QuitLine program and quit tobacco use.
- Ran TV ads targeting pregnant women and the dangers of secondhand smoke and a CDC “Tips from Former Smokers” commercial focusing on smoking during pregnancy.
- Developed and aired a ‘how-to-use” the QuitLine TV ad on broadcast and social media platforms.
- Made available a QuitLine Facebook page to pregnant women with a push to call button which allows users to have the QuitLine call them for services that help them quit. Participants enter basic contact information in order to receive a call from a Quit Coach within one business day to begin enrollment.
- Provided QuitLine services to pregnant women at no cost. All pregnant women must get a doctor’s prescription before getting NRT or cessation medication. Pregnant women are also able to enroll with greater frequency than the general public.
- Partnered with the Teddy Bear Den in Sioux Falls to promote tobacco cessation. Volunteers at the Teddy Bear Den were educated on how the QuitLine works and how to help pregnant women with the initial call to the

QuitLine.

Very low birth weight infants delivered at facilities for high-risk deliveries and neonates

- 2015 South Dakota birth certificate data reflects 81.5% of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates vs. 88.6% in 2014.
- Collaborated with DSVR to monitor the number of very low birth weight infants born at locations other than facilities with Level III nurseries.
- Collaborated with GPTEC and tribal health representatives to share data and foster working relationships.
- Supported statewide TV, radio, and social media campaigns to educate women on early signs of pregnancy, the importance of early and adequate prenatal care, and healthy lifestyle choices.
- Contracted with SDSU/EA Martin to manage distribution, collection, and analysis of population-based survey using PRAMS model/methodology.
- Provided education to women of childbearing age at OCFS and delegate family planning sites to promote preconception health, pregnancy planning and spacing, pregnancy awareness, early and regular prenatal care.
- Partnered with Medicaid to assess all pregnant women seen at OCFS sites for risks with the potential to affect pregnancy outcomes and provided case management for high-risk women .
- Provided NFP Bright Start Home Visiting Program in service areas targeting populations at highest risk.
- Monitored local OCFS agency health education and marketing plans for services to pregnant women including monthly contact with all on caseload to monitor health, to provide ongoing education regarding signs/symptoms of preterm labor and other complications of pregnancy, and facilitate early referrals.

Breastfeeding at 6 months of age

- 2014 National Immunization Survey (NIS) data reflects 45.6% of women breastfed their infant at 6 months vs. 49.7% in 2013. The Breastfeeding Report Card is no longer published each year.
- OCDPHP (Nutrition & Physical Activity and Healthy SD) and the WIC State Breastfeeding Coordinator participate on the South Dakota Breastfeeding coalition. Collaboration between these representatives has resulted in joint support to increase breastfeeding rates/duration across the state.
- Formed a Breastfeeding & Infant Mortality Team to work on breastfeeding promotion in South Dakota. The team has worked with communities to promote general community and peer support for breastfeeding mothers and to promote employer/business support for breastfeeding employees through policy implementation by providing support materials in the Business Kit. Brookings was selected as the pilot community for this Breastfeeding-Friendly Business Initiative and over 100 Brookings business have taken the Breastfeeding-Friendly Business Pledge to support breastfeeding mothers in the workplace, whether they are employees or customers.
- Identified a Breastfeeding Coordinator in each OCFS clinic to assist the State WIC Breastfeeding Coordinator promote World Breastfeeding Week and National Breastfeeding Month in all offices in the state.
- Updated the Breastfeeding website (www.bestfeeding.com) and promoted Best-Feeding Mom’s and Physicians kits to help to change society/social norm to make breastfeeding more accepted and for moms to feel comfortable nursing for a longer period of time.
- Worked with Growing Up Together and the Breastfeeding Peer Counselor Program to provide peer-to-peer support to mothers facing challenges in deciding to breastfeed, initiating breastfeeding, and breastfeeding for longer durations. Looking at ways to make breastfeeding peer counseling support available statewide.
- Many factors can affect breastfeeding rates and duration including perceptions that infant is not satisfied, minor problems such as plugged milk ducts, sore or cracked nipples, returning to work or school, lack of support and society views of breastfeeding. In the past year the WIC Program has been able to provide to many breastfeeding women a single user pump to help reduce these minor problems.

- Coordinated websites within the DOH with shared links to assure access to other relevant websites.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

Improve early identification and referral of developmental delays

NPM

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

Objectives

By June 30, 2020, increase the percent of children from non-metropolitan areas who have a developmental screening completed from 19.4% to 20.4%.

Strategies

Convene a partner team to look at developmental screening and referral

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

ESMs

ESM 6.1 - Number and type of partnerships to promote early childhood screening

NOMs

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

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

State Action Plan Table - Child Health - Entry 2

Priority Need

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

SPM

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

Objectives

By June 30, 2020, decrease the percentage of students 5-6 years old with a BMI at or above the 85th percentile from 26.6% to 25.2%

Strategies

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

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

Integrate nutrition and physical education into broader health promotion efforts

Promote childcare training to improve public awareness and nutrition policy

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

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.8	23.9	24	24.1	24.3	24.4

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	23.5 %	2.5 %	12,793	54,515
2007	18.8 %	2.3 %	9,922	52,682

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 6.1 - Number and type of partnerships to promote early childhood screening

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	5.0	6.0	7.0	8.0	9.0

Child Health - Plan for the Application Year

The priority needs identified for this population domain are: (1) promoting positive child and youth development to reduce morbidity and mortality including intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization; and (2) improving early identification and referral of developmental delays. The overarching objectives and strategies are aimed at increased awareness of importance of developmental screening and early identification of concerns and risk factors that affect positive child and youth development.

In order to address the ESM chosen for this domain (ESM 6.1: Number and type of partnerships to promote early childhood screening), the DOH will begin to engage other agencies and providers to identify and implement strategies to increase awareness of the importance of early childhood screening and referral for services. Some additional activities that will be implemented include:

- Continue to supply federally-funded vaccines to all enrolled clinics and state-funded vaccine to state clinics.
- Work with DSS to update immunization requirements for licensed daycares in SD.
- Track dental sealant use among children ages 6-9 enrolled in Medicaid.
- Collaborate with DSS to assist with child safety seat distribution across the state.
- Utilize Abstinence and PREP funding to educate youth on risk reduction and appropriate decision making.
- Partner with other state agencies to provide education and resources on the importance of early identification and referral of developmental delays.
- Encourage staff to add to their annual Statewide Nutrition Program a goal to reduce BMI rates among children 2-5 years of age.
- Coordinate activities with other Nutrition programs to increase consumption of fresh fruits and vegetables.
- Coordinate services with other Nutrition Programs to increase knowledge of cooking with WIC foods.
- Reduce sugary beverage intake by educating parents on impact on overall caloric intake and BMI.

The SPM chosen for this domain is SPM 2: Percentage of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile.

Child Health - Annual Report

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

- 2014 South Dakota WIC Participant and Program Characteristics (WIC PC) data reflects 36.5% of children ages 2-5 receiving WIC services have a BMI at or above the 85th percentile. WIC PC data are not directly comparable to past PedNSS data.
- Utilized the Harvest of the Month curriculum to provide creative ways to increase vegetable and fruit consumption for all ages. The tracking on the website showed that 19 childcare providers have utilized the program.
- Included several activities and objectives to address overweight and other chronic diseases in the 2015 Nutrition and Physical Activity State Plan.
- Made educational brochures available on the DOH website to provide updated consumer and provider resources for overweight and obese children.
- Offered the fitCare program face-to-face meeting format and online to increase the availability of the program. There are 502 childcare providers trained in the fitCare program.
- Initiated Physical Activity Technical Assistance (PATA). Four childcare centers have adopted physical activity policies and 32 are working toward adoption of policies.
- Promoted National Nutrition Month and National Fruit and Vegetable Month in WIC offices to promote healthy habits and partnered with SDSU Extension to provide WIC participants with monthly newsletters featuring healthy eating tips and recipes.

School-aged children and adolescents with a BMI at or above the 95th percentile (overweight or obese)

- The obesity rate in school age children has remained relatively stable the past four years. For the 2014-15 school year, the rate of obesity was 16.0%. This data represents 37.3% of the state's students and was collected from 181 schools with a total of 54,363 students. Many activities have addressed how to make better food choices and be more physically active.
- Sent Munchcode toolkits to 21 different organizations in 16 South Dakota communities to promote and encourage healthy eating. Munchcode is a color coded labeling program to show what foods are the healthiest to eat and has a model policy promoting healthy concessions.
- Utilized Harvest of the Month curriculum to provide creative ways to increase vegetable and fruit consumption for all ages. The tracking on the website showed that 175 contacts have been established by child care providers, teachers, parent and students to utilize the lesson plans.
- Included several activities and objectives to address overweight and other chronic diseases in the 2015 Nutrition and Physical Activity State Plan.
- Made educational brochures available on the DOH website to provide updated consumer and provider resources for overweight and obese children.
- Collaborated with GFP to promote physical activity in state parks through the “Go Fourth” project where every 4th grade student in South Dakota receives a free day pass certificate to be used in any state park.
- Purchased 17 eye-level beam scales and 23 wall-mounted stadiometers for 26 schools to ensure accurate data for the school height-weight surveillance project.

19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diptheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B

- 2014 NIS data shows the coverage for Measles, Mumps, Rubella, Polio, Diphtheria, Pertussis, Haemophilus Influenzea, and Hepatitis B was at 82.3%. In 2013 coverage was 74.5%.
- Supplied federally-funded vaccines to all enrolled clinics and state-funded vaccines to DOH clinics.
- Provided clinics with clinic-specific immunization coverage rates three times a year along with county, state, and national rates.
- Provided three hospital systems with their overall coverage rate and the rates for each of their clinics.
- Worked with providers to address vaccine hesitancy including methods to talk to their patients on the importance of vaccinations. Vaccine hesitancy always is an issue. Some parents do not wish to get their children vaccinated or wish to spread out the vaccinations over time and not receive all the recommended vaccines at the same time.
- Promoted the use of a reminder/recall activities in clinics.
- Provided off-site vaccination clinics for multiple rural Hutterite Colony families in eastern South Dakota. The Hutterite population is often averse to allowing more than one or two vaccinations per visit, so frequent visits are used to achieve vaccination coverage.
- Trained multiple nurses to provide immunizations at the largest OCFS site in Sioux Falls to increase opportunities to vaccinate children who are onsite for other public health services.
- Assessed immunization status of children during WIC visits and provided needed immunizations.
- Added immunization messages to the SD Infant Mortality media campaign featuring the First Lady Linda Daugaard highlighting the importance of keeping infants and children current with immunizations.
- Worked with DSS to update daycare vaccination requirements.
- Worked toward billing insurance for immunization services provided in OCFS offices.

Deaths to children aged 14 years and younger caused by motor vehicle crashes

- 2013-2015 South Dakota death certificate data and 2013-2014 South Dakota population estimates reflect 4.0 per 100,000 deaths caused by motor vehicle crashes.
- Utilized OCFS offices to promote community awareness campaigns designed to increase seat belt us and decrease distracted driving (i.e. May Mobilization Seat Belt Campaign).
- Collaborated with DSS to maintain the Child Safety Seat Distribution Program. DOH provides funding to support the purchase of safety seats for CSHCN.
- Utilized Abstinence Education funding to collaborate with Boys and Girls Club to provide risk reduction education including drug and alcohol use and appropriate decision making.

Third grade children who have received protective sealants on at least one permanent molar tooth

- In 2013-2014, the fourth Basic Screening Survey of 3rd grade students in 36 randomly selected elementary schools in South Dakota showed 56.6% of 3rd grade students had dental sealants which is higher than the national average of 33% (1994-2004 NHANES). and an increase from the baseline reported in 2003 of 49.4%.
- Provided OCFS staff with oral health training, educational materials, and hygiene resources for distribution to families served statewide.
- Updated the Oral Health State Plan which includes a strategy to expand school-based sealant programs.
- Included oral health on the South Dakota PRAMS-like survey.
- Translated the oral health and sugar sweetened brochures into Spanish to broaden outreach to targeted populations.
- Provided oral health information (including importance of preventive interventions, i.e., dental sealants, water fluoridation, and fluoride varnish applications)) to non-dental health professionals and students, Head Start/Early Head Start staff, WIC clinics (including Tribal), monthly school nurse newsletters, meetings/conferences, and via the oral health website.
- Provided two oral health brochures for the Bright Start Welcome boxes sent out monthly to approximately 1,000

new mothers.

- Collaborated with OCDPHP to incorporate oral health information into health promotion messaging, (i.e., the Nutrition and Physical Activity Program to promote water consumption and disseminate sugar sweetened beverage information, TCP to disseminate tobacco cessation and oral cancer information to dental professionals, and the Cancer Registry to disseminate oral cancer and HPV information statewide).

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

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

NPM

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

Objectives

By June 30, 2020, decrease the percentage of students who report they drove when drinking alcohol in the past 30 days from 7.9% to 7%.

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

By June 30, 2020, decrease the percentage of students who report they texted or e-mailed while driving a car or other vehicle in the past 30 days from 61.3% to 58.5%.

Strategies

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

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

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

Explore the development of a collaborative website for adolescent health information

ESMs

ESM 7.1 - Number of partners convened specific to motor vehicle safety activities

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 - Adolescent Health - Entry 2

Priority Need

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

NPM

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

Objectives

By June 30, 2020, increase the immunization rate for the >1 dose of meningococcal vaccine for adolescents 13-17 years of age from the baseline of 57% to 80%.

Strategies

Convene a DOH-wide team to address adolescent health

Implement outreach to insurance groups to promote adolescent well visits

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

Include well child visit messages in social media and other communications

Target messaging regarding tobacco cessation coaching for adolescents

Implement 6th grade vaccination requirement

ESMs

ESM 10.1 - Number of providers offered resources and outreach regarding Bright Futures

NOMs

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

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

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

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

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

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

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

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

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

State Action Plan Table - Adolescent Health - Entry 3

Priority Need

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

NPM

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

Objectives

By June 30, 2020, increase the number of adolescents 13-18 years old that enroll in the SD QuitLine from 45 to 50

Strategies

Convene a DOH-wide team to address adolescent health

Implement outreach to insurance groups to promote adolescent well visits

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

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

Target messaging regarding tobacco cessation coaching for adolescents

ESMs

ESM 10.1 - Number of providers offered resources and outreach regarding Bright Futures

NOMs

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

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

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

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

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

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

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

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

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

State Action Plan Table - Adolescent Health - Entry 4

Priority Need

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

SPM

Percent of suicide attempts by adolescents 12 through 17 years of age

Objectives

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

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

Strategies

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

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

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	337.2	334.3	331.5	328.6	325.7	322.9

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	342.9	17.4 %	390	113,725
2012	309.9	16.5 %	355	114,565
2011	339.7	17.4 %	382	112,466
2010	399.6	18.9 %	447	111,854
2009	344.1	17.5 %	387	112,460
2008	377.3	18.4 %	423	112,110

Legends:

Indicator has a numerator ≤10 and is not reportable

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

ESM 7.1 - Number of partners convened specific to motor vehicle safety activities

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	6.0	7.0	8.0	9.0

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	74.3	74.8	75.4	76	76.5	77.1

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	72.6 %	2.5 %	45,469	62,654
2007	80.2 %	1.7 %	52,984	66,070
2003	66.7 %	2.1 %	45,671	68,490

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 10.1 - Number of providers offered resources and outreach regarding Bright Futures

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	2,000.0	2,000.0	2,000.0	2,000.0	2,000.0

Adolescent Health - Plan for the Application Year

The priority needs identified for this population domain are to: (1) improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN; and (2) promote positive child and youth development to reduce morbidity and mortality. The overarching objectives and strategies are aimed at preventing adolescent injuries, suicides, and motor vehicle deaths through awareness of importance of preventive service visits and healthy lifestyle choices.

The ESMs chosen for this domain are: (a) ESM 7.1: Number of partners convened specific to motor vehicle safety activities; and (b) ESM 10.1: Number of providers offered resources and outreach regarding Bright Futures. In order to address these ESMs, the DOH will begin to engage other agencies and providers to identify and implement strategies to increase awareness of and promote motor vehicle safety education, including prevention efforts focused on drug and alcohol use and texting while driving. Additional activities that will be implemented for this domain include:

- Collaborate with GFP to promote physical activity in SD parks through the Go Fourth Project where every fourth grade student in SD receives a free day pass certificate issued by GFP to be used at any state park.
- Support and promote HelpLine Center 24/7 statewide crisis line, follow up crisis calls, teen crisis texting support, and youth mental health first aid training.
- Utilize Abstinence and PREP funding to educate youth on risk reduction and appropriate decision making.
- Work with media firm to provide public education outreach to youth to encourage fruit and vegetable consumption.
- Promote community awareness campaigns designed to increase seat belt use and decrease distracted driving through OCFS community offices.

- Provide evidence-based tobacco prevention curriculum to South Dakota schools.
- Conduct counter marketing/public education campaigns targeting youth that is specific to tobacco prevention and cessation.
- Collaborate with GFP to produce and distribute a camping cookbook that includes healthy recipes for camping. Cookbooks will be distributed in campgrounds and various Nutrition and Physical Activity meetings across the state.
- Provide height and weight equipment to schools upon request for use for the purpose of collecting data for the school height and weight surveillance project.
- Provide counseling, education, medical and contraceptive services to youth at risk for unintended pregnancies.
- Collaborate/strengthen partnerships across the state to use evidence-based, up-to-date resources as a way to continue making progress around healthy lifestyle choices, injury prevention, motor vehicle safety, suicide prevention, preventive service visits, and immunizations.

The SPM chosen for this domain is SPM 1: Percent of suicide attempts by adolescents ages 14 through 18.

Adolescent Health - Annual Report

School-aged children and adolescents with a BMI at or above the 95th percentile (overweight or obese)

- The obesity rate in school age children has remained relatively stable the past four years. For the 2014-2015 school year, the rate of obesity was 16%. This data represents 37.3% of the state's students and was collected from 181 schools with a total of 54,363 students.
- Promoted Munchcode to 93 non-school organizations to promote and encourage healthy eating in communities.
- Utilized Harvest of the Month curriculum to provide creative ways to increase vegetable and fruit consumption for all ages. The tracking on the website showed that 192 new accounts have been established by child care providers, teachers, parent and students to utilize the lesson plans.
- Included activities and objectives to address obesity in schools in the 2015 Nutrition and Physical Activity State Plan.
- Made educational brochures available on the DOH website to schools and others who serve the youth.
- The effectiveness of the current program strategies is evident since the rate of obesity has not increased. The use of technology has improved the reach of available resources. Staff retention has also contributed to the success and growth of the effort to reduce the rate of obesity in school aged children.
- Environmental factors contribute significantly to a person’s health and physical activity behavior, specifically access to physical activity opportunities. South Dakota’s rural geography greatly impacts access to physical activity opportunities. Less than half of South Dakota youth have access to parks, community centers, and sidewalks in their neighborhood. Another challenge that affects physical activity opportunity is the weather in South Dakota.

Teen births for 15-17 years

- 2015 South Dakota birth certificate data and 2014 South Dakota population estimates reflect 9.3 per 1,000 teen births -- down from 13.3 in 2014.
- Provided family planning services (i.e., counseling, education, medical exams, STI screening, contraceptive supplies) to 1,295 adolescents age 19 and under during CY15; approximately 36% of adolescents seen were 17 years of age or younger.
- Provided community/school education services related to reproductive health to 3,775 adolescents in CY15.
- Utilized PREP grant funds to provide instruction utilizing evidence-based curriculum “Reducing the Risk” to 101

adolescents in corrections or foster care from August 1, 2014 through July 31, 2015. 170 adolescents in the care of DSS received instruction utilizing evidenced based curriculum “Be Proud Be Responsible” or “Reducing the Risk” funded by the PREP grant.
- Provided abstinence education to 227 youth ages 9-11 (10-01-14 to 09-30-15).
- Provided community/school education services related to reproductive health upon request to adolescents.

High School youth who self- reported tobacco use in the past 30 days

- 2015 Youth Risk Behavior Survey (YRBS) data show 10.1% of high school youth self-report use of tobacco in the past 30 days -- a decrease from 16.5% in 2013.
- Referred individuals for tobacco cessation services via the QuitLine at no cost to the caller.
- Funded 23 school districts to help implement evidence-based youth prevention and cessation programming. Student-led tobacco control activities in these districts reached 6,087 students and adults.
- Provided resources to community groups, schools, parents, health care providers, and others working on tobacco prevention.
- Assisted with awareness of non-traditional media like Pandora, YouTube pre-roll, and Facebook to reach youth and young adults.
- Promoted Rethink Tobacco (www.rethinktobaco.com) which is an interactive tobacco prevention and cessation website for teens and young adults that includes engaging content on tobacco industry threats and the dangers of tobacco use, resources on how to quit and stay quit, online games, etc. The Rethink Tobacco facebook page compliments the website and is geared toward prevention efforts.

Suicide deaths among youths aged 15 through 19

- 2013-2015 South Dakota death certificate data and 2013-2014 South Dakota population estimates reflect 29.5 per 100,000 suicide deaths among youth aged 15 through 19.
- Supported and promoted HelpLine Center 24/7 statewide crisis line, Crisis texting program, suicide prevention website, and mental health first aid training for youth.
- Participated on the South Dakota Youth Suicide Prevention Advisory Committee. Targets/activities include: (1) Emergency Departments – targets youth (ages 10-24) who are admitted with suicidal ideation or suicide attempts and then discharged; (2) Inpatient Behavioral Health Units – targets youth (ages 10-24) who are admitted to an inpatient behavioral health unit with suicidal ideation or suicide attempts; (3) Colleges/Universities – works with three targeted colleges to train faculty and staff on identification of at-risk youth and a formal referral protocol. (4) Juvenile Justice Programs – staff at juvenile justice programs will be provided the Shield of Care training program, including a review of protocols to help at-risk youth. (5) K-12 schools – an online training program to assist school staff in identifying at-risk students will be introduced; (6) RRSR (Recognizing and Responding to Suicide Risk) a two-day training provided by the American Association of Suicidology for clinicians to better identify and manage suicide risk in their clients; and (7) developing public awareness campaigns.

Accidental death rate among adolescents aged 15 through 19 years

- 2015 South Dakota death certificate data and 20134South Dakota population estimates reflect an accidental death rate among adolescents aged 15 through 19 years of 22.5 per 100,000 vs. 31.3 in 2014.
- Utilized OCFS office to promote community awareness campaigns designed to increase seat belt use and decrease distracted driving (i.e. May Mobilization Seat Belt Campaign).
- Collaborated with DSS to maintain the Child Safety Seat Distribution Program. OCFS offices assist in the distribution of the car seats. DOH provides funding to support the purchase of safety seats for CSHCN.
- Utilized Abstinence Education funding to collaborate with Boys and Girls Club to provide risk reduction

education including drug and alcohol use and appropriate decision making.

Children with Special Health Care Needs

State Action Plan Table

State Action Plan Table - Children with Special Health Care Needs - Entry 1

Priority Need

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

NPM

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

Objectives

By June 30, 2020, increase the percentage of CYSHCN who report receiving care in a well-functioning system from 17.6% to 18.6%.

By June 30, 2020, all infants whose newborn screening test results are outside the normal limits for a newborn screening disorder will receive prompt and appropriate follow-up testing.

Strategies

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

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

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

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

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

Coordinate the newborn screening infrastructure including: (a) contract laboratory for newborn screening of all South Dakota births; (b) medical consultants to address appropriate testing and treatment for presumptive positive; and (c) birth certificate match and short-term follow-up to ensure all babies are screened

ESMs

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

NOMs

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

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

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

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

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

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

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

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	53.9	54.3	54.7	55.1	55.6	56

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	52.7 %	4.0 %	15,450	29,333
2007	51.9 %	3.7 %	16,620	32,006

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	63.2 %	1.7 %	105,889	167,521
2007	65.7 %	1.6 %	102,113	155,519

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives

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

Children with Special Health Care Needs - Plan for the Application Year

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

In order to address the ESM chosen for this domain (ESM 11.1: Number of trainings for providers on components of medical home model), the DOH will provide information and education on the Medical Home Model to primary care providers, pediatric specialists, and community providers. Some additional activities that will be implemented for this domain include:

- Strengthen partnerships with the Medicaid Health Home program.
- Collaborate with SDPC on parent training opportunities, FILEs, Transition clinics, Family to Family contacts, and other activities to support families.
- Strengthen relationships with medical specialists in South Dakota to assure appropriate follow-up and medical management for infants with positive newborn metabolic screening results.
- Provide service coordination and financial assistance to children with chronic medical conditions and their families to ensure comprehensive care.
- Maintain a listserv to share training and resource information to families in a more timely manner.

Children with Special Health Care Needs - Annual Report

Screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs

- 99.6% of all infants born in South Dakota received a dried blood spot specimen for mandated newborn screening testing. For those infants confirmed to have a newborn screening disorder, 100% are receiving medical management.
- Contracted with SHL for the provision of newborn screening laboratory services for South Dakota's mandated newborn screening of 29 Core Conditions listed on the RUSP.
- Partnered with Sanford Children's Specialty Clinic for newborn screening program medical consultants, genetic counseling and program recommendations.
- Collaborated with SHL and South Dakota healthcare providers to locate and follow-up on all infants with out-of-normal range test results.
- Utilized EVRSS to match metabolic newborn screening records to the birth certificate ensuring follow-up and identification of "Never Tested" infants.
- Monitored program quality indicators such as poor quality specimen percentage rates, incomplete specimen card information, and specimen timeliness.
- Participated on the Heartland Regional Genetics and Newborn Screening Collaborative Advisory Committee.
- Began testing for SCID September 1, 2015.
- Held face-to-face newborn screening meeting with Sanford medical consultants, SHL director, SHL biochemist, and short-term follow-up coordinator to discuss cystic fibrosis CFTR mutations common among Hutterite population groups and review of SCID Protocols.
- Discontinued Newborn Screening Long-Term Follow-up Program due to statute revisions to newborn screening language and definitions.
- Modified parent letter regarding information and linkage to the HealthKiCC program.

CYSHCN whose families partner in decision making and are satisfied with services; receive coordinated, ongoing, comprehensive care within a medical home; whose families have adequate private and/or public insurance to pay for the services they need; whose families report the community-based service systems are organized so they can use them easily; and receive the services necessary to make transitions to all aspects of adult life.

- Data is from the 2009-2010 CSHCN survey. There is no new data to report.
- Collaborated with SDPC on parent training opportunities, FILEs, Family to Family contacts, and other activities to support families. For reporting year SDPC served 707 families through 1,842 contacts. Of 1,421 total dependents count (duplicated), child/youth ages were identified as 15% ages 0-5, 50% ages 6-12, and 35% ages 13 and above. In addition 794 professionals were served through 1,591 contacts.

- SD Parent Connection (Family Training Center) acts as the coordinator for identifying parents of individuals with disabilities that are willing to serve as a family advocate/voice on multiple committees/councils/trainings.
- Supported MyFILE transition tool trainings for youth/families in 7 locations in 2015. Youth/family trainings utilize the MyFile transition tool and are delivered in collaboration with local partners, such as school and a wide variety of community organizations. The trainings provide opportunities for youth and parents to connect directly with the adult service systems/providers they are likely to utilize. This builds awareness of services available and establishes personal links that will help bridge the transition to systems/services that may otherwise seem overwhelming. These partnerships are especially important when delivering trainings in underserved communities such as the state's Indian nations, where partnership with a trusted community organization is essential for success.
- Strengthened relationships with medical specialists in South Dakota to assure appropriate follow-up and medical management for infants with positive newborn metabolic screening results.
- Provided service coordination and financial assistance to children with chronic medical conditions and their families to ensure comprehensive care.
- Maintained e-mail address and website for families to access assistance via the internet. Maintain a listserv to share training and resource information to families in a more timely manner.
- Contracted for genetic outreach services in western South Dakota.
- Collaborated with community programs to identify available community resources for families
- Represented DOH on the RHOP Consortium Leadership Team to bring together a broad group of stakeholders to engage in information exchange, problem-solving, and consensus-building around the national agenda for CYSHCN.
- Collaborated with DHS and SSA to facilitate resource/referral mailings to all individuals who applied for SSI Disability and were denied.
- Provided financial support to the State's Respite Care program which was able to serve 962 children and adults in 701 families.
- Collaborated with DSS Child Care Services to provide 11 special needs car seats as a part of their Child Safety Seat Distribution Program.

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - Cross-Cutting/Life Course - Entry 1

Priority Need

Promote oral health for all populations

NPM

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

Objectives

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

By June 30, 2020, increase by 10 percentage points the proportion of children who received a dental sealant on at least one permanent molar from 57% to 59.9%.

Strategies

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

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

Identify a target population and oral health messaging to enhance public awareness efforts including messaging on DOH media platforms

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

Conduct Oral Health Basic Screening Survey of 3rd graders

ESMs

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

NOMs

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

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

State Action Plan Table - Cross-Cutting/Life Course - Entry 2

Priority Need

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

NPM

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

Objectives

By June 30, 2020, increase the percent of adults who report smoking is not allowed anywhere in their home from 86% to 90.3%.

By June 30, 2020, reduce the percentage of pregnant females that smoke from 14.8% to 8.1%.

Strategies

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

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

ESMs

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

NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

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

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

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

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

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

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

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

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

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

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

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

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

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

State Action Plan Table - Cross-Cutting/Life Course - Entry 3

Priority Need

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

SPM

MCH data is analyzed and disseminated

Objectives

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

Strategies

- Review all data sets available and identify any gaps
- Identify data collection methods to address gaps
- Implement new data collection efforts as needed
- Develop and disseminate fact sheets on findings
- Analyze the data to identify future program efforts

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	48.1	48.4	48.8	49.2	49.5	49.9

FAD not available for this measure.

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	79.7	80.4	81.0	81.7	82.3	83.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	77.8 %	1.4 %	147,938	190,201
2007	80.7 %	1.3 %	146,392	181,494

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	2.0	3.0	4.0	5.0

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	12.6	11.4	10.3	9.2	8.1	7.0

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	14.8 %	0.3 %	1,807	12,204
2013	15.1 %	0.3 %	1,837	12,184
2012	16.5 %	0.3 %	1,992	12,056
2011	16.9 %	0.4 %	1,987	11,765
2010	17.2 %	0.4 %	2,003	11,679
2009	18.5 %	0.4 %	2,183	11,778

Legends:

Indicator has a numerator <10 and is not reportable

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

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

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	26.8	26.5	26.2	25.9	25.5	25.2

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	27.5 %	1.5 %	55,055	200,548
2007	25.0 %	1.4 %	48,253	193,314
2003	34.9 %	1.5 %	57,491	164,827

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	2.0	3.0	4.0	5.0

Cross-Cutting/Life Course - Plan for the Application Year

The priority needs identified for this population domain are to: (1) promote oral health for all populations; promote positive child and youth development to reduce morbidity and mortality; and (2) improve state and local surveillance, data collection, and evaluation capacity. The overarching objectives and strategies are aimed at increased awareness of importance of oral health across the lifespan, dangers of tobacco use across the lifespan, and importance of data to support need for programs and effectiveness of efforts.

The ESMs chosen for this domain include: (a) ESM 13.1: Number of media platforms (i.e., websites, Facebook, TV, radio, print) that promote oral health messaging; and (b) ESM 14.1: Number of media platforms (i.e., websites, Facebook, TV, radio, print) that includes tobacco prevention/cessation messages. In order to address the ESMs chosen for this domain, the DOH will begin to engage other agencies and providers to include oral health and tobacco prevention/cessation messaging as a component of all of media platforms. Some additional activities that will be implemented for this domain include:

- Collect, track and analyze PRAMS data to monitor awareness of the importance of oral health throughout pregnancy, including before and after.
- Collect, track and analyze PRAMS data to monitor access to dental care for pregnant women.
- Track preventative dental services for children enrolled in Medicaid.
- Track dental sealant use among children ages 6-9 enrolled in Medicaid.
- Collaborate with Home Visiting programs to provide oral health resources and materials for staff and families that they serve.
- Provide links to DSS Medicaid website.
- Provide information on the ACA and Healthcare.gov to families.
- Assist families with accessing IHS contracted services/assistance as appropriate.
- Distribute letters to families with children having a disorder detected through newborn screening to offer them additional information on such topics as locating providers, support groups, services, and financial assistance.
- Partner with providers across the state to provide education and resources on importance of oral health and tobacco cessation.
- Work with data and epidemiology staff to identify data gaps and begin implementation of steps to collect needed data.

The SPM chosen for this domain is SPM 4: MCH data is analyzed and disseminated. Activities to be implemented include implementation of CDC PRAMS in 2017 and dissemination of PRAMS data using data briefs and infographics.

Cross-Cutting/Life Course - Annual Report

Children without health insurance

- 2015 BRFSS weighted data and 2014 South Dakota population estimates reflect 2.4% of children do not have access to health insurance.
- Referred families seeking services at OCFS offices to DSS Medicaid program as appropriate and assisted with completion of forms as needed.
- Provided links to DSS Medicaid website.
- Required all clients requesting financial assistance from CSHS to apply for Medicaid.
- Provided information on the ACA and Healthcare.gov to families.
- Assisted families with accessing IHS-contracted services/assistance as appropriate
- Mailed letters to families with children in the metabolic LTFU program offering then additional information on such topics as locating providers, support groups/services, and financial assistance.

Other Programmatic Activities

At the time of grant submission, South Dakota was uncertain as to what investments might fall outside a direct linkage to state priorities. The MCH team purposely wrote the need statements to be overarching of many areas of concern. South Dakota will continue to fine tune objectives and strategies via review of data and determine the ongoing justification for continuance or discontinuance.

II.F.2 MCH Workforce Development and Capacity

As was mentioned earlier, Division of Family and Community Health is the health care service delivery arm of the DOH and administers MCH services and consists of three offices.

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

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

OCDPHP coordinates programs designed to promote health and prevent disease. The office coordinates statewide activities to promote early detection and education of breast and cervical cancer, colorectal cancer, cardiovascular disease, stroke, diabetes, overweight and obesity, and tobacco control. In addition, the DOH has a chronic disease epidemiologist who provides epidemiological support for the chronic disease and health promotion programs as well as for MCH programs.

ODPS provides vaccines for South Dakota's children to prevent such childhood diseases as measles, mumps, rubella, varicella, HiB, hepatitis B, and bacterial meningitis and provides recommendations and education on adult immunizations such as influenza, pneumonia, and tetanus. Staff investigate sources of STI infections, provide treatment and apply preventive measures to those exposed. Field offices provide confidential counseling and testing

for HIV/ AIDS as well as educational materials, training for the public/schools/health care providers, and assistance with health care costs for those with HIV disease. The office provides TB clinics and contracts with the private medical sector for evaluation, treatment, and follow-up of TB cases. ODPS also conducts disease outbreak investigations in the state.

Projections indicate that thousands of additional healthcare workers will be needed in the healthcare industry in South Dakota in the near future. In addition, there will be a substantial decrease in the number of high school graduates in our state. At the same time as the number of young people decreases, the number of elderly is increasing significantly. By the year 2025, South Dakota is projected to have the 9th highest portion of elderly nationally. In order to begin to address these needs, the South Dakota Healthcare Workforce Initiative, a collaborative effort between DOH, DOE, the Department of Labor, and the Board of Regents, has been implemented. The overall goal of this initiative is to address healthcare workforce issues in South Dakota and to work toward ensuring a competent and qualified healthcare workforce that meets the needs of all South Dakota citizens. The South Dakota Healthcare Workforce Center was established within ORH to function as a clearinghouse for healthcare workforce-related data and information. The Center is also designed to develop and implement programs and projects that assist individuals, agencies, and facilities in their efforts to address current and projected workforce needs. ORH also works to improve the delivery of health services to rural and medically underserved communities, emphasizing access. Specific program examples include recruitment of health professionals, assistance to facilities such as hospitals and rural health clinics, helping interested organizations develop and use technology applications and general information and referral. ORH manages the J-1 Visa Waiver Program to help rural communities recruit foreign or international medical graduate physicians.

In addition, MCH workforce development includes internal training/staff development opportunities. Staff orientation modules have been developed to assist new hires in acclimating to the OCFS infrastructure and program delivery. Formal needs assessments are conducted every other year to assist in identifying training needs of the OCFS staff. In addition, as a part of our performance appraisal system there is a section entitled: Development. Staff are to identify at least one behavior or one performance expectation to develop over the coming year and what means will be used to evaluate progress made during follow up coaching and evaluation sessions. This is one way of addressing individual workforce development needs.

II.F.3. Family Consumer Partnership

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

MCH staff serve on multiple advisory panels, councils, and workgroups that bring together family/consumer partners. These groups while each having their own focus all include consumers that provide insight and direction to inform decision making at all levels. This includes the advisory group for the HRSA Hearing Grant, early intervention State Interagency Coordinating Council, Developmental Disabilities Council, SD Youth Suicide Prevention Advisory Committee, and Jolene's Law Task Force (child sexual abuse). This assists in ensuring our services are targeted to best meet consumer needs.

As the DOH moves forward through this five year grant cycle and the ongoing development of the state’s action plan,

it will continue to identify ways to engage families/consumers in planning, development and evaluation.

All MCH programs attempt to implement processes which result in a workforce that is culturally and linguistically competent and a system that attempts to facilitate the highest quality of care to all communities while acknowledging and respecting the consumer's health-related beliefs and cultural values. In addition, demographic data was looked at for each population domain during the needs assessment population to identify areas where there were disparities and the potential for new strategies to address those disparities.

II.F.4. Health Reform

South Dakota does not operate a state-based marketplace, which means that under federal law South Dakotans are part of a federally facilitated marketplace. An online portal is available for individuals to enroll through the marketplace in the individual market. In addition, Get Covered South Dakota, a statewide initiative developed by CHAD is available to work with CHCs and other community leaders to find solutions for improving healthcare options throughout the Dakotas. Get Covered South Dakota connects people to affordable healthcare options and enhances access to quality primary care. This initiative links South Dakota residents with enrollment specialists in their local communities. Free impartial assistance is available to help consumers understand and find affordable healthcare coverage. South Dakota MCH programs continue to assist MCH populations served with information and referral to assistance programs to identify what is the best form of insurance coverage available to them. Financial assistance under the Health KiCC continues to be provided as a gap-filler for those families that are uninsured or underinsured.

In March 2015, Governor Daugaard submitted a concept paper to HHS asking the federal government to reconsider how it funds Medicaid services for IHS eligible that are provided outside of the IHS system. Eligible South Dakota Native Americans are served by the Great Plains Indian Health Service Unit. However, actual access to IHS is limited in all areas of the state, and IHS contract care budgets do not meet the demand for healthcare beyond even limited emergency services. As a result, Native Americans eligible for IHS services use non-IHS services at high rates, and often at higher cost than if they were able to access care earlier and closer to home.

The state Medicaid program pays almost twice as much for health care for Native Americans by non-IHS providers as IHS providers. For Native Americans eligible for IHS services and also Medicaid eligible, health care expenditures provided through IHS are reimbursed at 100% federal funds through Medicaid. Health care expenditures for Medicaid eligible Native Americans by a non-IHS provider are reimbursed at the state's regular FMAP (51.62% federal/48.38% state in state fiscal year 2016). For this reason it is fiscally beneficial to the state to help eligible Native Americans get care from IHS instead of non-IHS providers. Given the capacity issues with IHS, the state is looking for innovative ways for eligible Native Americans to get care that qualifies for 100% federal funding as it would if IHS were able to provide it.

The state, in collaboration with IHS and non-IHS health care provider, is specifically seeking to implement different strategies to significantly augment services that can be provided to Medicaid eligibles through 100% federal funding authority through a variety of strategies. Examples include using health care specialists available through non-IHS providers to serve patients at IHS sites via telehealth or specialty clinic arrangements. Other examples include use of telehealth emergency room services to reduce non-emergency transfers of patients from IHS to non-IHS providers in the state and the provision of clinic services in non-reservation population centers to better serve IHS eligible Native Americans. For these strategies to work there would need to be flexibility in how IHS services are defined in terms of providers and locations of services for the purposes of Medicaid reimbursement. That means CMS would pay the same match rate (100% federal) as they would today for IHS services to Medicaid eligibles, but for more services

than the current IHS system can accommodate. These strategies would benefit both the current Medicaid population and the Medicaid expansion population eligible for services from IHS.

The result of increasing access to services to individuals eligible for IHS would include better health outcomes for South Dakota Native Americans. With an increase in IHS funded services through Medicaid at 100% federal funds, state general funds used now to pay for services to this population would be redirected to offset the costs of expanding Medicaid in South Dakota. That would result in coverage for 48,000 additional people in South Dakota, more than a quarter of whom are Native American.

In October 2015, Governor Daugaard appointed a SD Health Care Solutions Coalition to explore the potential for Medicaid expansion in South Dakota and the Governor's FY17 recommended budget included increased federal funding authority in the state budget to expand Medicaid. However, South Dakota did not receive a formal decision on the IHS policy change from HHS until the last week of session and the Legislature did not have adequate time to thoroughly consider the issue so the funding was removed from the budget. Governor Daugaard has committed to continuing to discuss the issue for possible consideration during the 2017 legislative session.

II.F.5. Emerging Issues

SB 28 added vaccination requirements and updated administrative rules that will go into effect at the start of the 2016 school year. This update highlights the work that is currently underway in the OCFS to include a billing process for immunizations administered by the community health nurses in field. The billing processes will be finalized in 2016 with opportunities beyond immunizations moving forward.

In June 2016, South Dakota participated in a Learning Collaborative on Improving Quality and Access to Care in Maternal and Child Health. As a part of this planning South Dakota will be working with our legislative, Medicaid and AAP partners to address NPM 10 focusing on adolescent well visits and SPM 3 to increase early and ongoing prenatal care. With a clear connection between well visits and improving adolescent vaccination rates the team will begin to work over the next year to review available data and engage additional partners to improve adolescent well visits.

Adolescent health within MCH will be under review in the next year to look for partners and assistance to move the measures and strategies forward. South Dakota is in a good position to look at data and gather information around what would motivate parents to utilize the opportunity of a well visit and how to work with providers on evidence based reminder-recall strategies.

Community Health Services offices are seeing an increase need for interpretation services to improve the quality of service and improve outcomes. Currently both in-person and phone translation is utilized for WIC and MCH services as well as Home Visiting. Immigrant populations are increasing in three locations in the state and the need continues to increase. The DOH will continue to monitor the interpreter needs as well as translation of key resources.

II.F.6. Public Input

The DOH made the FY 2017 MCH block grant available for public review and comment via the DOH website, Facebook page, Health KiCC list serve, and twitter. The summary was also provided to all MCH team members asking them to forward to any partners that would be involved in our MCH activities and initiatives. These team members and partners then in turn shared the summary via Facebook pages, websites, list serves, newsletters, and email. A few of the partners reached were SD Parent Connection and the families they serve, tribal representatives,

Infant Death Review team members, Birth to 3 Early Intervention families and providers, Behavioral health providers, and DD Council members. In addition, the summary was provided to DOH field offices to display for clients to request, review, and provide comments on the state plan. The DOH received one public comment from a physical therapist suggesting another way to measure gains for children ages 0-3 identified as having a developmental delay in future grants. The DOH will refer to this comment when ongoing needs assessment and State Action Plan activities and measures are reviewed and modified as appropriate.

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

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

II.F.7. Technical Assistance

The MCH program is committed to assuring all MCH populations in the state receive the highest quality care and have optimal health. The MCH program has currently not identified any technical assistance needs for the FY2017 MCH block grant. As needs are identified, the MCH program will seek technical assistance.

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,236,264	$2,629,154	$2,097,088	$2,511,344
Unobligated Balance	$0	$336	$0	$0
State Funds	$1,718,000	$1,558,348	$1,615,000	$1,675,612
Local Funds	$400,000	$485,427	$400,000	$523,814
Other Funds	$0	$0	$0	$10,348
Program Funds	$300,000	$661,953	$403,000	$736,796
SubTotal	$4,654,264	$5,335,218	$4,515,088	$5,457,914
Other Federal Funds	$18,516,582	$21,937,122	$19,918,149	
Total	$23,170,846	$27,272,340	$24,433,237	$5,457,914

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,133,894	$2,476,338	$2,236,264	
Unobligated Balance	$0	$0	$0	
State Funds	$1,575,000	$1,766,341	$1,680,000	
Local Funds	$450,000	$487,134	$500,000	
Other Funds	$0	$22,650	$0	
Program Funds	$625,000	$810,181	$740,000	
SubTotal	$4,783,894	$5,562,644	$5,156,264	
Other Federal Funds	$19,329,349	$24,556,280	$20,239,995	
Total	$24,113,243	$30,118,924	$25,396,259	

	2017	
	Budgeted	Expended
Federal Allocation	$2,476,338	
Unobligated Balance	$0	
State Funds	$1,766,341	
Local Funds	$487,134	
Other Funds	$22,650	
Program Funds	$810,181	
SubTotal	$5,562,644	
Other Federal Funds	$20,613,679	
Total	$26,176,323	

III.A. Expenditures

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

The budget amounts reflect anticipated activities of program and field staff but actual expenditures can vary based on the state economy and public health events (i.e., outbreaks, natural disasters). South Dakota law prohibits deficit spending so the Governor and state Legislature control the spending of general funds that in turn affect dollars that are available for MCH block grant match.

III.B. Budget

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

The budget outlines areas for which Title V funds will be allocated. Development of the budget complies with the "30-30" requirement for primary and preventive care and special health care needs for children and adolescents and is consistent with the requirements to limit administrative costs to no more than ten percent. The DOH maintains the overall level of funds for MCH at the level established in FFY 1989. For this reporting year, South Dakota allocated 30.6% of the federal dollars for CYSHCN. The DOH monitors funding allocations quarterly to ensure compliance. The DOH spends more than one year of federal allocation but is difficult to reflect due to the overlapping periods of obligation under the previous fiscal year and the spending of funds in the current fiscal year. The DOH continues to

align funding resources to support the MCH priority areas and selected measures.

Appropriation of general funds for MCH state match is at the discretion of the Legislature, Governor's Office, and DOH. State match funding sources are state funds (including general funds appropriate by the Legislature), local match, program income, and other sources. The level of funds utilized from each match source varies from one year to the next based on availability of funds and the state's allocation process. Increasing inflationary costs have depleted revenue reserves within the DOH and the state as a whole requiring shifts in match fund sources. Private donations to support infant mortality/safe sleep were available this year.

Budget development is subject to rules and requirements set by BFM dictating both the process and content of the budget, including availability of funds and limitations on authorization levels. State MCH programs were first required to use the current format of reporting budgets and expenditures (including levels of the pyramid) in FFY 1999. Since that time, South Dakota has been refining the budget development and expenditure process to meet both state and federal rules and requirements. The DOH continues to work to move to accounting programs that more easily reflect population group and pyramid level reporting requirements. The DOH receives funding for the MIECHV, EHDI, Abstinence, PREP, Family Planning, SSDI, and WIC and continues to partner with other state agencies to plan and implement services related to these grants.

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

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

Supporting Document #01 - DOHStrategicPlan.pdf

Supporting Document #02 - mch org charts.pdf

Supporting Document #03 - MaternalChildHealth_06-16_SD.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: South Dakota

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,476,338	
A. Preventive and Primary Care for Children	$ 788,961	(31.9%)
B. Children with Special Health Care Needs	$ 786,980	(31.8%)
C. Title V Administrative Costs	$ 74,290	(3%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,766,341	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 487,134	
5. OTHER FUNDS (Item 18e of SF-424)	$ 22,650	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 810,181	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 3,086,306	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 5,562,644	
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)	$ 20,613,679	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 26,176,323	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 75,104
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 105,347
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 17,117,047
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 212,897
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 230,118
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,186,339
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,298,277
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 138,550
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,133,894		$ 2,476,338	
A. Preventive and Primary Care for Children	$ 682,846	(32%)	$ 759,303	(30.7%)
B. Children with Special Health Care Needs	$ 661,507	(31%)	$ 757,246	(30.6%)
C. Title V Administrative Costs	$ 106,695	(5%)	$ 92,604	(3.7%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,575,000		$ 1,766,341	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 450,000		$ 487,134	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 22,650	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 625,000		$ 810,181	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,650,000		$ 3,086,306	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 4,783,894		$ 5,562,644	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 19,329,349		$ 24,556,280	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 24,113,243		$ 30,118,924	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 123,209
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 122,802
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 21,400,233
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 149,661
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 207,945
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 987,942
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,130,439
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 184,049
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Reduction in administrative charges to grant	
4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.	
5.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.	
6.	**Field Name:**	**6. PROGRAM INCOME**

	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.	
7.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Reflects the overlapping period of obligation under the previous fiscal year and the spending of funds in the current fiscal year.	

Data Alerts: None

Form 3a

Budget and Expenditure Details by Types of Individuals Served

State: South Dakota

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 420,000	$ 421,588
2. Infants < 1 year	$ 330,000	$ 331,248
3. Children 1-22 years	$ 790,000	$ 788,936
4. CSHCN	$ 790,000	$ 786,879
5. All Others	$ 146,337	$ 147,686
Federal Total of Individuals Served	$ 2,476,337	$ 2,476,337

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 580,000	$ 790,234
2. Infants < 1 year	$ 510,000	$ 434,768
3. Children 1-22 years	$ 810,000	$ 1,034,682
4. CSHCN	$ 660,000	$ 715,025
5. All Others	$ 90,000	$ 111,598
Non Federal Total of Individuals Served	$ 2,650,000	$ 3,086,307
Federal State MCH Block Grant Partnership Total	$ 5,126,337	$ 5,562,644

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: Includes administrative costs	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: Includes administrative costs	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Includes administrative costs	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Includes administrative costs	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: South Dakota

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 175,000	$ 113,486
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	$ 175,000	$ 113,486
2. Enabling Services	$ 1,390,050	$ 1,392,109
3. Public Health Services and Systems	$ 911,288	$ 970,743
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		$ 80,136
Physician/Office Services		$ 11,254
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 13,622
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 2,598
Laboratory Services		$ 5,608
Other		
Optometrist Services		$ 268
Direct Services Line 4 Expended Total		$ 113,486
Federal Total	$ 2,476,338	$ 2,476,338

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 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	$ 1,751,500	$ 2,107,884
3. Public Health Services and Systems	$ 1,168,500	$ 978,422
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 2,920,000	$ 3,086,306

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4

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

State: South Dakota

Total Births by Occurrence: 12,969

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	12,901 (99.5%)	495	16	16 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methyglutaric aciduria	Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, βeta-thalassemia	S,C disease
Biotinidase deficiency	Critical congenital heart disease	Cystic fibrosis	Severe combined immunodeficiences	Classic galactosemia

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

LTFU discontinued July 1, 2015

Form Notes for Form 4:

CCHD - legislation requiring hospitals to perform - no data collected by DOH. Newborn hearing - no legislative mandates but DOH collects data under CDC grant

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: South Dakota

Reporting Year 2015

		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	4,580	64.9	0.7	19.9	8.6	5.9
2. Infants < 1 Year of Age	12,969	30.0	0.0	66.7	3.0	0.3
3. Children 1 to 22 Years of Age	36,697	71.4	0.8	9.7	3.3	14.8
4. Children with Special Health Care Needs	3,574	39.6	0.0	56.4	4.0	0.0
5. Others	6,406	57.9	0.9	18.8	7.3	15.1
Total	64,226					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

None

Form 5b
Total Recipient Count of Individuals Served by Title V

State: South Dakota

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	124,535
2. Infants < 1 Year of Age	13,155
3. Children 1 to 22 Years of Age	127,729
4. Children with Special Health Care Needs	40,081
5. Others	22,567
Total	328,067

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

None

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

State: South Dakota

Reporting Year 2015

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	12,202	8,960	275	1,972	274	11	440	270
Title V Served	4,582	3,365	103	741	103	4	165	101
Eligible for Title XIX	4,653	2,283	208	1,851	117	12	0	182
2. Total Infants in State	12,313	9,540	264	1,612	177	17	703	0
Title V Served	12,313	9,540	264	1,612	177	17	703	0
Eligible for Title XIX	5,935	2,959	367	2,135	149	61	0	264

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	11,631	554	17	12,202
Title V Served	4,368	208	6	4,582
Eligible for Title XIX	4,479	174	0	4,653
2. Total Infants in State	11,601	712	0	12,313
Title V Served	11,601	712	0	12,313
Eligible for Title XIX	5,672	263	0	5,935

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	2017 Application Year	2015 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 305-3064	(800) 305-3064
2. State MCH Toll-Free "Hotline" Name	Bright Start	Bright Start
3. Name of Contact Person for State MCH "Hotline"	Scarlett Bierne	Scarlett Bierne
4. Contact Person's Telephone Number	(605) 773-4439	(605) 773-4439
5. Number of Calls Received on the State MCH "Hotline"		1,334

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names	National Suicide Prevention Lifeline; Suicide Prevention Texting	National Suicide Prevention Lifeline; Suicide Prevention Texting
2. Number of Calls on Other Toll-Free "Hotlines"		2,314
3. State Title V Program Website Address	N/A	N/A
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites	MunchCode, ForBabySakeSD, WIC, Family Planning	MunchCode, ForBabySakeSD, WIC, Family Planning
6. Number of Hits to the State Title V Program Social Media Websites		129,239

Form Notes for Form 7:

Websites:
- www.MunchCode.org/
- Forbabysakesd.com/
- www.facebook.com/MunchCodeSD/
- www.Facebook.com/ForbabysakeSD/
- http://doh.sd.gov/family/wic
- http://doh.sd.gov/family/pregnancy/family-planning.aspx

Social Media Hits:
- MunchCode (website) - 2,587
- MunchCode (Facebook) - 336
- forbabysakeSD (website) - 10,174
- forbabysakeSD Facebook - 104,845
- WIC (website) - 10,539
- Family Planning (website) - 758

Form 8
State MCH and CSHCN Directors Contact Information

State: South Dakota

1. Title V Maternal and Child Health (MCH) Director	
Name	Scarlett Bierne
Title	MCH Director
Address 1	600 East Capitol Avenue
Address 2	
City/State/Zip	Pierre / SD / 57501
Telephone	(605) 773-4439
Extension	
Email	scarlett.bierne@state.sd.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Barb Hemmelman
Title	CSHCN Director
Address 1	600 East Capitol Avenue
Address 2	
City/State/Zip	Pierre / SD / 57501
Telephone	(605) 773-4749
Extension	
Email	barb.hemmelman@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 2017

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

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

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

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: South Dakota

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

NPM 5 - 2014 SD PRAMs data:
Annual Indicator - 86.7%
Numerator - 967
Denominator - 1,115
Standard Error - 1.0%

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
2014	76.4 %	0.4 %	9,248	12,103
2013	72.3 %	0.4 %	8,693	12,021
2012	70.7 %	0.4 %	8,367	11,843
2011	69.9 %	0.4 %	8,120	11,622
2010	71.2 %	0.4 %	8,255	11,596
2009	67.3 %	0.4 %	7,919	11,760

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	132.3	10.7 %	154	11,645
2012	119.4	10.3 %	137	11,477
2011	132.7	10.9 %	151	11,382
2010	127.9	10.8 %	143	11,179
2009	122.5	10.4 %	140	11,426
2008	98.0	9.4 %	111	11,322

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2014	24.9	6.4 %	15	60,292
2009_2013	26.7	6.7 %	16	59,943
2008_2012	16.7	5.3 %	10	59,766
2007_2011	16.7	5.3 %	10	59,923
2006_2010	NR	NR	NR	NR
2005_2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 3 - Notes:

None

Data Alerts: None

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.6 %	0.2 %	804	12,280
2013	6.3 %	0.2 %	766	12,237
2012	6.2 %	0.2 %	748	12,098
2011	6.3 %	0.2 %	744	11,839
2010	6.8 %	0.2 %	806	11,801
2009	5.8 %	0.2 %	696	11,929

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.0 %	0.1 %	125	12,280
2013	1.0 %	0.1 %	120	12,237
2012	1.1 %	0.1 %	135	12,098
2011	1.1 %	0.1 %	127	11,839
2010	1.3 %	0.1 %	150	11,801
2009	1.1 %	0.1 %	129	11,929

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.5 %	0.2 %	679	12,280
2013	5.3 %	0.2 %	646	12,237
2012	5.1 %	0.2 %	613	12,098
2011	5.2 %	0.2 %	617	11,839
2010	5.6 %	0.2 %	656	11,801
2009	4.8 %	0.2 %	567	11,929

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.5 %	0.3 %	1,040	12,268
2013	8.1 %	0.3 %	993	12,221
2012	7.8 %	0.2 %	946	12,084
2011	7.9 %	0.3 %	940	11,832
2010	8.6 %	0.3 %	1,013	11,788
2009	7.9 %	0.3 %	944	11,912

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.1 %	0.1 %	261	12,268
2013	2.0 %	0.1 %	241	12,221
2012	2.2 %	0.1 %	267	12,084
2011	2.2 %	0.1 %	257	11,832
2010	2.5 %	0.1 %	298	11,788
2009	2.1 %	0.1 %	244	11,912

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.4 %	0.2 %	779	12,268
2013	6.2 %	0.2 %	752	12,221
2012	5.6 %	0.2 %	679	12,084
2011	5.8 %	0.2 %	683	11,832
2010	6.1 %	0.2 %	715	11,788
2009	5.9 %	0.2 %	700	11,912

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	24.0 %	0.4 %	2,948	12,268
2013	22.9 %	0.4 %	2,795	12,221
2012	22.3 %	0.4 %	2,696	12,084
2011	23.5 %	0.4 %	2,781	11,832
2010	24.7 %	0.4 %	2,906	11,788
2009	26.1 %	0.4 %	3,106	11,912

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 6 - Notes:

None

Data Alerts: None

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

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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
2013	2.5	0.5 %	31	12,248
2012	2.8	0.5 %	34	12,104
2011	2.5	0.5 %	29	11,846
2010	2.3	0.4 %	27	11,811
2009	2.9	0.5 %	35	11,934

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	212.3	41.7 %	26	12,248
2012	214.8	42.2 %	26	12,104
2011	168.8	37.8 %	20	11,846
2010	211.7	42.4 %	25	11,811
2009	167.6	37.5 %	20	11,934

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	130.6	32.7 %	16	12,248
2012	90.9	27.4 %	11	12,104
2011	92.9	28.0 %	11	11,846
2010	118.5	31.7 %	14	11,811
2009	134.1	33.5 %	16	11,934

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.8	0.5 %	33	11,645
2012	2.4	0.5 %	27	11,477
2011	2.6	0.5 %	29	11,382
2010	2.8	0.5 %	31	11,179
2009	1.5	0.4 %	17	11,426
2008	1.2	0.3 %	13	11,322

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 11 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	17.3 %	1.3 %	32,842	190,188

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2014	37.0	5.7 %	42	113,630
2013	44.5	6.3 %	50	112,318
2012	44.0	6.3 %	49	111,395
2011	43.8	6.3 %	49	112,012
2010	56.5	7.1 %	63	111,588
2009	65.2	7.6 %	73	111,893

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	19.1	3.3 %	33	172,681
2011_2013	17.4	3.2 %	30	172,774
2010_2012	24.3	3.8 %	42	172,983
2009_2011	29.4	4.1 %	51	173,766
2008_2010	33.2	4.4 %	58	174,643
2007_2009	35.2	4.5 %	62	176,399

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	22.6	3.6 %	39	172,681
2011_2013	22.0	3.6 %	38	172,774
2010_2012	20.8	3.5 %	36	172,983
2009_2011	24.2	3.7 %	42	173,766
2008_2010	28.6	4.1 %	50	174,643
2007_2009	24.9	3.8 %	44	176,399

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	14.8 %	1.1 %	29,885	201,731
2007	17.4 %	1.1 %	33,703	194,049
2003	16.0 %	1.0 %	30,767	192,623

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	17.6 %	3.1 %	3,877	22,073

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.7 %	0.4 %	2,902	168,545
2007	0.7 %	0.2 %	1,137	160,112

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	7.0 %	0.9 %	11,757	168,655
2007	6.2 %	0.8 %	9,969	160,047

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	63.6 %	6.1 %	8,053	12,661
2007	69.7 %	6.0 %	7,895	11,325
2003	72.9 %	5.4 %	8,328	11,421

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	91.7 %	0.8 %	185,027	201,731
2007	90.1 %	0.9 %	174,735	194,049
2003	89.0 %	0.9 %	171,361	192,623

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.5 %	2.1 %	22,299	84,051
2007	28.4 %	2.0 %	24,048	84,664
2003	25.8 %	1.9 %	23,768	92,091

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	32.2 %	0.5 %	2,584	8,033

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	25.1 %	1.6 %	9,491	37,874
2011	23.9 %	1.3 %	9,309	38,957
2009	22.0 %	1.3 %	8,451	38,353
2007	23.4 %	1.2 %	9,544	40,789
2005	24.4 %	1.6 %	10,009	41,028

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.3 %	1.2 %	15,285	209,494
2013	7.3 %	1.0 %	14,974	205,982
2012	3.9 %	0.8 %	7,869	204,137
2011	5.7 %	0.8 %	11,454	202,877
2010	7.1 %	1.2 %	14,562	204,414
2009	6.7 %	0.9 %	13,342	199,435

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	76.3 %	4.2 %	13,098	17,159
2013	73.9 %	3.9 %	12,072	16,346
2012	63.6 %	3.3 %	10,370	16,301
2011	62.9 %	5.3 %	10,532	16,741
2010	48.7 %	3.5 %	8,257	16,951
2009	42.8 %	3.6 %	7,179	16,786

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2015	64.4 %	2.4 %	124,290	192,937
2013_2014	68.5 %	2.1 %	131,211	191,596
2012_2013	73.2 %	3.3 %	140,455	192,009
2011_2012	58.2 %	2.6 %	107,634	184,949
2010_2011	53.7 %	4.6 %	100,976	188,037
2009_2010	56.5 %	2.6 %	95,462	168,959

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	61.0 %	4.8 %	16,366	26,826
2013	56.0 %	4.9 %	15,038	26,838
2012	51.0 %	5.1 %	13,523	26,499
2011	58.1 %	7.0 %	15,380	26,460
2010	68.8 %	4.0 %	18,651	27,098
2009	62.4 %	4.5 %	16,790	26,900

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	34.4 %	4.7 %	9,846	28,613
2013	22.1 %	3.6 %	6,263	28,360
2012	19.8 %	4.2 %	5,518	27,870
2011	NR	NR	NR	NR

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	75.0 %	3.0 %	41,570	55,439
2013	70.0 %	3.3 %	38,650	55,198
2012	65.9 %	3.3 %	35,845	54,368
2011	54.4 %	5.2 %	29,467	54,183
2010	52.5 %	3.2 %	29,225	55,702
2009	39.6 %	3.4 %	22,002	55,527

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	57.0 %	3.4 %	31,618	55,439
2013	51.7 %	3.4 %	28,523	55,198
2012	40.0 %	3.5 %	21,743	54,368
2011	37.4 %	4.8 %	20,280	54,183
2010	30.9 %	3.0 %	17,198	55,702
2009	24.9 %	2.9 %	13,838	55,527

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: South Dakota

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	70.7	71.3	71.8	72.4	73.0	73.6

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	69.5 %	2.3 %	97,430	140,254
2013	68.4 %	2.2 %	94,349	137,883
2012	68.9 %	1.9 %	92,628	134,431
2011	64.5 %	2.4 %	85,260	132,208
2010	71.1 %	2.4 %	94,741	133,263
2009	74.5 %	2.0 %	100,984	135,490

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	88.2	88.9	89.6	90.3	91.1	91.8

FAD not available for this measure.

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.8	23.9	24.0	24.1	24.3	24.4

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	23.5 %	2.5 %	12,793	54,515
2007	18.8 %	2.3 %	9,922	52,682

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	337.2	334.3	331.5	328.6	325.7	322.9

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	342.9	17.4 %	390	113,725
2012	309.9	16.5 %	355	114,565
2011	339.7	17.4 %	382	112,466
2010	399.6	18.9 %	447	111,854
2009	344.1	17.5 %	387	112,460
2008	377.3	18.4 %	423	112,110

Legends:

Indicator has a numerator ≤10 and is not reportable

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

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	74.3	74.8	75.4	76.0	76.5	77.1

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	72.6 %	2.5 %	45,469	62,654
2007	80.2 %	1.7 %	52,984	66,070
2003	66.7 %	2.1 %	45,671	68,490

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	53.9	54.3	54.7	55.1	55.6	56.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	52.7 %	4.0 %	15,450	29,333
2007	51.9 %	3.7 %	16,620	32,006

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	63.2 %	1.7 %	105,889	167,521
2007	65.7 %	1.6 %	102,113	155,519

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	48.1	48.4	48.8	49.2	49.5	49.9

FAD not available for this measure.

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	79.7	80.4	81.0	81.7	82.3	83.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	77.8 %	1.4 %	147,938	190,201
2007	80.7 %	1.3 %	146,392	181,494

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	12.6	11.4	10.3	9.2	8.1	7.0

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	14.8 %	0.3 %	1,807	12,204
2013	15.1 %	0.3 %	1,837	12,184
2012	16.5 %	0.3 %	1,992	12,056
2011	16.9 %	0.4 %	1,987	11,765
2010	17.2 %	0.4 %	2,003	11,679
2009	18.5 %	0.4 %	2,183	11,778

Legends:

Indicator has a numerator <10 and is not reportable

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

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	26.8	26.5	26.2	25.9	25.5	25.2

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	27.5 %	1.5 %	55,055	200,548
2007	25.0 %	1.4 %	48,253	193,314
2003	34.9 %	1.5 %	57,491	164,827

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: South Dakota

SPM 1 - Percent of suicide attempts by adolescents 12 through 17 years of age

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	8.6	8.6	8.5	8.4	8.3

Field Level Notes for Form 10a SPMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	27.1	25.1	23.2	21.3	19.3

Field Level Notes for Form 10a SPMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	78.8	79.5	80.1	80.8	81.4

Field Level Notes for Form 10a SPMs:

None

SPM 4 - MCH data is analyzed and disseminated

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

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or-Informed Strategy Measures (ESMs)

State: South Dakota

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	6.0	7.0	8.0	9.0

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	107,100.0	109,200.0	111,300.0	113,400.0	115,500.0

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	32.2	33.8	35.4	37.1	38.9

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - Number and type of partnerships to promote early childhood screening

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	6.0	7.0	8.0	9.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.1 - Number of partners convened specific to motor vehicle safety activities

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	6.0	7.0	8.0	9.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.1 - Number of providers offered resources and outreach regarding Bright Futures

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2,000.0	2,000.0	2,000.0	2,000.0	2,000.0

Field Level Notes for Form 10a ESMs:

None

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

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

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	2.0	3.0	4.0	5.0

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	2.0	3.0	4.0	5.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: South Dakota

SPM 1 - Percent of suicide attempts by adolescents 12 through 17 years of age
Population Domain(s) – Adolescent Health

Goal:	Promote positive child and youth development to reduce morbidity and mortality
Definition:	**Numerator:** # of students who actually attempted suicide one or more times during the past 12 months **Denominator:** # of students who completed survey **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MHMD-2: Reduce suicide attempts by adolescents
Data Sources and Data Issues:	YRBS
Significance:	In 2013, South Dakota had the 14th highest suicide rate in the U.S. and the rate of attempted suicides has increased significantly between 2009 and 2013 (http://doh.sd.gov/documents/Bulletin/July 2015.pdf)

SPM 2 - Percentage of children, ages 2-5, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)
Population Domain(s) – Child Health

Goal:	Promote positive child and youth development to reduce morbidity and mortality
Definition:	**Numerator:** # of children aged 2 to 5 years receiving WIC with a BMI at or above 85th percentile (overweight or obese) **Denominator:** # of children aged 2 to 5 years receiving WIC **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	NWS-10.1: Reduce the proportion of children aged 2 to 5 years who are considered obese
Data Sources and Data Issues:	State PedNSS
Significance:	Body weight is related to health status and good nutrition is important to the growth and development of children. Children who are at a healthy weight are less likely to develop chronic diseases and more likely to be at a healthy weight as an adult.

SPM 3 - Percent of women (15-44 years of age) with a live birth whose observed to expected prenatal visits are greater than or equal to 80%
Population Domain(s) – Women/Maternal Health

Goal:	Promote preconception/interconception health and reduce infant mortality
Definition:	**Numerator:** # of pregnant women aged 15-44 with a live birth whose observed to expected prenatal visits are greater than or equal to 80% **Denominator:** # of women aged 15-44 with a life birth **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-10.2: Increase the proportion of pregnant women who receive early and adequate prenatal care
Data Sources and Data Issues:	DOH Vital Records. NOTE: The EVINDEX variable in the Kotelchuck program will be used to calculate observed to expected prenatal visits. A gestational age equivalent will be imputed from birth weight for those records with missing gestational age (within Kotelchuck SAS program).
Significance:	Barriers to a healthy pregnancy and birth include lack of appropriate health care before and during pregnancy. Insuring that a mother attends prenatal care visits can provide an opportunity to identify health risks and increase her knowledge of the importance of preconception/interconception health.

SPM 4 - MCH data is analyzed and disseminated
Population Domain(s) – Cross-Cutting/Life Course

Goal:	Improve state and local surveillance, data collection, and evaluation capacity
Definition:	**Numerator:** 2 (# of reports developed and disseminated) **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	N/A
Significance:	Important for program to make data driven decisions and collaborate with partners.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: South Dakota

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets

State: South Dakota

ESM 1.1 - Number of partners who collaborate to promote well women visits
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Combine efforts to most effectively and efficiently increase awareness and promotion of importance of well woman visits
Definition:	**Numerator:** # of partners **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Meeting minutes/contact sheets identifying partners and collaboration efforts
Significance:	Collaborating with partners in awareness and promotion of well women visits will assist in ensuring that all women are aware of this important preventive medical visit. It will also assist with more consistent and effective messaging.

ESM 5.1 - Number of page engagements to the For Baby's Sake Facebook page
NPM 5 – Percent of infants placed to sleep on their backs

Goal:	Increase the awareness of safe sleep environments through Facebook messaging
Definition:	**Numerator:** # of page engagements **Denominator:** NA **Unit Type:** Count **Unit Number:** 130,000
Data Sources and Data Issues:	"For Baby's Sake" Facebook data
Significance:	Consumers, especially the younger generation, use social media to research and make health decisions. "For Baby's Sake" already has an established following and is an excellent way to reach young mothers.

ESM 5.2 - Percent of infant deaths reviewed for which a SUIDI reporting form was received and reviewed as part of the Infant Death Review Team meeting.
NPM 5 – Percent of infants placed to sleep on their backs

Goal:	Collect data on causes of infant deaths to better inform efforts on education and reduction in numbers
Definition:	**Numerator:** # of completed SUIDI forms **Denominator:** # of SUID deaths reviewed **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	SUIDI forms and death reviews
Significance:	Provides information that can be used to recognize and inform on risk factors of SUID and SIDS.

ESM 6.1 - Number and type of partnerships to promote early childhood screening
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Combine efforts to most effectively and efficiently increase awareness and completion of developmental screenings
Definition:	**Numerator:** # and types of partners **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Meeting minutes/contact sheets identifying partners and collaboration efforts
Significance:	Collaborating with partners to ensure more children receive developmental screenings and decrease duplicate screenings by multiple providers

ESM 7.1 - Number of partners convened specific to motor vehicle safety activities
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Goal:	Combine efforts to most effectively and efficiently increase awareness and promotion of motor vehicle safety activities.
Definition:	**Numerator:** # of partners **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Meeting minutes/contact sheets identifying partners and collaboration efforts
Significance:	Collaborating with partners in awareness and promotion will assist in implementing more consistent and effective messaging and pooling of resources to best meet the needs and challenges around motor vehicle safety in a rural state with a young driving age.

ESM 10.1 - Number of providers offered resources and outreach regarding Bright Futures
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Goal:	Increase awareness and understanding of the importance and components of an adolescent well visit
Definition:	**Numerator:** # of providers reached **Denominator:** N/A **Unit Type:** Count **Unit Number:** 2,000
Data Sources and Data Issues:	Log of number of providers receiving information on Bright Futures
Significance:	Bright Future Guidelines provide theory-based and evidence-driven guidance for all preventive care screenings and well-child visits. Ensuring providers are aware of and using this resource will ensure well visits are effective in identifying and meeting the needs of adolescents.

ESM 11.1 - Number of trainings for providers on components of medical home model
NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	Increase the number of providers implementing medical home components
Definition:	**Numerator:** # of trainings for providers **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	Training logs
Significance:	Providing comprehensive care to children in a medical home is the standard of pediatric practice. Children with a stable and continuous source of healthcare are more likely to receive appropriate preventive care, are less likely to be hospitalized, and are more likely to be diagnosed early for chronic conditions.

ESM 13.1 - Number of media platforms (i.e., websites, Facebook, TV, radio, print) that promote oral health messaging
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Goal:	Promote oral health for all populations
Definition:	**Numerator:** # of media platforms that have oral health messaging **Denominator:** N/A **Unit Type:** Count **Unit Number:** 5
Data Sources and Data Issues:	Media platform messages on oral health
Significance:	Education on the importance of oral health will assist in early dental visits and overall dental care/visits.

ESM 14.1 - Number of media platforms (i.e., websites, Facebook, TV, radio, print) that include tobacco prevention/cessation messages
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Goal:	Promote tobacco prevention and cessation
Definition:	**Numerator:** # of media platforms that have tobacco prevention/cessation messaging **Denominator:** N/A **Unit Type:** Count **Unit Number:** 5
Data Sources and Data Issues:	Media platforms promoting tobacco prevention/cessation
Significance:	Awareness of effects of smoking during pregnancy and exposure to secondhand smoke

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: South Dakota

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	18	16	13	21	16
Denominator	18	16	13	21	16
Data Source	Metabolic Screening Program	Metabolic Screening Program	Metabolic Screening Program	Metabolic Screening Program	Metabolic Screening Program
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 South Dakota Metabolic Screening Program data. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.	
2.	**Field Name:**	**2014**
	Field Note: 2014 South Dakota Metabolic Screening Program data. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.	
3.	**Field Name:**	**2013**
	Field Note: 2011-2013 South Dakota Metabolic Screening Program data. Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.	
4.	**Field Name:**	**2012**

	Field Note: 2010-2012 South Dakota Metabolic Screening Program data - Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.	
5.	**Field Name:**	**2011**
	Field Note: 2009-2011 South Dakota Metabolic Screening program data. Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.	

Data Alerts: None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	97.8	75.0	73.5	74.0	78.3
Annual Indicator	69.7	69.7	69.7	69.7	69.7
Numerator	16,784	16,784	16,784	16,784	16,784
Denominator	24,087	24,087	24,087	24,087	24,087
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	97.4	50.0	49.4	50.4	58.6
Annual Indicator	42.2	42.2	42.2	42.2	42.2
Numerator	9,962	9,962	9,962	9,962	9,962
Denominator	23,585	23,585	23,585	23,585	23,585
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	91.5	65.0	67.1	67.8	73.2
Annual Indicator	62.4	62.4	62.4	62.4	62.4
Numerator	14,753	14,753	14,753	14,753	14,753
Denominator	23,631	23,631	23,631	23,631	23,631
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
4.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	94.5	70.0	67.1	67.4	69.9
Annual Indicator	64.9	64.9	64.9	64.9	64.9
Numerator	15,711	15,711	15,711	15,711	15,711
Denominator	24,218	24,218	24,218	24,218	24,218
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	85.0	55.0	49.6	49.8	51.3
Annual Indicator	48.3	48.3	48.3	48.3	48.3
Numerator	4,918	4,918	4,918	4,918	4,918
Denominator	10,177	10,177	10,177	10,177	10,177
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	84.5	84.5	75.2	75.3	76.1
Annual Indicator	76.8	74.5	74.5	74.5	82.3
Numerator	14,261	13,118	13,221	13,221	14,119
Denominator	18,566	17,616	17,750	17,750	17,155
Data Source	SD Immunization Information System	SD Immunization Information System	SD Immunization Information System	SD Immunization Information System	SD Immunization Information System
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 South Dakota Immunization Information System data	
2.	**Field Name:**	**2014**
	Field Note: 2013 South Dakota Immunization Information System data	
3.	**Field Name:**	**2013**
	Field Note: 2013 South Dakota Immunization Information System data	
4.	**Field Name:**	**2012**
	Field Note: 2012 South Dakota Immunization Information System data.	
5.	**Field Name:**	**2011**
	Field Note: 2011 South Dakota Immunization Information System data	

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	15.7	15.0	15.8	13.3	13.3
Annual Indicator	15.2	16.4	13.3	13.3	9.3
Numerator	245	264	214	216	153
Denominator	16,094	16,094	16,097	16,271	16,383
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth certificate	Birth certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 South Dakota birth certificate data. Rate based on 2014 South Dakota population estimate.	
2.	**Field Name:**	**2014**
	Field Note: 2014 South Dakota birth certificate data - Rate based on 2013 South Dakota population estimate	
3.	**Field Name:**	**2013**
	Field Note: 2013 South Dakota birth certificate data. Rate based on 2012 South Dakota population estimate. South Dakota DOH 2020 rate was set at 14.8 based on a 10% improvement over 2012 rate. Since 2013 rate was 13.3, future rates were set at 13.3.	
4.	**Field Name:**	**2012**
	Field Note: 2012 South Dakota birth certificate data. Rate based on 2011 South Dakota population estimate.	
5.	**Field Name:**	**2011**
	Field Note: 2011 South Dakota birth certificate data. Rate based on 2011 South Dakota population estimate.	

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	59.0	59.5	55.1	56.6	56.7
Annual Indicator	54.8	54.8	56.6	56.6	56.6
Numerator	5,568	5,568	6,538	6,538	6,538
Denominator	10,160	10,160	11,552	11,552	11,552
Data Source	SD Oral Health Survey	SD Oral Health Survey	SD Oral Health Survey	SD Oral Health Survey	SD Oral Health Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2013-2014 South Dakota Oral Health Survey and South Dakota Department of Education 2013 Fall Census Enrollment for 3rd Grade.	
2.	**Field Name:**	**2014**
	Field Note: 2013-2014 South Dakota Oral Health Survey and South Dakota Department of Education 2013 Fall Census Enrollment for 3rd Grade.	
3.	**Field Name:**	**2013**
	Field Note: Numerator is 2013 3rd grade Fall Census Enrollment (11,552) multiplied by the percent of children with sealants from 2013-2014 oral health survey. Denominator is South Dakota Department of Education, 3rd Grade Enrollment for SD, 2013 Fall Census Enrollment.	
4.	**Field Name:**	**2012**
	Field Note: 2010 South Dakota oral health survey weighted data.	
5.	**Field Name:**	**2011**
	Field Note: 2010 South Dakota oral health survey weighted data.	

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	4.0	4.0	4.0	3.5	3.5
Annual Indicator	4.2	4.1	3.5	4.0	4.0
Numerator	7	7	6	7	7
Denominator	168,300	169,755	170,440	172,928	175,939
Data Source	Death Certificate	Death Certificate	Death Certificate	Death certificate	Death certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2013-2015 South Dakota death certificate data. Rates are based on 2013-2014 South Dakota population estimates.	
2.	**Field Name:**	**2014**
	Field Note: 2012-2014 South Dakota death certificate data	
3.	**Field Name:**	**2013**
	Field Note: 2011-2013 South Dakota death certificate. Rates are based on 2011-2012 South Dakota population estimates. Future rates se to maintain rate of 3.5/100,000.	
4.	**Field Name:**	**2012**
	Field Note: 2010-2012 South Dakota death certificate data. Rates are based on 2010-2011 South Dakota population estimates.	
5.	**Field Name:**	**2011**
	Field Note: 2009-2011 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rates are based on 2009-2011 South Dakota population estimates.	

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	48.5	48.5	57.5	51.3	52.9
Annual Indicator	44.5	57.1	49.7	45.6	45.6
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 National Immunization Survey (NIS) data. Numerator and denominator are not available. The Breastfeeding Report Care is no longer published every year. If will be published every other year.	
2.	**Field Name:**	**2014**
	Field Note: 2014 National Immunization Survey (NIS) data - Numerator and denominator are not available.	
3.	**Field Name:**	**2013**
	Field Note: 2013 National Immunization Survey (NIS) data. Numerator and denominator are not available.	
4.	**Field Name:**	**2012**
	Field Note: 2012 National Immunization Survey (NIS) data. Numerator and denominator are not available.	
5.	**Field Name:**	**2011**
	Field Note: 2011 National Immunization Survey (NIS) data. Numerator and denominator are not available.	

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	98.0	98.0	98.0	97.3	97.4
Annual Indicator	97.1	97.5	97.2	98.2	97.6
Numerator	12,105	12,397	12,565	12,721	12,659
Denominator	12,470	12,720	12,922	12,959	12,969
Data Source	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Hearing Screening Program
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 South Dakota Newborn Hearing Screening Program data	
2.	**Field Name:**	**2014**
	Field Note: 2014 South Dakota Newborn Hearing Screening Program data	
3.	**Field Name:**	**2013**
	Field Note: 2013 South Dakota Newborn Hearing Screening Program data.	
4.	**Field Name:**	**2012**
	Field Note: 2011 South Dakota Newborn Hearing Screening Program data.	
5.	**Field Name:**	**2011**
	Field Note: 2011 South Dakota Newborn Hearing Screening Program data.	

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	2.1	1.0	2.6	1.5	1.3
Annual Indicator	1.3	3.0	1.7	0.9	2.4
Numerator	2,594	6,095	3,471	1,872	5,050
Denominator	193,976	203,156	204,169	207,959	210,407
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 BRFSS weighted data. Rates based on 2014 South Dakota population estimates.	
2.	**Field Name:**	**2014**
	Field Note: 2014 Behavioral Risk Factor Surveillance System weighted data - Rate based on 2013 South Dakota population estimate	
3.	**Field Name:**	**2013**
	Field Note: 2013 BRFSS weighted data. Rate based on 2012 South Dakota population estimates.	
4.	**Field Name:**	**2012**
	Field Note: 2012 BRFSS weighted data. Rate based on 2011 South Dakota population estimate.	
5.	**Field Name:**	**2011**
	Field Note: 2011 BRFSS weighted data. Rate based on 2011 South Dakota population estimate.	

Data Alerts: None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	34.0	33.0	30.3	28.9	25.7
Annual Indicator	33.2	33.2	32.1	30.8	36.5
Numerator	3,437	3,437	2,467	1,927	1,871
Denominator	10,351	10,351	7,679	6,253	5,126
Data Source	PedNSS	PedNSS	WIC PC	WIC PC	WIC PC
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 SD WIC Participant and Program Characteristics (WIC PC) data. It should be noted WIC PC data are not directly comparable to past PedNSS data.	
2.	**Field Name:**	**2014**
	Field Note: 2013 SD WIC Participant and Program Characteristics (WIC PC) data. It should be noted WIC PC data are not directly comparable to past PedNSS data.	
3.	**Field Name:**	**2013**
	Field Note: 2012 South Dakota WIC Participant and Program Characteristics (WIC PC) data. WIC PC data are not directly comparable to past PedNSS data.	
4.	**Field Name:**	**2012**
	Field Note: 2011 South Dakota Pediatric Nutrition Surveillance System (PedNSS) data. Due to the discontinuation of CDC support for PedNSS, 2011 data was used. South Dakota is currently looking at options to enable collection of updated data in future years.	
5.	**Field Name:**	**2011**
	Field Note: 2011 South Dakota Pediatric Nutrition Surveillance System (PedNSS) data.	

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	11.8	11.0	10.2	9.3	8.0
Annual Indicator	11.5	11.4	10.5	10.2	9.5
Numerator	1,336	1,360	1,268	1,227	1,148
Denominator	11,661	11,908	12,051	12,081	12,068
Data Source	Birth Certificate	Birth Certificate	Birth Certficate	Birth certificate	Birth certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 South Dakota birth certificate data	
2.	**Field Name:**	**2014**
	Field Note: 2014 South Dakota birth certificate data	
3.	**Field Name:**	**2013**
	Field Note: 2013 South Dakota birth certificate data.	
4.	**Field Name:**	**2012**
	Field Note: 2012 South Dakota birth certificate data.	
5.	**Field Name:**	**2011**
	Field Note: 2011 South Dakota birth certificate data.	

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	28.0	24.0	20.7	32.7	30.6
Annual Indicator	24.1	20.8	34.8	22.6	29.5
Numerator	14	12	20	13	17
Denominator	58,038	57,820	57,439	57,429	57,688
Data Source	Death Certificate	Death Certificate	Death Certificate	Death certificate	Death certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2013-2015 South Dakota death certificate data. Rates are based on 2013-2014 South Dakota population estimates.	
2.	**Field Name:**	**2014**
	Field Note: 2012-2014 South Dakota death certificate data. Rates are based on 2012-2013 South Dakota population estimates.	
3.	**Field Name:**	**2013**
	Field Note: 2013 South Dakota death certificate data. Rates are based on 2012 South Dakota population estimates.	
4.	**Field Name:**	**2012**
	Field Note: 2010-2012 South Dakota death certificate data. Rate is based on 2010-2011 South Dakota population estimates.	
5.	**Field Name:**	**2011**
	Field Note: 2009-2011 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rate is based on 2009-2011 South Dakota population estimates.	

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	87.9	87.9	89.0	86.8	88.3
Annual Indicator	85.8	88.0	85.3	88.6	81.5
Numerator	103	110	99	109	106
Denominator	120	125	116	123	130
Data Source	Birth Certificate	Birth Certificate	Birth Certfficate	Birth certificate	Birth certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 South Dakota birth certificate data	
2.	**Field Name:**	**2014**
	Field Note: 2014 South Dakota birth certificate data	
3.	**Field Name:**	**2013**
	Field Note: 2013 South Dakota birth certificate data.	
4.	**Field Name:**	**2012**
	Field Note: 2012 South Dakota birth certificate data.	
5.	**Field Name:**	**2011**
	Field Note: 2011 South Dakota birth certificate data.	

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	70.0	70.3	70.0	71.7	72.7
Annual Indicator	68.3	68.9	70.6	71.0	71.5
Numerator	8,085	8,332	8,645	8,725	8,813
Denominator	11,834	12,092	12,243	12,281	12,323
Data Source	Birth Certificate	Birth Certificate	Birth Certfcate	Birth certificate	Birth certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 South Dakota birth certificate data. Trimester of prenatal care was determined using date last menses began and date of first prenatal care visit.	
2.	**Field Name:**	**2014**
	Field Note: 2014 South Dakota birth certificate data. Trimester of prenatal care was determined using date last normal menses began and date of first prenatal care visit, data prior to 2006 used the months prenatal care began provided on the birth certificate.	
3.	**Field Name:**	**2013**
	Field Note: 2013 South Dakota birth certificate data. Trimester of prenatal care was determined using date last normal menses began and date of first prenatal care visit on birth certificate.	
4.	**Field Name:**	**2012**
	Field Note: 2012 South Dakota birth certificate data. Trimester of prenatal care was determined using date last normal menses began and date of first prenatal care visit on birth certificate.	
5.	**Field Name:**	**2011**
	Field Note: 2011 South Dakota birth certificate data. Trimester of prenatal care was determined using date last normal menses began and date of first prenatal care visit on birth certificate.	

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: South Dakota

SPM 1 - Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.

	2011	2012	2013	2014	2015
Annual Objective	33.0	33.0	34.0	34.2	33.9
Annual Indicator	34.9	34.2	34.5	34.8	34.6
Numerator	4,274	4,157	4,292	4,382	4,342
Denominator	12,243	12,170	12,450	12,577	12,557
Data Source	Birth certificate	Birth certificate	Birth Certficate	Birth certificate	Birth certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: Prorated 2014 South Dakota birth certificate data based on the 2009 Perinatal Health Risk Assessment Survey data and 2014 South Dakota abortion data.	
2.	**Field Name:**	**2014**
	Field Note: Prorated 2013 South Dakota birth certificate data based on the 2009 Perinatal Health Risk Assessment Survey data and 2013 South Dakota abortion data. South Dakota is actively pursuing another data source to replace the Perinatal Health Risk Assessment Survey.	
3.	**Field Name:**	**2013**
	Field Note: Prorated 2012 South Dakota birth certificate data based on the 2009 Perinatal Health Risk Assessment Survey data and 2012 South Dakota abortion data.South Dakota has initiated a PRAMS survey to replace the Perinatal Health Risk Assessment effective January 2014.	
4.	**Field Name:**	**2012**
	Field Note: Prorated 2011 South Dakota birth certificate data based on 2009 Perinatal Health Risk Assessment Survey data and 2011 South Dakota abortion data. South Dakota is actively pursuing another data source to replace the Perinatal Health Risk Assessment Survey.	

5.	**Field Name:**	**2011**

Field Note:
Prorated 2010 South Dakota birth certificate data based on 2009 Perinatal Health Risk Assessment Survey data and 2010 South Dakota abortion data.

Data Alerts: None

SPM 2 - Percent of singleton birth mothers who achieve a recommended weight gain during pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	30.0	30.0	28.8	29.5	30.0
Annual Indicator	28.5	28.3	29.1	28.4	28.1
Numerator	3,277	3,316	3,444	3,372	3,358
Denominator	11,490	11,731	11,828	11,880	11,935
Data Source	Birth certificate	Birth certificate	Birth Certficate	Birth certificate	Birth certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 South Dakota birth certificate data	
2.	**Field Name:**	**2014**
	Field Note: 2014 South Dakota birth certificate data	
3.	**Field Name:**	**2013**
	Field Note: 2013 South Dakota birth certificate data.	
4.	**Field Name:**	**2012**
	Field Note: 2012 South Dakota birth certificate data.	
5.	**Field Name:**	**2011**
	Field Note: 2011 South Dakota birth certificate data.	

Data Alerts: None

SPM 3 - Percent of pregnant women aged 18 through 24 who smoked during pregnancy

	2011	2012	2013	2014	2015
Annual Objective	25.8	25.0	22.5	20.4	17.2
Annual Indicator	26.6	25.5	23.6	23.6	21.0
Numerator	946	910	813	769	688
Denominator	3,557	3,574	3,451	3,264	3,269
Data Source	Birth certificate	Birth certificate	Birth Certficate	Birth certificate	Birth certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 South Dakota birth certificate data	
2.	**Field Name:**	**2014**
	Field Note: 2014 South Dakota birth certificate data	
3.	**Field Name:**	**2013**
	Field Note: 2013 South Dakota birth certificate data.	
4.	**Field Name:**	**2012**
	Field Note: 2012 South Dakota birth certificate data.	
5.	**Field Name:**	**2011**
	Field Note: 2011 South Dakota birth certificate data.	

Data Alerts: None

SPM 4 - Percent of infants exposed to secondhand smoke.

	2011	2012	2013	2014	2015
Annual Objective	9.3	9.2	19.8	19.7	19.4
Annual Indicator	8.1	20.0	20.0	20.0	26.2
Numerator	58	2,361	2,361	2,429	3,225
Denominator	720	11,805	11,805	12,143	12,313
Data Source	SD Perinatal Health Risk Assessment	BRFSS	BRFSS	BRFSS	BRFSS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2011-2015 BRFSS data. Five years of data were combined in order to enlarge the same size to create a more stable rate.	
2.	**Field Name:**	**2014**
	Field Note: 2006-2010 Behavioral Risk Factor Surveillance System (BRFSS). Five years of data were combined in order to enlarge the sample size to create a more stable rate. Due to the BRFSS methodology change in 2011 it is not possible to combine data prior to that year. Therefore, we continue to use data from 2006-2010 until we gather enough data since 2011 to be deemed reliable.	
3.	**Field Name:**	**2013**
	Field Note: 2006-2010 BRFSS. Five years of data were combined in order to enlarge the sample size to create a more stable rate. Due to the BRFSS methodology change in 2011 it is not possible to combine data prior to that year. Therefore, data from 2006-2010 will continue to be used until enough data is gathered to be deemed reliable.	
4.	**Field Name:**	**2012**
	Field Note: 2006-2010 Behavioral Risk Factor Surveillance System (BRFSS) data. Due to discontinuation of the Perinatal Health Risk Assessment Survey, South Dakota will use BRFSS data. Five years of data were combined in order to enlarge the sample size to create a more stable rate. Data prior to 2012 is no longer comparable.	
5.	**Field Name:**	**2011**
	Field Note: 2009 South Dakota Perinatal Health Risk Assessment Survey data.A 2011 Perinatal Health Risk Assessment Survey was not conducted.	

Data Alerts: None

SPM 6 - Percent of school-aged children and adolescents with a Body Mass Index (BMI) at or above the 95th percentile.

	2011	2012	2013	2014	2015
Annual Objective	15.6	15.4	15.7	15.8	15.6
Annual Indicator	15.2	15.9	16.0	15.8	16.0
Numerator	7,470	7,962	8,135	7,184	8,698
Denominator	49,146	50,078	50,845	45,469	54,363
Data Source	SD School Height-Weight	SD School Height-Weight	SD School Height-Weight	SD School Height-Weight	SD School Height-Weight
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014/2015 school year SD School Height and Weight data	
2.	**Field Name:**	**2014**
	Field Note: 2013/2014 school year South Dakota School Height and Weight data	
3.	**Field Name:**	**2013**
	Field Note: 2012/2013 school year. South Dakota School Height and Weight data.	
4.	**Field Name:**	**2012**
	Field Note: 2011/2012 South Dakota school year School Height and Weight data.	
5.	**Field Name:**	**2011**
	Field Note: 2010/2011 South Dakota school year School Height and Weight data.	

Data Alerts: None

SPM 7 - Percent of high school youth who report having smoked cigarettes in the past 30 days.

	2011	2012	2013	2014	2015
Annual Objective	24.4	24.4	22.8	16.5	16.5
Annual Indicator	23.1	23.1	16.5	16.5	10.1
Numerator	9,894	9,894	6,879	6,879	4,221
Denominator	42,830	42,830	41,692	41,692	41,792
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014/2015 South Dakota school enrollment based on 2015 YRBS data	
2.	**Field Name:**	**2014**
	Field Note: 2012/2013 South Dakota school enrollment based on 2013 Youth Risk Behavior Survey data	
3.	**Field Name:**	**2013**
	Field Note: 2012/2013 South Dakota school enrollment based on 2013 YRBS data.	
4.	**Field Name:**	**2012**
	Field Note: 2010/2011 South Dakota school enrollment based on 2011 YRBS data.	
5.	**Field Name:**	**2011**
	Field Note: 2010/2011 South Dakota school enrollment based on 2011 YRBS data.	

Data Alerts: None

SPM 8 - Accidental death rate (per 100,000) among adolescents aged 15 through 19 years

	2011	2012	2013	2014	2015
Annual Objective	39.3	39.3	33.5	15.7	15.7
Annual Indicator	24.2	34.5	15.7	31.3	22.5
Numerator	14	20	9	18	13
Denominator	57,916	57,916	57,439	57,419	57,823
Data Source	Death certificate	Death certificate	Death Certificate	Death certificate	Death certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 South Dakota death certificate data. Rate based on 2014 South Dakota population estimate.	
2.	**Field Name:**	**2014**
	Field Note: 2014 South Dakota death certificate data - Rate based on 2013 South Dakota population estimate	
3.	**Field Name:**	**2013**
	Field Note: 2013 South Dakota deat certificate data. Rate based on 2012 South Dakota population estimate.	
4.	**Field Name:**	**2012**
	Field Note: 2012 South Dakota death certificate data. Rate based on 2011 South Dakota population estimate.	
5.	**Field Name:**	**2011**
	Field Note: 2011 South Dakota death certificate data. Rate based on 2011 South Dakota population estimate.	

Data Alerts: None

Form 11
Other State Data

State: South Dakota

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

State Action Plan Table

State: South Dakota

Please click the link below to download a PDF of the full version of the State Action Plan Table.
State Action Plan Table

Abbreviated State Action Plan Table

State: South Dakota

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Promote preconception/inter-conception health	NPM 1 - Well-Woman Visit	ESM 1.1	
Promote preconception/inter-conception health			SPM 3

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce infant mortality	NPM 5 - Safe Sleep	ESM 5.1 ESM 5.2	

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)			SPM 2
Improve early identification and referral of developmental delays	NPM 6 - Developmental Screening	ESM 6.1	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)	NPM 7 - Injury Hospitalization	ESM 7.1	
Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN	NPM 10 - Adolescent Well-Visit	ESM 10.1	
Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)	NPM 10 - Adolescent Well-Visit	ESM 10.1	
Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)			SPM 1

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN	NPM 11 - Medical Home	ESM 11.1	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Promote oral health for all populations	NPM 13 - Preventive Dental Visit	ESM 13.1	
Improve state and local surveillance, data collection, and evaluation capacity			SPM 4
Promote positive child and youth development to reduce morbidity and mortality (intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, other drug utilization)	NPM 14 - Smoking	ESM 14.1	