Maternal and Child Health Services Title V Block Grant

South Dakota

FY 2020 Application/ FY 2018 Annual Report

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

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This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

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FY 2020 Application/FY 2018 Annual Report Update

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Needs Assessment Update

During this reporting period states had the opportunity to determine the best combination of measures to address the MCH priority needs that were identified based on the findings of their previous Five-Year Needs Assessment. This application/annual report reflects South Dakota's realignment to continue to address only five National Performance Measures and two State Performance Measures. Below are the maintained measures.

NPM #		MCH Population Domains					Cross-cutting/ Systems Building
		Women/ Maternal Health	Perinatal/ Infant Health	Child Health	Adolescent Health	Children with Special Health Care Needs	
1	Well-woman visit	x					
5	Safe sleep		x				
6	Developmental screening			x			
10	Adolescent well-visit				x		
11	Medical home*					x	
	SPM#						
2	2 to 5 yrs. BMI overweight/obese			x			
4	Data usage						x

To assist with identifying which measures best aligned with our priorities, needs, and resources, the South Dakota MCH Impact Team developed detail sheets for each National and State Performance Measure that would capture both qualitative and quantitative data. Using a scale of 0-3, each NPM/SPM workgroup member rated the degree to which the South Dakota Title V program implemented evidence-based or informed strategies to assure implementation of each performance measure. In addition, the detail sheet captured quantitative data specific to each element. This new ESM process allowed us to better report progress to date on all strategies and was used to assist in the determination of continuation of a measure as well as future strategies/activities. Links to these detail sheets are included in the State Action Plan Narrative by Domain.

In order to begin to capture the health status and needs of our MCH population, the Dept. of Health has undertaken the following:

Beginning April of 2017, the MCH program contracted to conduct a survey designed to gather experiences of families with children or youth with special health care needs (CYSHCN) to guide program planning and activities. In addition, focus groups were facilitated with providers to address their perceived needs of CYSHCN and what their practices are doing for this population as well as gaps in services. The findings of these surveys will be used to assist the program in identifying the on-going needs of families of CYSHCN and the providers who serve them.

In April of 2018, the MCH program contracted to conduct a series of focus groups with parents of middle school children to gain a better understanding of what parents feel is important when it comes to their child's health. A number of youth risk behavior topics were discussed over the course of six sessions in an effort to gain insight from the participants as to their attitudes, opinions, and knowledge. The findings of these focus groups will be used to assist the program in future planning efforts specific to our adolescent population.

MCH WORKFORCE DEVELOPMENT AND CAPACITY UPDATES

Preventive and primary care services to the MCH population are provided through Office of Child and Family Services (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 86 field staff utilizing 18.47 FTE. This also includes 17 Central Office Staff which utilizes 7.87 FTE. Linda Ahrendt is the OCFS Administrator and Title V Administrator and has been with the DOH for 18 years. Scarlett Bierne is the OCFS Assistant Administrator and MCH Director and has been with the DOH for 11 years. Barb Hemmelman serves as the CYSHCN Director. Barb has been with the DOH since September 2004. Other MCH team members include the following:

Sue Alverson, State Nutritionist
Rhonda Buntrock, WIC Program Administrator
Carolyn McGlade, State WIC Nutrition Coordinator
Carrie Churchill, Home Visiting Program Manager
Dee Dee Dugstad, Tobacco Control Program Coordinator
Laura Streich, Tobacco Disparities Coordinator
Lucy Fossen, Newborn Metabolic/Hearing Screening Coordinator
Sara Gloe, South Dakota Family Planning (SDFP) Program Nurse Manager
Emily Johnson, SDFP Nurse Consultant/Sexual Violence Prevention Coordinator
Jill Munger, MCH Nurse Consultant/Infant Death Review Coordinator
Sarah Barclay, MCH Child/Adolescent Coordinator
Tim Heath, Immunization Program
Wade Huntington, Regional Manager
Tammy Hybertson, Regional Manager
Cherie Koch, Regional Manager
Julie Miller, Regional Manager
Daphne Filbert, Regional Manager
Jennifer Fouberg, Regional Manager
Dana Sandine, Regional Manager
Peggy Seurer, OCFS Assistant Administrator – Public Health/Clinical Services Manager
Mark Gildemaster, Manager, Data and Statistics
Virginia Peterson, Data and Statistics
Ashley Miller, Chronic Disease Epidemiologist
Katelyn Strasser, MCH Epidemiologist
EA Martin, SDSU contract MCH and home visiting epidemiology
Derrick Haskins, Communication Director
Beth Honerman, Breastfeeding and Oral Health Coordinator

The DOH contracts with an epidemiology group and has a designated MCH epidemiologist to continually analyze our available data and develop fact sheets/articles based on their findings. This information is shared with our MCH Impact Team and partners for increased awareness and program planning purposes.

The South Dakota MCH program is currently working to improve its website content and outreach to increase our effectiveness in improving the health and wellness of women, infants, children, and adolescents within our state.

PARTNERSHIPS, COLLABORATION, AND COORDINATION UPDATES

***Other Federal Investments* –**

HRSA Early Hearing Detection and Intervention **-** HRSA Early Hearing Detection and Intervention (EHDI) funds were used to establish the SD EHDI Collaborative in partnership with the University of South Dakota to provide EHDI support and engagement activities with hospitals, physicians, audiologists, nurse midwives and parents.

Family Planning – South Dakota Family Planning Program (SDFP) delivers services across South Dakota through a network

of 21 sites. The South Dakota Family Planning Program is dedicated to providing services to low income individuals to increase healthy maternal/fetal outcomes. In calendar year 2017, the SDFPP provided services to 5,055 clients. The SDFPP is currently accepting proposals for an Electronic Health Record to increase continuity of care for their clients.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - WIC serves participants through 79 clinic sites statewide (all but 3 counties in the state have a clinic). In addition the WIC program works cooperatively with three Indian Tribal Organizations (Cheyenne River, Rosebud Sioux, and Standing Rock) to ensure the entire state is covered for WIC services. In federal fiscal year 2017 WIC served on average 16,409 participants. Overall, WIC is serving 57% of all WIC income eligible participants.

Bright Start Home Visitation Program – The South Dakota Department of Health (DOH), Office of Child and Family Services (OCFS) is both the grantee and the implementing agency for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) funded services. Bright Start uses the Nurse Family Partnership (NFP) model in seven sites. In calendar year 2017, the Bright Start program provided 5191 nurse home visits to 522 South Dakota families to support improved pregnancy and child health outcomes.

State Personal Responsibility Education Program (SPREP) grant - SPREP provides young people ages 14 to 19 years of age with knowledge and life skills needed to reduce risky behaviors and make healthy choices.

Abstinence Education grant - Provides youth ages 9 to 13 years evidence based SMART Moves Curriculum. This curriculum provides self-awareness activities to develop respect for one's own body; how to handle feelings and cultivate healthy habits; and how to interact and work in groups.

Rape Prevention Education (RPE) grant - The RPE program focuses on community mobilization, coalition building, policy education, social norms change, and prevention activities that include the implementation of sexual violence prevention programs as well as the provision of training and technical assistance to organizations on the implementation of sexual violence strategies.

***Other DOH Programs* –**

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. As of 2017, the SD QuitLine has assisted over 95,000 South Dakotans in their efforts to quit smoking.

The South Dakota Vaccines for Children program supplies vaccine to 250 facilities across the state. South Dakota has approximately 116,600 children 0 through 18 eligible for the program which is 53% of all persons in that age group.

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 Office of Data, Statistics and Vital Records (DSVR) provides technical assistance for the development, implementation, and evaluation of data collection activities.

Office of Rural Health 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.

***Other Government Agencies* –**

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

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

The DOH partnered with Office of Public Safety to develop an injury prevention toolkit to reduce adolescent injury. The toolkit provides education on child car seat guidelines and encourages seatbelt usage.

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

***Tribes/Tribal Organizations* –**

The South Dakota home visiting program is implemented in three Native American reservation areas; therefore cultural competence is very important related to working with Native clients and community partners.

The WIC program works cooperatively with three Indian Tribal Organizations (Cheyenne River, Rosebud Sioux, and Standing Rock) to ensure the entire state is covered for WIC services.

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. The program includes two trucks that serve as mobile clinics to provide preventive, diagnostic and restorative care, and dental hygienists and community health workers based on the state's Native American reservations. Since 2012, hygienists and community health workers based on South Dakota's Native American reservations have focused on preventive care through education, cleaning, sealants, and fluoride treatments at clinics hosted at schools and Head Start programs. Around 4,000 kids are served at these clinics each year.

Emerging Public Health Issues:

Opioid use and abuse- The South Dakota Department of Health (SD DOH) was awarded the *Prescription Drug Overdose: Data-Driven Prevention Initiative* planning grant from the Centers for Disease Control and Prevention (CDC) to support and build efforts to track and understand the full impact of opioid use and abuse in South Dakota. An Opioid Abuse Advisory Committee was formed in 2016 to oversee this work, comprised of stakeholders representing multiple agencies, programs, legislators and family/victim advocates.

Maternal mortality- Rates of maternal mortality are increasing in the United States. South Dakota is currently reviewing data sources, processes, and healthcare partner interest to support monitoring maternal mortality in our state. In addition, South Dakota will be a part of the Region VIII Technical Assistance request. The goal of this TA request is to convene a regional summit on Maternal Mortality to develop a collaborative approach to address maternal mortality in Region VIII, including exploring opportunities to leverage resources across states to regionalize and strengthen the quality of the data; and to identify ways to use the data to drive public health recommendations to reduce maternal deaths.

Adolescent mortality- The 2015 Youth Risk Behavior Survey shows that in South Dakota, 74% of all deaths among youth and young adults aged 14-18 years result from three causes: suicide (35%), motor vehicle crashes (28%), and other unintentional injuries (11%). Based on 2016 National Vital Statistic System data, South Dakota is ranked 50th in adolescent mortality and 46th out of 49 in adolescent motor vehicle mortality. The DOH continues to work with our state partners to determine how to reach this population with awareness and education. Of additional concern for adolescents is the use of nicotine in any form, including Electronic Nicotine Delivery Systems (ENDS).

FY 2018 Application/FY 2016 Annual Report Update

II.B. Five Year Needs Assessment Summary

PROCESS UPDATES

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

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

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

TITLE V PROGRAM CAPACITY UPDATES

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

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

AGENCY CAPACITY UPDATES

The DOH operates the Bright Start program in 12 counties (Pennington, Butte, Lawrence, Oglala Lakota, Bennett, Stanley, Lyman, Hughes, Beadle, Marshall, Day and Roberts) while Children's Home Society operates the program in partnership with the DOH in Sioux Falls and the surrounding communities. Bright Start uses Maternal Infant and Early Childhood Home Visiting (MIECHV) funds in 11 of the counties, and state Medicaid and TANF funds in Rapid City, Sioux Falls and Pine Ridge. The program uses the Nurse Family Partnership (NFP) model, as well as a home-grown curriculum in non-MIECHV funded counties. In FY 2016, 596 Bright Start families were served by the DOH.

The DOH operates the WIC program statewide. Since 2013 WIC has worked to update the SDWIC-IT system and in 2016 developed a committee of clinic representatives to assist us with prioritizing development and recommendations for

improvements. WIC is currently in the process of implementing Electronic Benefit Transfer from a paper check process with statewide implementation to occur by mid-September 2017. WIC had approximately 193 full service grocery stores authorized to accept WIC benefits in FFY2016.

MCH WORKFORCE DEVELOPMENT AND CAPACITY UPDATES

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

Sue Alverson, State Nutritionist
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Emily Johnson, SDFP Nurse Consultant/Sexual Violence Prevention Coordinator
Jill Munger, MCH Nurse Consultant/Infant Death Review Coordinator
Connie Johnson, MCH Child/Adolescent Coordinator
Tim Heath, Immunization Program
Megan Hlavacek, Healthy Foods Coordinator
Wade Huntington, Regional Manager
Tammy Hybertson, Regional Manager
Cherie Koch, Regional Manager
Julie Miller, Regional Manager
Vacant, Regional Manager
Jennifer Fouberg, Regional Manager
Jessica Scharfenberg, Regional Manager
Peggy Seurer, OCFS Assistant Administrator – Public Health/Clinical Services Manager
Bobbi Jo Peltier, Aberdeen Area IHS
Susan Sporrer, Director of Policy and Special Projects
Marty Link, Trauma Program Manager
Mark Gildemaster, Manager, Data and Statistics
Michelle Hoffman, Data and Statistics
Ashley Miller, Chronic Disease Epidemiologist
EA Martin, SDSU contract MCH and home visiting epidemiology

PARTNERSHIPS, COLLABORATION, AND COORDINATION UPDATES

Other Federal Investments –

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

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

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

Other DOH Programs –

As of 2016, the SD QuitLine has assisted nearly 91,000 South Dakotans in their efforts to quit smoking. The SD QuitLine has one of the most successful quit rates in the country at 42.9%.

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

Other Government Agencies –

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

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

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

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

Tribes/Tribal Organizations –

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

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

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

Delta Dental Mobile Program - The DOH promotes and refers individuals to Delta Dental of South Dakota's mobile dental program which has provided preventive and restorative care to underserved children across South Dakota since 2004. Delta Dental manages, operates and staff the two mobile dental trucks, and works with local community site partners to identify children up to age 21 most in need of care who can least afford it. Dental services provided include teeth cleaning, fillings for cavities, tooth extractions, dental sealants, fluoride treatments, instructions on care of teeth/gums, and tobacco/smoking cessation counseling. The dental trucks typically spend a week in each community and each truck is on the road roughly 40 weeks a year. Since September 2004, the Delta Dental Mobile Program has visited 81 communities across the state (including 30 Native American communities) and has served nearly 35,000 children. The retail dollar value of care provided is more than $17.4 million. After completing a three-year grant-funded program in 2015 that focused on reducing disparities by providing preventive oral care on South Dakota's nine Native American reservations, Delta Dental elected to combine that program into a new version of the Delta Dental Mobile Program. That aspect of the program includes seven dental hygienists and three community health workers who provide reservation-based services including teeth cleanings, dental sealants and fluoride applications as well as oral health education and care coordination. In 2016, the community-based staff served 4,720 children ages 0 through the 8th grade. In total, Delta Dental's clinical services program served 8,553 patients in 2016.

FY 2017 Application/FY 2015 Annual Report Update

PROCESS UPDATES

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

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

ESMs

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

SPMs

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

TITLE V PROGRAM CAPACITY UPDATES

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

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

AGENCY CAPACITY UPDATES

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

counties. In FY 2015, 636 Bright Start families were served by the DOH.

MCH WORKFORCE DEVELOPMENT AND CAPACITY UPDATES

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

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

PARTNERSHIPS, COLLABORATION, AND COORDINATION UPDATES

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

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

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

Tribes/Tribal Organizations - During the past year Home Visiting program staff collaborated with the Maine MIECHV program to share tribal outreach strategies and tribal government systems in order to enhance the DOH's ability to provide tribal outreach in SD.
The Home Visiting program is implemented in three of the nine reservations in SD reservation areas so cultural competence is very important to working with native clients/community partners. The two home visitors on the Pine Ridge team are Lakota and members of the Oglala Sioux Tribe and the site coordinator has lived within 30 miles of the reservation for 20 years. The Pine Ridge Reservation site is currently a part of a Tribal Formative project that is guided by staff at the Prevention Resource Center (PRC) at the University of Colorado, which serves as the research arm of NFP. This formative work involves two innovations to the traditional NFP model: (1) admitting non-first time (multiparous) women who are less than 28 weeks gestation; (2) assessing and amending the Visit to Visit Guidelines and other service delivery methods to meet the needs of the local American Indian/Alaska Native population. South Dakota chose to have Pine Ridge participate in this Formative Project due to the extremely high needs of the Oglala-Lakota people, and also to increase the potentially eligible caseload by including multiparous women as clients.
In Sisseton, the Home Visitation program has linked with GPTCHB on ECCS grant activities. The Nurse Home Visitor and Rural Team Site Coordinator are members of the First 1000 Days Interagency Committee formed to carry out the next steps from the Community GONA (Gathering of Native Americans) and the ECCS project on mitigating toxic stress in childhood. The First 1000 Days group supports the work plan of the ECCS project, and has completed a wide variety of activities including community presentations on ACES, planning for the first MCH Resiliency Conference, focus groups for the development of marketing materials, and a community resource directory.

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

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

II.B.1. Process

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

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

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

Improve the Health Behaviors of South Dakotans to Reduce Chronic Disease

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

Strengthen the Healthcare Delivery System in South Dakota

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

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

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

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

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

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

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

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

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

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

Women/Maternal Health

South Dakota's data shows:

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

Conclusions:

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

Child Health

South Dakota's data shows:

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

Conclusions:

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

Adolescent Health

South Dakota's data shows:

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

Conclusions:

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

Children and Youth with Special Health Care Needs

South Dakota's data shows:

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

Conclusions:

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

Cross-cutting or Life Course

South Dakota's data shows:

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

Conclusions:

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

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

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

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

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

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

II.B.2.b Title V Program Capacity

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

The DOH is an executive-level department with the Secretary of Health appointed by, and reporting to, the Governor. The mission of the DOH is to promote, protect, and improve the health and well-being of all South Dakotans. The DOH is charged with the protection of the public health by appropriate measures set forth and authorized by state law. South Dakota Codified Law (SDCL) 34-1-21 designates the DOH as the sole state agency to receive, administer, and disburse federal Title V monies and authorizes the DOH to adopt rules to administer the Title V program relating to MCH and CSHS services. Administrative Rules of South Dakota (ARSD) 44:06 provides guidance on the delivery of services to CYSHCN and

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

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

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

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

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

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

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

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

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

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

South Dakota Family Planning (SDFP) offers men and women of childbearing age reproductive health education, contraceptive counseling and methods, physical examinations, and STI counseling, testing and treatment. Payment for

family planning services is based on a sliding fee schedule according to family size and income.

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

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

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

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

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

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

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

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

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

The Oral Health program coordinates activities to increase awareness of the importance of oral health and preventive care,

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

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

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

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

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

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

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

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

Preventive and primary care services to the MCH population are provided through OFCH. OFCH provides direction to state-employed nurses, nutrition educators, and dietitians for the provision of public health services in the state. Field staff

providing primary preventive services for mothers, infants, and children include 6.97 FTE for mothers and infants and 6.37 FTE for children and adolescents. Another 3.55 FTE provide family planning services in the state. In addition, OFCH field staff spend 3.07 FTE on case management to pregnant women which is billed to DSS Medicaid. OFCH and OCDPHP central office program staff dedicated to providing program direction to specific MCH program areas include: 1.89 for child and adolescent health, 0.77 for perinatal health, 2.14 for family planning services; and 2.55 for CSHS.

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

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

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

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

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

Other MCH Investments

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

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

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

Other Federal Investments

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

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

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

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

Other HRSA Programs

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

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

Other DOH Programs

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

Other Government Agencies

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

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

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

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

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

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

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

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

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

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

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

DHS administers the state's Respite Care Program. The program is jointly funded with state general funds, MCH block grant funds, and some DHS federal grant funds. MCH block grant funds are used to provide services for children on the program diagnosed with chronic medical conditions. CSHS program staff assist families with referral to the Respite Care Program. The program has an advisory group with representation from various state programs serving families who have children with

special needs including special education, child protection, developmental disabilities, mental health, and CYSHCN. Parents are also represented on this group.

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

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

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

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

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

Health Professional Education Programs/Universities
The DOH has a long-standing collaborative relationship with the Center for Disabilities within the USD SOM Department of Pediatrics. The South Dakota Leadership Education Excellence in Caring for Children with Neurodevelopmental and Related Disorders (LEND) is a program of the Center for Disabilities that works to improve the health status of infants, children, and adolescents with neurodevelopmental and related disabilities. The LEND program provides one year of specialized training focusing on the interdisciplinary training of professionals for leadership roles in the provision of health and related services to infants, children and adolescents with neurodevelopmental and related disabilities and their families. The program

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

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

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

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

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

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

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,236,264	$2,591,754	$2,476,338	$2,415,470
State Funds	$1,680,000	$1,920,916	$1,766,341	$1,695,079
Local Funds	$500,000	$87,243	$487,134	$117,472
Other Funds	$0	$0	$22,650	$0
Program Funds	$740,000	$842,904	$810,181	$1,378,312
SubTotal	$5,156,264	$5,442,817	$5,562,644	$5,606,333
Other Federal Funds	$20,239,995	$23,744,990	$20,613,679	$24,799,643
Total	$25,396,259	$29,187,807	$26,176,323	$30,405,976

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,149,068	$0	$2,149,068	
State Funds	$1,700,080		$1,695,079	
Local Funds	$87,000		$117,472	
Other Funds	$0		$0	
Program Funds	$810,000		$1,378,312	
SubTotal	$4,746,148		$5,339,931	
Other Federal Funds	$20,193,754		$20,487,960	
Total	$24,939,902		$25,827,891	

	2020	
	Budgeted	Expended
Federal Allocation	$0	
State Funds	$0	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$0	
Other Federal Funds	$0	
Total	$0	

III.D.1. Expenditures

III.D.2. Budget

III.E. Five-Year State Action Plan

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

State: South Dakota

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

III.E.2.b. Supportive Administrative Systems and Processes

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

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

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

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

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

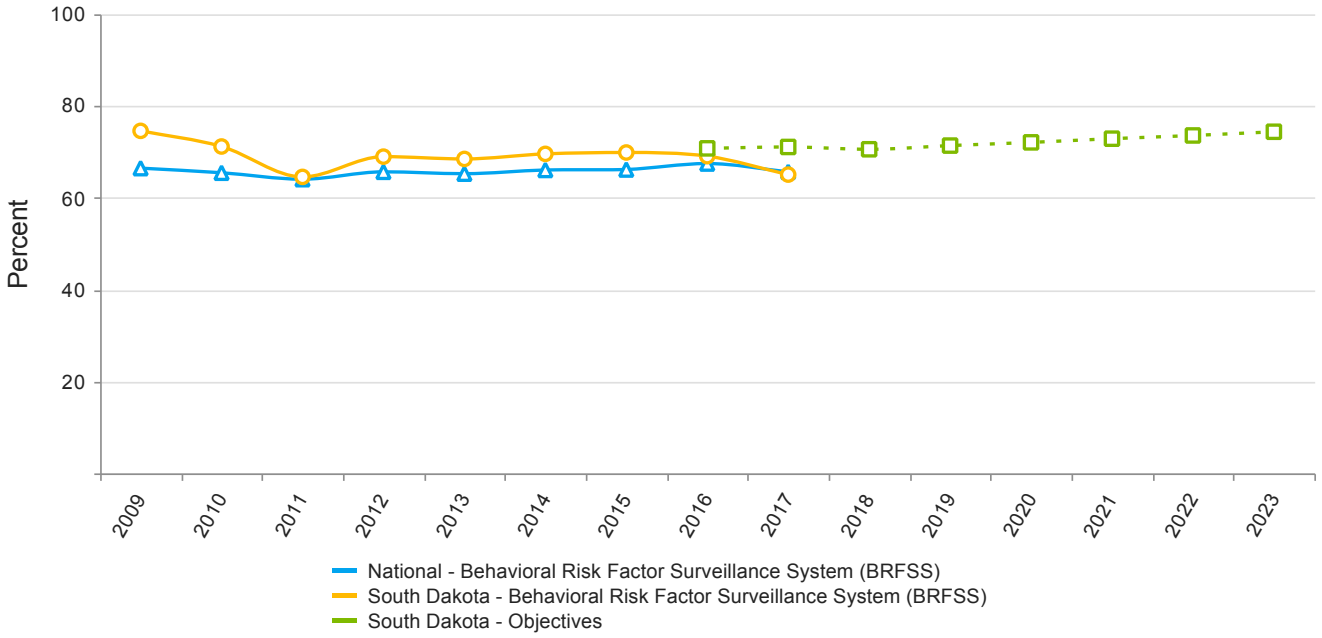
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	88.3	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2017	6.9 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2017	9.3 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2017	25.3 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2016	5.7	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	4.9	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	2.5	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	2.4	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2016	97.8	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2017	8.3 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2016	1.8	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	22.6	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2017	14.3 %	NPM 1

National Performance Measures

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



Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	70.7	71	70.5
Annual Indicator	69.8	69.0	65.0
Numerator	98,560	98,280	92,476
Denominator	141,180	142,541	142,186
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	71.3	72.0	72.8	73.5	74.3	

Evidence-Based or –Informed Strategy Measures

ESM 1.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure that all women are aware of the importance of annual well women visits.

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0	

State Action Plan Table

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

Priority Need

Promote preconception/inter-conception health

NPM

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

Objectives

By June 30, 2020, increase the percent of 18-24 year old women who had a preventive medical visit in the past year from 59.3% (2016) to 66.2% (BRFSS)

Strategies

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

1.2 Educate women on the importance of yearly preventive visits.

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

ESMs	Status
ESM 1.1 - Number of partners who collaborate to promote well women visits	Inactive
ESM 1.1 - Number of partners who collaborate to promote well women visits	Inactive
ESM 1.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure that all women are aware of the importance of annual well women visits.	Active
ESM 1.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure that all women are aware of the importance of annual well women visits.	Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

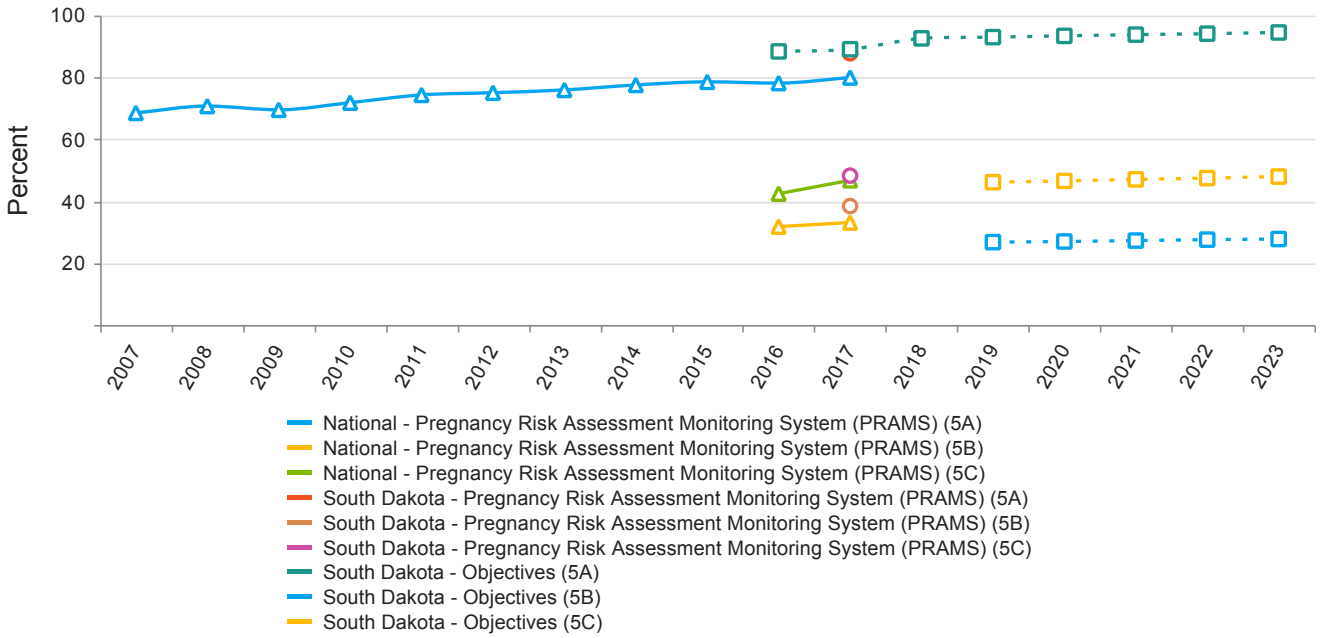
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	4.9	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	2.4	NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	122.2	NPM 5

National Performance Measures

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



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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	92.4
Annual Indicator	87.6
Numerator	9,793
Denominator	11,174
Data Source	PRAMS
Data Source Year	2017

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	92.8	93.2	93.6	93.9	94.3	

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	38.4
Numerator	4,014
Denominator	10,466
Data Source	PRAMS
Data Source Year	2017

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

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	26.8	27.0	27.3	27.6	27.8	

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	48.2
Numerator	5,069
Denominator	10,516
Data Source	PRAMS
Data Source Year	2017

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

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	46.1	46.5	47.0	47.4	47.9	

Evidence-Based or –Informed Strategy Measures

ESM 5.3 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure implementation of infant safe sleep practices.

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0	

State Action Plan Table

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

Priority Need

Reduce infant mortality

NPM

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

Objectives

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

Strategies

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

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

5.3 Collaborate with community partners to provide infant death review.

5.4 Develop Safe Sleep Process orientation for clerical in Office of Child and Family Services.

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

ESMs	Status
ESM 5.1 - Number of page engagements to the For Baby's Sake Facebook page	Inactive
ESM 5.1 - Number of page engagements to the For Baby's Sake Facebook page	Inactive
ESM 5.2 - Percent of Sudden Unexpected Infant Deaths reviewed for which a SUIDI reporting form was received and reviewed as part of the Infant Death Review Team meeting.	Inactive
ESM 5.2 - Percent of Sudden Unexpected Infant Deaths reviewed for which a SUIDI reporting form was received and reviewed as part of the Infant Death Review Team meeting.	Inactive
ESM 5.3 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure implementation of infant safe sleep practices.	Active
ESM 5.3 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure implementation of infant safe sleep practices.	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Perinatal/Infant Health - Application Year

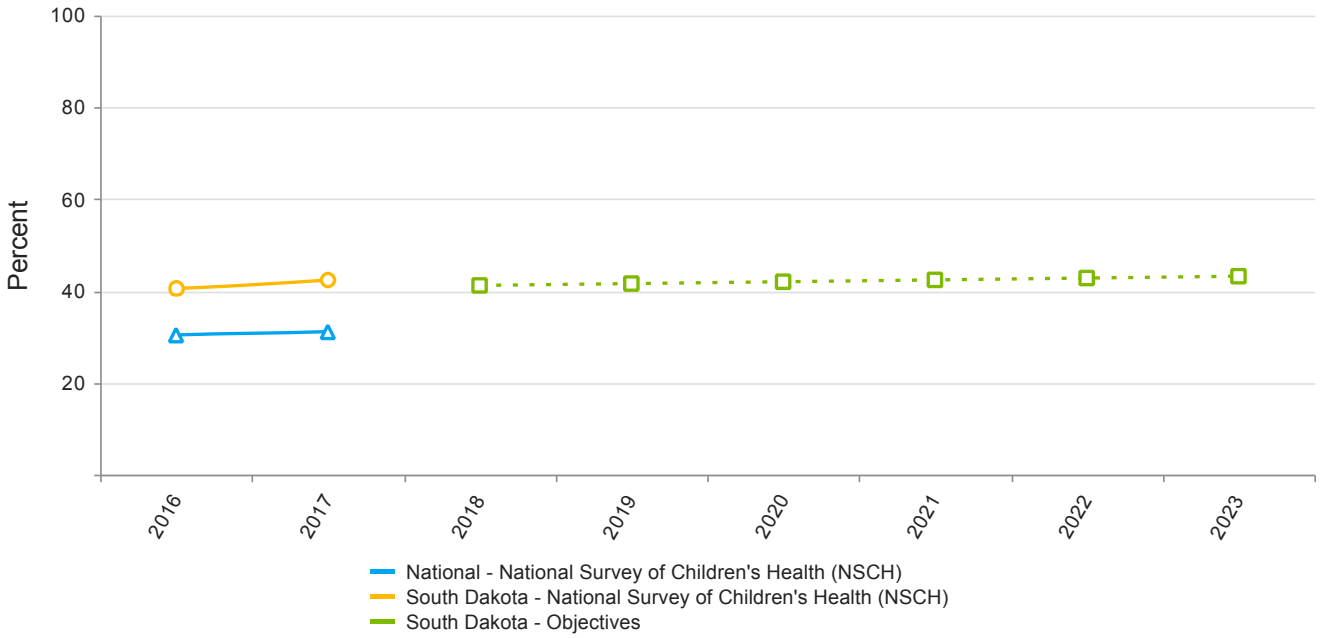
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	93.7 %	NPM 6

National Performance Measures

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



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			41.2
Annual Indicator		40.4	42.4
Numerator		12,135	10,542
Denominator		30,030	24,884
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	41.6	42.0	42.4	42.8	43.2	

Evidence-Based or –Informed Strategy Measures

ESM 6.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to improve early identification and referral of developmental delays.

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0	

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		29.4	32.1
Annual Indicator	36.1	33.1	
Numerator	1,868	2,415	
Denominator	5,179	7,295	
Data Source	FAD NOM 20 WIC data	PedNss	
Data Source Year	2014	2016	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	31.6	31.1	30.6	30.1	29.6	

State Action Plan Table

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

Priority Need

Improve early identification and referral of developmental delays

NPM

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

Objectives

By June 20, 2020, increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year from 25.6% (2016) to 26.6% (NSCH).

Strategies

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

6.2 Partner with "Learn the Signs, Act Early" Champion to promote developmental screening within the State of South Dakota.

6.3 Provide ASQ and ASQ SE screenings at Community Health Offices as per DOH policy.

ESMs	Status
ESM 6.1 - Number of partners who collaborate to promote early childhood screening	Inactive
ESM 6.1 - Number of partners who collaborate to promote early childhood screening	Inactive
ESM 6.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to improve early identification and referral of developmental delays.	Active
ESM 6.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to improve early identification and referral of developmental delays.	Active

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

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

SPM

SPM 2 - 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 of age with a BMI at or above the 85th percentile from 27.2% (2017) to 22.1% (School height/weight data).

By June 30, 2020, decrease the percentage of American Indian children ages 2 to 5 years with a BMI at or above the 85th percentile (overweight or obese) from 39.5% (2016) to 37.9% (PedNSS).

Strategies

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

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

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

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

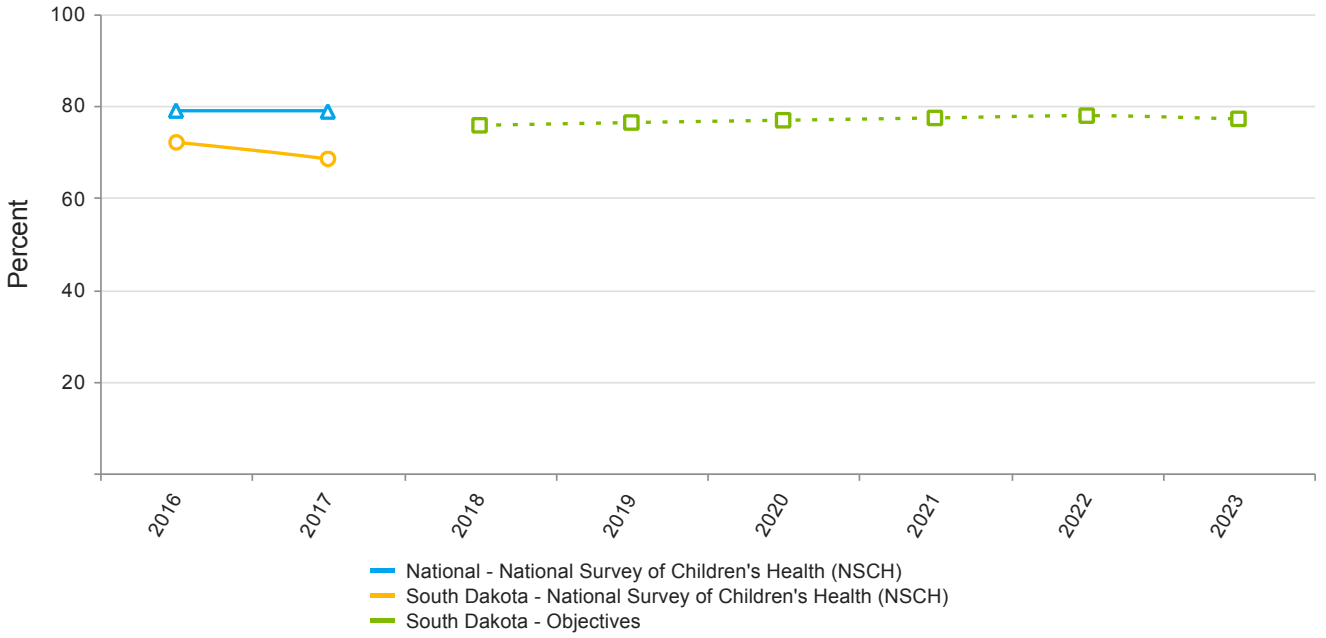
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2017	51.7	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	24.1	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	30.0	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	60.9 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	93.7 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016_2017	13.6 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	17.1 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	14.7 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2017_2018	64.4 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2017	63.2 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2017	79.5 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2017	74.5 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	22.6	NPM 10

National Performance Measures

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



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

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

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	76.3	76.8	77.3	77.8	77.1	

Evidence-Based or –Informed Strategy Measures

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

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0	

State Action Plan Table

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

Priority Need

Promote oral health for all populations

NPM

NPM 10 - 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 65.7% (2016) to 71.4% (NIS).

By June 30, 2020, increase the percent of adolescents (14-18 years of age) who smoke that enroll in the SD QuitLine from 0.79% (2016) to 0.82% (QuitLine & YRBS).

Strategies

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

10.2 Identify and implement ways to promote yearly adolescent visit.

10.3 Encourage individual and family engagement.

10.4 Target messaging regarding tobacco cessation coaching for adolescents.

10.5 Promote 6th grade vaccination requirements.

ESMs	Status
ESM 10.1 - Number of publications/mailings promoting outreach regarding Bright Futures	Inactive
ESM 10.1 - Number of publications/mailings promoting outreach regarding Bright Futures	Inactive
ESM 10.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to increase the percent of adolescents with an annual preventive medical visit.	Active
ESM 10.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to increase the percent of adolescents with an annual preventive medical visit.	Active

NOMs

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

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

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

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 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

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

Children with Special Health Care Needs

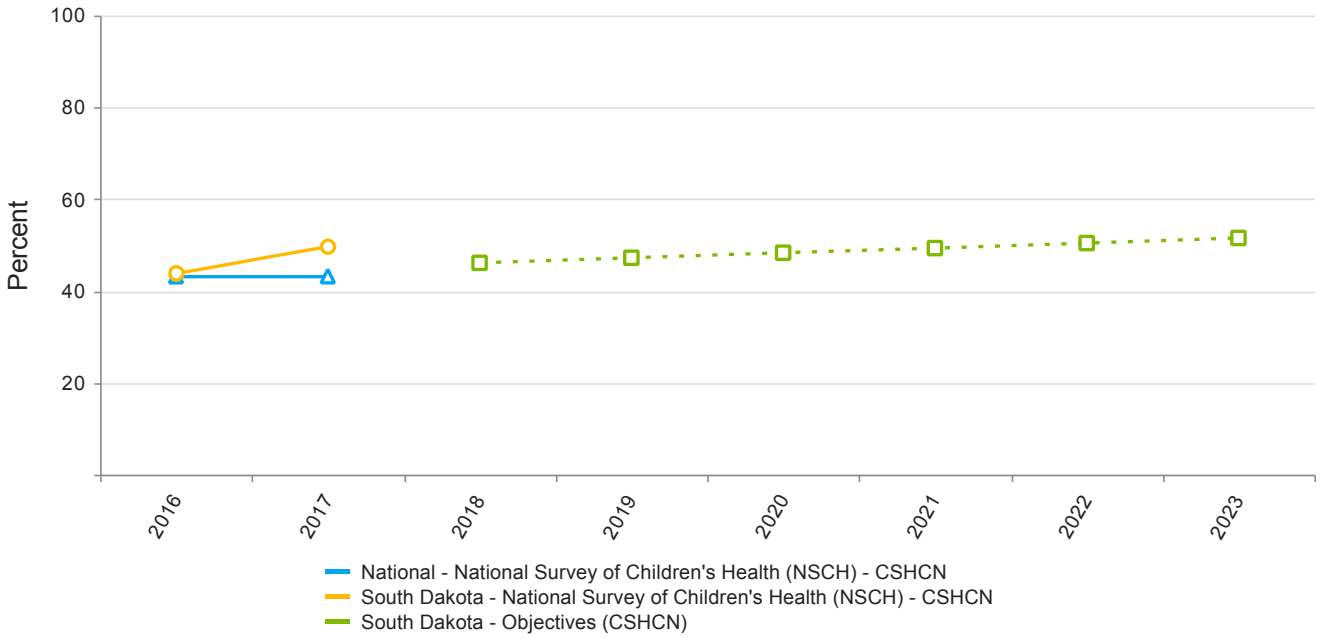
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016_2017	15.6 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	60.9 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	93.7 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016_2017	3.1 %	NPM 11

National Performance Measures

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

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			46.1
Annual Indicator		43.9	49.6
Numerator		14,361	16,789
Denominator		32,704	33,876
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	47.2	48.3	49.3	50.4	51.5	

Evidence-Based or –Informed Strategy Measures

ESM 11.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure access to a medical home.

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0	

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

By June 30, 2020, increase the percentage of children and youth with special health care needs who report receiving care in a well-functioning system from 9.3% (2016) to 9.7% (NSCH).

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

Strategies

11.1.1 Collect data specific to the needs of families of children and youth with special health care needs and the providers that serve them.

11.1.2 Enhance family access to needed supports and services.

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

11.2.1 Coordinate the newborn screening infrastructure.

11.2.2 Implement a quality improvement effort in the newborn screening program.

ESMs	Status
ESM 11.1 - Number of trainings for providers on components of medical home model	Inactive
ESM 11.1 - Number of trainings for providers on components of medical home model	Inactive
ESM 11.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure access to a medical home.	Active
ESM 11.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure access to a medical home.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Children with Special Health Care Needs - Application Year

Cross-Cutting/Systems Building

State Performance Measures

SPM 4 - MCH data are analyzed and disseminated

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		Yes	Yes
Annual Indicator	Yes	Yes	
Numerator			
Denominator			
Data Source	NA	NA	
Data Source Year	NA	NA	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	Yes	Yes	Yes	Yes	Yes	

State Action Plan Table

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

Priority Need

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

SPM

SPM 4 - MCH data are analyzed and disseminated

Objectives

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

Strategies

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

S4.2 Identify data collection methods to address gaps.

S4.3 Implement new data collection efforts as needed.

S4.4 Develop and disseminate fact sheets on findings.

S4.5 Analyze the data to identify future program efforts.

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

III.G. Technical Assistance

IV. Title V-Medicaid IAA/MOU

V. Supporting Documents

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

VI. Organizational Chart

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: South Dakota

	FY 20 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 0	
A. Preventive and Primary Care for Children		(%)
B. Children with Special Health Care Needs		(%)
C. Title V Administrative Costs		(%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 0	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 0	
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)	$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 0	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
No Other Federal Programs were provided by the State on Form 2 Line 9.	

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,149,068			
A. Preventive and Primary Care for Children	$ 687,702	(32%)		(%)
B. Children with Special Health Care Needs	$ 687,702	(32%)		(%)
C. Title V Administrative Costs	$ 85,962	(4%)		(%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,461,366		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,700,080			
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 87,000			
5. OTHER FUNDS (Item 18e of SF-424)	$ 0			
6. PROGRAM INCOME (Item 18f of SF-424)	$ 810,000			
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,597,080		$ 0	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 4,746,148		$ 0	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 20,193,754		$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 24,939,902		$ 0	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 159,943	
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,428	
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 212,897	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,018,486	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,045,000	
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 17,000,000	

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

Data Alerts:

- The value in Line 1, Federal Allocation, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1A, Preventive And Primary Care Expended, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
- The value in Line 3, State MCH Funds, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
- The value in Line 4, Local MCH Funds, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
- The value in Line 6, Program Income, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

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

State: South Dakota

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women		
2. Infants < 1 year		
3. Children 1 through 21 Years		
4. CSHCN		
5. All Others		
Federal Total of Individuals Served		

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women		
2. Infants < 1 year		
3. Children 1 through 21 Years		
4. CSHCN		
5. All Others		
Non-Federal Total of Individuals Served		
Federal State MCH Block Grant Partnership Total		

Form Notes for Form 3a:

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: South Dakota

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services		
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One		
B. Preventive and Primary Care Services for Children		
C. Services for CSHCN		
2. Enabling Services		
3. Public Health Services and Systems		
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		
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Line 4 Expended Total		
Federal Total		

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services		
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One		
B. Preventive and Primary Care Services for Children		
C. Services for CSHCN		
2. Enabling Services		
3. Public Health Services and Systems		
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Line 4 Expended Total		
Non-Federal Total		

Form Notes for Form 3b:

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: **Data Source Year:**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions				

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Form Notes for Form 4:

Field Level Notes for Form 4:

None

Data Alerts: None

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

State: South Dakota

Annual Report Year 2018

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

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women						
2. Infants < 1 Year of Age						
3. Children 1 through 21 Years of Age						
3a. Children with Special Health Care Needs						
4. Others						
Total						

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

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women						
2. Infants < 1 Year of Age						
3. Children 1 through 21 Years of Age						
3a. Children with Special Health Care Needs	Not Available		Not Available			
4. Others						

Form Notes for Form 5:

Field Level Notes for Form 5a:

None

Field Level Notes for Form 5b:

None

Data Alerts:

1.	Form 5 has not yet been started. Please access and complete the form.
2.	This form has not yet been started. Please fill out all sections in the form.

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

State: South Dakota

Annual Report Year 2018

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State									
Title V Served									
Eligible for Title XIX									
2. Total Infants in State									
Title V Served									
Eligible for Title XIX									

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	2020 Application Year	2018 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number		
2. State MCH Toll-Free "Hotline" Name		
3. Name of Contact Person for State MCH "Hotline"		
4. Contact Person's Telephone Number		
5. Number of Calls Received on the State MCH "Hotline"		

B. Other Appropriate Methods	2020 Application Year	2018 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

Form 8
State MCH and CSHCN Directors Contact Information

State: South Dakota

1. Title V Maternal and Child Health (MCH) Director	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

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

Form Notes for Form 8:

Form 9
List of MCH Priority Needs

State: South Dakota

Application Year 2020

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 10
National Outcome Measures (NOMs)

State: South Dakota

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

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	88.3	10.3	74	8,385
2014	97.1	9.4	108	11,122
2013	111.0	10.1	122	10,988
2012	93.8	9.3	102	10,873
2011	111.7	10.3	120	10,742
2010	104.2	10.0	110	10,554
2009	100.0	9.7	108	10,796
2008	89.0	9.1	96	10,784

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

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

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	9.3 %	0.3 %	1,125	12,121
2016	9.0 %	0.3 %	1,098	12,268
2015	8.5 %	0.3 %	1,053	12,325
2014	8.5 %	0.3 %	1,040	12,268
2013	8.1 %	0.3 %	993	12,221
2012	7.8 %	0.2 %	946	12,084
2011	7.9 %	0.3 %	940	11,832
2010	8.6 %	0.3 %	1,013	11,788
2009	7.9 %	0.3 %	944	11,912

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 6 - Notes:

None

Data Alerts: None

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

Data Source: CMS Hospital Compare

Multi-Year Trend

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

Legends:

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
2016	5.7	0.7	70	12,319
2015	6.8	0.7	84	12,374
2014	6.3	0.7	78	12,326
2013	6.4	0.7	79	12,292
2012	8.8	0.9	107	12,147
2011	6.3	0.7	75	11,882
2010	8.4	0.9	100	11,864
2009	5.8	0.7	69	11,962

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ 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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	8.3 %	1.0 %	919	11,073

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 10 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

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

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 11 - Notes:

None

Data Alerts: None

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

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

NOM 12 - Notes:

None

Data Alerts: None

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

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

NOM 13 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	8.7 %	1.2 %	16,828	193,935
2016	9.6 %	1.4 %	18,332	191,693

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	51.7	6.7	60	115,978
2016	63.7	7.5	73	114,680
2015	56.6	7.1	64	113,106
2014	37.0	5.7	42	113,630
2013	44.5	6.3	50	112,318
2012	44.0	6.3	49	111,395
2011	43.7	6.3	49	112,012
2010	56.5	7.1	63	111,588
2009	65.2	7.6	73	111,893

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	24.1	3.8	41	170,094
2014_2016	23.4	3.7	40	171,242
2013_2015	14.5	2.9	25	171,823
2012_2014	19.1	3.3	33	172,681
2011_2013	17.4	3.2	30	172,774
2010_2012	24.3	3.8	42	172,983
2009_2011	29.3	4.1	51	173,766
2008_2010	33.2	4.4	58	174,643
2007_2009	35.1	4.5	62	176,399

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	30.0	4.2	51	170,094
2014_2016	28.0	4.1	48	171,242
2013_2015	29.1	4.1	50	171,823
2012_2014	22.6	3.6	39	172,681
2011_2013	22.0	3.6	38	172,774
2010_2012	20.8	3.5	36	172,983
2009_2011	24.2	3.7	42	173,766
2008_2010	28.6	4.1	50	174,643
2007_2009	24.9	3.8	44	176,399

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	16.1 %	1.3 %	33,876	210,513
2016	15.7 %	1.4 %	32,704	208,339

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	15.6 %	3.8 %	5,296	33,876
2016	9.6 %	1.9 %	3,144	32,704

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	1.5 %	0.5 %	2,649	171,841
2016	2.0 %	0.8 %	3,263	166,826

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	6.5 %	1.0 %	10,997	170,388
2016	7.0 %	0.9 %	11,719	166,311

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	60.9 %	5.9 %	10,629	17,449
2016	51.8 %	7.0 %	8,075	15,596

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	93.7 %	0.9 %	196,224	209,466
2016	92.7 %	1.1 %	191,296	206,419

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	17.1 %	0.5 %	884	5,179
2012	14.8 %	0.4 %	1,190	8,020
2010	17.3 %	0.4 %	1,363	7,884
2008	16.1 %	0.4 %	1,121	6,946

Legends:

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

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	14.7 %	1.3 %	5,536	37,559
2013	12.1 %	1.1 %	4,574	37,828
2011	9.9 %	0.9 %	3,830	38,861
2009	9.6 %	1.0 %	3,698	38,344
2007	9.1 %	1.2 %	3,698	40,750
2005	10.5 %	1.1 %	4,276	40,792

Legends:

Indicator has an unweighted denominator <100 and is not reportable

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	13.6 %	2.3 %	11,680	86,126
2016	13.0 %	2.2 %	10,488	80,613

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	6.1 %	1.0 %	12,936	212,391
2016	4.3 %	0.8 %	9,120	213,902
2015	7.4 %	1.3 %	15,401	209,556
2014	7.3 %	1.2 %	15,285	209,494
2013	7.3 %	1.0 %	14,974	205,982
2012	3.9 %	0.8 %	7,869	204,137
2011	5.7 %	0.8 %	11,454	202,877
2010	7.1 %	1.2 %	14,562	204,414
2009	6.7 %	0.9 %	13,342	199,435

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, 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
2017	74.7 %	3.4 %	13,587	18,177
2016	70.4 %	3.4 %	12,914	18,339
2015	75.6 %	3.5 %	13,599	17,989
2014	76.3 %	4.2 %	13,098	17,159
2013	73.9 %	3.9 %	12,072	16,346
2012	63.6 %	3.3 %	10,370	16,301
2011	62.9 %	5.3 %	10,532	16,741
2010	48.7 %	3.5 %	8,257	16,951
2009	42.8 %	3.6 %	7,179	16,786

Legends:

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

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

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	64.4 %	2.0 %	128,145	198,957
2016_2017	63.2 %	2.4 %	125,737	199,014
2015_2016	70.8 %	2.0 %	139,014	196,236
2014_2015	64.4 %	2.4 %	124,290	192,937
2013_2014	68.5 %	2.1 %	131,211	191,596
2012_2013	73.2 %	3.3 %	140,455	192,009
2011_2012	58.2 %	2.6 %	107,634	184,949
2010_2011	53.7 %	4.6 %	100,976	188,037
2009_2010	56.5 %	2.6 %	95,462	168,959

Legends:

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

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

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	63.2 %	3.2 %	35,462	56,124
2016	55.9 %	3.4 %	30,966	55,423
2015	46.0 %	3.2 %	25,628	55,733

Legends:

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

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

NOM 22.3 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	79.5 %	2.8 %	44,628	56,124
2016	79.4 %	2.9 %	43,986	55,423
2015	72.4 %	2.9 %	40,325	55,733
2014	75.0 %	3.0 %	41,570	55,439
2013	70.0 %	3.3 %	38,650	55,198
2012	65.9 %	3.3 %	35,845	54,368
2011	54.4 %	5.2 %	29,467	54,183
2010	52.5 %	3.2 %	29,225	55,702
2009	39.6 %	3.4 %	22,002	55,527

Legends:

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

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

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	74.5 %	2.9 %	41,838	56,124
2016	65.7 %	3.2 %	36,400	55,423
2015	55.5 %	3.2 %	30,918	55,733
2014	57.0 %	3.4 %	31,618	55,439
2013	51.7 %	3.4 %	28,523	55,198
2012	40.0 %	3.5 %	21,743	54,368
2011	37.4 %	4.8 %	20,280	54,183
2010	30.9 %	3.0 %	17,198	55,702
2009	24.9 %	2.9 %	13,838	55,527

Legends:

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

Estimates with 95% confidence interval half-widths > 10 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	22.6	0.9	614	27,226
2016	25.1	1.0	681	27,149
2015	26.5	1.0	720	27,214
2014	26.7	1.0	735	27,483
2013	29.4	1.0	812	27,650
2012	33.5	1.1	929	27,747
2011	34.3	1.1	964	28,066
2010	34.8	1.1	975	28,045
2009	38.7	1.2	1,092	28,228

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 23 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	14.3 %	1.2 %	1,604	11,203

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	3.1 %	0.7 %	6,559	210,083
2016	2.3 %	0.7 %	4,772	207,703

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: South Dakota

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

Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	70.7	71	70.5
Annual Indicator	69.8	69.0	65.0
Numerator	98,560	98,280	92,476
Denominator	141,180	142,541	142,186
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	71.3	72.0	72.8	73.5	74.3	

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	92.4
Annual Indicator	87.6
Numerator	9,793
Denominator	11,174
Data Source	PRAMS
Data Source Year	2017

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

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	92.8	93.2	93.6	93.9	94.3	

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	38.4
Numerator	4,014
Denominator	10,466
Data Source	PRAMS
Data Source Year	2017

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

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	26.8	27.0	27.3	27.6	27.8	

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	48.2
Numerator	5,069
Denominator	10,516
Data Source	PRAMS
Data Source Year	2017

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

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	46.1	46.5	47.0	47.4	47.9	

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			41.2
Annual Indicator		40.4	42.4
Numerator		12,135	10,542
Denominator		30,030	24,884
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	41.6	42.0	42.4	42.8	43.2	

Field Level Notes for Form 10 NPMs:

None

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

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

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

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	76.3	76.8	77.3	77.8	77.1	

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			46.1
Annual Indicator		43.9	49.6
Numerator		14,361	16,789
Denominator		32,704	33,876
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

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

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	47.2	48.3	49.3	50.4	51.5	

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: South Dakota

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

Measure Status:	Active

State Provided Data	2016	2017	2018
Annual Objective		29.4	32.1
Annual Indicator	36.1	33.1	
Numerator	1,868	2,415	
Denominator	5,179	7,295	
Data Source	FAD NOM 20 WIC data	PedNss	
Data Source Year	2014	2016	
Provisional or Final ?	Final	Final	

Annual Objectives	2019	2020	2021	2022	2023	2024
Annual Objective	31.6	31.1	30.6	30.1	29.6	

Field Level Notes for Form 10 SPMs:

None

SPM 4 - MCH data are analyzed and disseminated

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		Yes	Yes
Annual Indicator	Yes	Yes	
Numerator			
Denominator			
Data Source	NA	NA	
Data Source Year	NA	NA	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	Yes	Yes	Yes	Yes	Yes	

Field Level Notes for Form 10 SPMs:

None

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

State: South Dakota

ESM 1.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure that all women are aware of the importance of annual well women visits.

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0	

Field Level Notes for Form 10 ESMs:

None

ESM 5.3 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure implementation of infant safe sleep practices.

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0	

Field Level Notes for Form 10 ESMs:

None

ESM 6.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to improve early identification and referral of developmental delays.

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0	

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0	

Field Level Notes for Form 10 ESMs:

None

ESM 11.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure access to a medical home.

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0	

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: South Dakota

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

Measure Status:	Active
Goal:	Promote positive child and youth development to reduce morbidity and mortality
Definition:	**Numerator:** # of children aged 2 to 5 years receiving WIC with a BMI at or above 85th percentile (overweight or obese) **Denominator:** # of children aged 2 to 5 years receiving WIC **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	NWS-10.1: Reduce the proportion of children aged 2 to 5 years who are considered obese
Data Sources and Data Issues:	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 4 - MCH data are analyzed and disseminated
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Improve state and local surveillance, data collection, and evaluation capacity
Definition:	**Numerator:** (# 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 10
State Outcome Measure (SOM) Detail Sheets

State: South Dakota

No State Outcome Measures were created by the State.

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

State: South Dakota

ESM 1.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure that all women are aware of the importance of annual well women visits.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Promote preconception/inter-conception health and promote oral health
Definition:	**Numerator:** Rating on implementation of each strategy on a scale of one to three. Each rating is added together for a combined score. **Denominator:** Total number of strategies multiplied by three (highest rating possible) **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	South Dakota MCH developed data collection form
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes.

ESM 5.3 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure implementation of infant safe sleep practices.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Reduce infant mortality
Definition:	**Numerator:** Rating on implementation of each strategy on a scale of one to three. Each rating is added together for a combined score. **Denominator:** Total number of strategies multiplied by three (highest rating possible) **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	South Dakota MCH developed data collection form
Significance:	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side or stomach sleep positions, the AAP has long recommended the back to sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment to include use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing) and without loose bedding.

ESM 6.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to improve early identification and referral of developmental delays.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Improve early identification and referral of developmental delays.
Definition:	**Numerator:** Rating on implementation of each strategy on a scale of one to three. Each rating is added together for a combined score. **Denominator:** Total number of strategies multiplied by three (highest rating possible). **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	South Dakota MCH developed data collection form.
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low.

ESM 10.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to increase the percent of adolescents with an annual preventive medical visit.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Improve and assure appropriate access to health services and promote positive child and youth development to reduce morbidity and mortality; and promote oral health
Definition:	**Numerator:** Rating on implementation of each strategy on a scale of one to three. Each rating is added together for a combined score. **Denominator:** Total number of strategies multiplied by three (highest rating possible) **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	South Dakota MCH developed data collection form
Significance:	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors, such as unsafe sexual activity, unsafe driving, and substance use, is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. An annual preventive well visit may help adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. The Bright Futures guidelines recommend that adolescents have an annual checkup from age 11 through 21. The visit should cover a comprehensive set of preventive services, such as a physical examination, immunizations, and discussion of health-related behaviors including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.

ESM 11.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure access to a medical home.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and children and youth with special health care needs.
Definition:	**Numerator:** Rating on implementation of each strategy on a scale of one to three. Each rating is added together for a combined score. **Denominator:** Total number of strategies multiplied by three (highest rating possible) **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	South Dakota MCH developed data collection form
Significance:	The AAP specific seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

Form 11
Other State Data

State: South Dakota

The Form 11 data are available for review via the link below.

Form 11 Data