Maternal and Child Health Services Title V Block Grant

South Dakota

FY 2021 Application/ FY 2019 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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SOUTH DAKOTA DEPARTMENT OF HEALTH

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

September 4, 2020

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

Dear Director:

I am pleased to submit the FY 2021 South Dakota Maternal and Child Health Block Grant application and annual report. Should you have any questions concerning this application, please contact Jennifer Folliard at 605.367.5374.

Sincerely,

Linda Ahrendt

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

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

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

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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

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

Priority	MCH Population Domain	NPM or SPM
Mental health/Substance abuse	Women/Maternal Health	NPM 1 Well-Woman Visit
Safe sleep	Perinatal/Infant Health	NPM 5 Safe Sleep
Parenting education and support	Child Health	NPM 6 Developmental Screening
Mental health/Suicide prevention	Adolescent Health	NPM 7 Injury Hospitalization
Access to care and services	CYSHCN	NPM 11 Medical Home
Healthy relationships	Adolescent Health	SPM 1
Data sharing and collaboration	Cross-Cutting	SPM 2

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

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

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

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

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

Program planning and development of action plans occurred in collaboration with key partners focused on issues that impact each MCH domain served. Action plans address priority issues including safe sleep, healthy relationships, mental health and substance abuse, parenting education and support, access to care and services, and a cross-cutting priority for data sharing and collaboration. The action plans will inform strategies and activities outlined to address priority health issues implemented in collaboration with MCH partners. South Dakota State University (SDSU) Population Health Evaluation Center will provide support and build state capacity for enhanced performance reporting.

Role of State Title V

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

Partnerships

The 2020-2025 needs assessment process assisted in furthering the development of long-standing partnerships and provided an opportunity to identify and engage emerging partners. Partnerships have always played a significant role in implementing SD MCH programs and initiatives through the Title V block grant.

Historically, MCH program leaders have focused their efforts on supporting and expanding the work of SD's public health system, which includes a centralized organizational structure where the DOH directly governs the state's 76 local community health offices. This focus has led to strong interagency partnerships, like the WIC program and Office of Rural Health to ultimately address a dire need for healthcare access, delivery of case management services for the MCH population and development of the MCH workforce. Program planning has been prioritized and cultivated throughout the needs assessment process in collaboration with interagency partnerships, such as the Department of Social Services (DSS). Specifically, DSS will expand the reach of Title V by addressing social needs and access to healthcare that are persistent issues in SD. Engagement of partners beyond state government is being leveraged to expand programming and reach to underserved MCH populations. Community and faith-based partners, such as Lutheran Social Services (LSS), were identified during the needs assessment as partners who extend into communities at risk for health disparities, including refugee, new American and American Indian (AI) communities. Actions continue to cultivate partnerships and innovative programming with the major healthcare systems in SD for children and youth with special health care needs (CYSHCN). Moreover, significant need for more intentional outreach and engagement with the nine sovereign native nations within the SD border is essential to better support American Indian populations across the state.

III.A.2. How Federal Title V Funds Support State MCH Efforts

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

III.A.3. MCH Success Story

Implementation of a comprehensive needs assessment process that emphasized health equity and engaged multi-sector partners and community members for the first time is a significant success that illustrates federal-state Title V partnerships in action. Specifically, the process engaged new external partners throughout the process, including data collection and action planning, and the Title V program continues to engage these partners. Community members, including adolescents, tribal communities, and underserved populations were engaged to ensure the voice of populations impacted by health issues was included in the process. Moreover, by including a focus on health equity throughout the process, the MCH program has established a foundation to ensure efforts moving forward are focused on addressing health equity across all domains. The needs assessment provided a foundation to build the capacity of the Title V program and federal-state partnerships in action.

III.B. Overview of the State

Demographics, Geography, Economy

South Dakota traverses over 75,000 square miles in the upper Midwest and is one of the United States' most rural and frontier geographic areas. SD is home to diverse landscape that is divided into east and west by the Missouri River. There are 882,235 living in SD with an average population density of 10.7 people per square mile. Of SD's 66 counties, 30 are rural and 34 are frontier (less than 6 people per sq. mile). The states' two most populated counties are located on opposite sides of the state. There are nine federally recognized American Indian tribes within the SD borders.

The state's population by race and Hispanic origin is 84.4% White, 9% American Indian (AI), 2.4% Black, 1.7% Asian, 2.4% Two or More Races and 4.1% Hispanic or Latino. The population by sex is 49.5% female and 50.5% male. Just under 25% of the state's population are persons under the age of 18, with 7% of persons under 5 years of age. Approximately 37% of the state's female population is of childbearing age, 15 through 44.

South Dakota's median household income is $56,499. Nearly 13% of SD households live below 100% of the Federal Poverty Level (FPL), with the 10 poorest counties either part of or adjacent to SD's AI reservations. Reservations experience significantly higher poverty levels ranging from 22.3%-48.6%. Almost 12% of persons under 65 years of age lack health insurance. In addition, 91.7% of persons aged 25 years and older are high school graduates or higher and 28.5% have a bachelor's degree or higher. Key industries that shape SD's economy include agriculture, mining, finance, manufacturing, and tourism.

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

Strengths and Challenges

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

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

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

Despite the growth in the healthcare industry and strategies to address the healthcare workforce, SD residents are challenged by the limited access to healthcare. Approximately two-thirds of the state is designated by the federal government as a Health Professional Shortage Area (HPSA). Health care provider shortages exist in primary care, dental health, and mental health. There are also 71 Medically Underserved Areas/Populations (MUA/P), including a shortage of primary care health services across the state. As of June 4, 2019, there were 4,442 physicians and 654 physician assistants licensed in SD. In addition, there were 1,140 actively licensed nurse practitioners and 34 actively licensed nurse midwives.

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

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

Roles, Responsibilities and Targeted Interests of State Health Agency

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

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

The strategic plan addresses the following goals:

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

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

The DOH also remains committed to providing comprehensive public health services and programs for and with

underserved populations and communities throughout the state. Much of the state is designated as a HPSA and is therefore underserved.

The DOH's centralized organizational structure delivers public health services across the state through 76 local community health offices. A wide array of public health services is provided including interpreter services, direct services, and outreach services provided by WIC, Title X Family Planning, and the Bright Start Home Visiting program. Community health staff provide infant safe sleep education, health and safety information, growth and development screening, prenatal education, immunizations, school nurse services, modified case management for high risk pregnant moms, postpartum care and support services for families with funding from and coordination with the MCH block grant. These offices are under the leadership of the Title V administrator and provide an avenue to gather input in program development as well as during program evaluation. A few examples of the communities that community health offices serve include the 54 Hutterite colonies throughout the state, the refugee resettlement of the Burmese Karen populations in the Huron and Aberdeen areas, and the expanding urbanization of Sioux Falls.

The DOH remains committed to fostering relationships with both Indian Health Service (IHS) staff and statewide tribal government/tribal health to identify opportunities to support MCH services on SD Indian reservations. The DOH has supported several tribal initiatives, such as the Project LAUNCH grant and Tribal MIECHV grants, by providing letters of support and community advisory board commitments. These partnerships are in place with the Sisseton Wahpeton Oyate MCH program, as well as Great Plains Tribal Chairmen's Health Board on behalf of the Rosebud Sioux Tribe and Sisseton Wahpeton Oyate.

South Dakota Systems of Care

According to federally available data, the MCH Block Grant in SD aims to serve approximately 11,000 pregnant women, 12,000 infants, 253,000 children and adolescents age 1 through 21, and 45,000 children and youth with special health care needs. SD has 49 general community hospitals, of which 38 are critical access hospitals and 32 provide routine obstetrical services. There are five federally qualified health centers (FQHCs) and 60 rural health clinics. There are also five IHS hospitals in SD, of which only two provide routine obstetrical services. SD has one children's hospital located on the East side of the state and 125 general pediatricians and approximately 75 subspecialists to serve the MCH population.

The Departments of Health and Social Services continue to prioritize and focus on social needs and behavioral health services integration. The OCFS is the outreach arm and community presence of the DOH and works closely with DSS programs that support health, social needs and behavioral health including Medicaid, Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). These programs work directly with the 76 community health offices that administer WIC program and the Bright Start home visiting program. These programs are also forging new partnerships and services to address behavioral health needs as an emerging issue within the state.

An average of 116,000 South Dakotans relies on Medicaid for their healthcare each month. The vast majority, 68%, are children. Half of the children born in SD each year will be on Medicaid during their first year of life and 35% of all Medicaid recipients are American Indian (SD Medicaid). Medicaid eligibility for FY20 includes pregnant women at 138% FPL; children under 6 at 182% FPL, children age 6-19 at 116% FPL, parent/caregiver/relatives of low-income children at 52% FPL; CHIP (Children's Health Insurance Program) at 209% FPL. Twelve percent of women of childbearing age are not insured by public or private insurance and 10 % of children under 200% FPL are uninsured (U.S. Census Bureau, ACS and Kaiser Family Foundation).

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

III.C.2.a. Process Description

Background and Introduction

The DOH's OCFS administers the Title V program and Title V MCH Block Grant for SD. The OCFS has conducted needs assessments every five years to understand the health needs for SD's pregnant women, mothers, infants, children, and CYSHCN. The needs assessment provides an opportunity for the OCFS to evaluate progress toward achieving performance measures, assess population health status for families and individuals (including underserved populations), assess capacity of OCFS staff and programs to serve families and individuals, and to select priorities to address. An external public health consultant, SLM Consulting LLC, was contracted to assist with planning and implementation of this needs assessment. In the fall of 2018, the OCFS initiated the needs assessment process, to help shape the 2020-2025 State Action Plan.

Planning took place between September and December 2018 and included identification of the process design and timelines, staff roles to support planning and implementation, guiding frameworks and principles, partner organization involvement, a communication plan, and data collection methods. Implementation of the needs assessment occurred between January 2019 through December 2019 focused on broad stakeholder engagement and comprehensive data collection and analysis that informed identification of priority needs for SD's maternal and child health population to address between 2020 and 2025. This report provides an overview of the MCH needs assessment process and findings, including strengths and needs of the process and health status of populations by domain.

Process, Goals, Frameworks and Guiding Principles

The goal, frameworks, and guiding principles that informed the needs assessment were chosen to ensure the process engaged priority populations across the lifespan and addressed health equity. The needs assessment was shaped by guiding principles that supported a comprehensive and inclusive process.

Two frameworks shaped the needs assessment process, including the Life Course Theory (LCT) and Health Equity Model (HEM). Utilization of the LCT was important to first understand health issues that impact the MCH population at all stages of life, including health patterns and disparities. Secondly, the HEM was used in alignment with the Life Course Approach to conceptualize social determinants of health that impact the MCH population across the life course. Specifically, understanding factors that contributed to health issues, including social, economic, and physical factors, was important to shape the needs assessment and identify root causes impacting health outcomes, priority needs, and action plans. The OCFS adapted the HEM of the Colorado Department of Public Health & Environment.

Guiding principles that supported the implementation of a comprehensive and inclusive process, as well as the needs assessment frameworks included:

- Evidence-based decision making;
- Using a health equity lens;
- Respond to emerging issues and trends that affect families and individuals in SD;
- Social determinants of health;
- Input from diverse stakeholders and partners;
- Do not reinvent the wheel; and
- Setting realistic priorities and performance measures.

Methodology

The needs assessment was shaped by a collaborative approach that engaged multi-sector partners, families, and individuals from across the state through data collection and information gathering approaches, including surveys, regional partner meetings, and focus groups. Input was sought from partner organizations, families, and individuals who represent broad perspectives, with targeted outreach to ensure representation from diverse SD geographies and underserved populations. New and existing partners were engaged throughout the process, with an emphasis on ensuring transparency regarding the process and fostering sustainable partnerships.

The roles that supported planning and implementation of the needs assessment included the following:

Needs Assessment Project Team: This team included a core group of OCFS staff, including the Administrator, MCH Program Director, Bright Start Home Visiting Manager, MCH Epidemiologist, and SLM Consulting. This team served as the core team who helped design and facilitate the process, develop guiding principles, a communication plan, and data collection methods, as well as identified the leadership roles necessary to implement the process. This team met every other week to support planning for the implementation of the needs assessment.

OCFS Advisory Committee: This team included OCFS program leaders who helped inform the process design and timelines, prioritization, and served as a pipeline to partner organizations, families and individuals. Advisory Committee members are in communities across South Dakota. The Advisory Committee was convened monthly starting in November 2018.

MCH Impact Team: This team includes DOH offices and program, including the Office of Chronic Disease Prevention and Health Promotion, Office of Health Statistics, Communications, Immunization Program, and the OCFS staff who helped to inform decisions on the process, data collection, and identification of priorities for the 2020-2025 Action Plan.

Partner Organizations: Partners included organizations, agencies, and stakeholders who the OCFS Needs Assessment Project Team, Advisory Committee, and MCH Impact Team identified as integral to support a collaborative needs assessment process.

Families & Individuals: These populations included men, women, children, and youth (including CYSHCN) who are served by the OCFS programs and partner organizations, providing a community perspective on health issues.

A comprehensive communication plan with media outlets shaped the implementation of the needs assessment. The plan was designed to engage and keep partners, key stakeholders, families, and individuals and the MCH Impact Team updated on the process. An internal DOH graphic designer formatted communication resources to ensure consistent branding and design.

Stakeholder Engagement

A collaborative approach was the foundation of the needs assessment process, focused on engaging diverse partners and stakeholders to inform a comprehensive understanding of health and well-being issues that impact families and individuals across SD. Input was gathered from stakeholders who represented state agencies, community-based organizations, health care providers, tribal agencies, as well as local community members, families, and individuals disproportionately impacted by health and well-being issues. The process engaged stakeholders across the state through regional partner meetings, focus groups, and surveys that gathered input from individuals, families, and communities.

Partner Organizations

The OCFS Needs Assessment Project Team and Advisory Committee identified existing and new partners to

participate in the needs assessment process for data collection, priority setting, and action planning. Engaging partners in this way provided an opportunity to expand the reach of Title V, understand shared priorities and strengthen the foundation of coordinated health and community systems of care.

Partners whose focus included working with women, infants, and children, including children with special health care needs, as well as families and individuals impacted by health disparities were invited to participate. Outreach totaled 110 partner organizations, representing 19 sectors, including but not limited to: state government staff, higher education, community-based organizations, family-led organizations, private businesses, faith-based organizations, health systems, health professional organizations, community coalitions, Tribal MCH programs including WIC, Tribal colleges, and Tribal government. Many of the partners work within all the MCH domains.

Partner organizations were invited to participate in the January 2019 launch of the needs assessment process via a webinar facilitated by the OCFS Needs Assessment Project Team. Partners were also invited to complete a survey which assessed priority health issues impacting families and individuals they work with in SD. Survey findings informed the design of other data collection methods utilized in the needs assessment including a youth survey, community input survey, and focus groups. Partners were also engaged through regional partner meetings.

Other data collection methods partners participated in included a community input survey to provide feedback on priority health issues impacting the MCH population across the state. Partners were asked to share the survey with their own stakeholders and other relevant organizations. After completion of data collection, partners were invited to participate in a webinar to learn about the key findings to inform priority setting by domain. In-person and virtual meetings were held with partners by domain to discuss key findings and identify two priorities to focus on in the 2020-2025 State Action Plan. Subsequent action planning was conducted in collaboration with partners to ensure diverse, meaningful input and collaboration moving forward.

Partners were also kept informed of the needs assessment process through a monthly newsletter devoted to providing information about MCH staff and on-going activities. It was important to be transparent with partners and keep them engaged throughout the entire process. The process provided a foundation to build existing and new partnerships that will be important to coordinate MCH programs and support the health and well-being of families and individuals served.

Families and Individuals

Engagement of families and individuals was identified as a key component of the needs assessment process early in the planning stage. It was important to inform an understanding of health and well-being issues directly from families and individuals experiencing them. Input was elicited from families and individuals supported by OCFS programs and partner organizations through a community input survey, youth survey, and focus groups. Efforts were made to engage underserved populations disproportionately affected by health and well-being issues, including American Indian, low-income, youth, and rural populations. Partner organizations were integral to support engagement of families and individuals in this process, particularly in communities where OCFS staff and programs did not have a footprint.

Quantitative and Qualitative Methods

Comprehensive quantitative and qualitative data collection methods were utilized to assess population health status and issues that impact families and individuals (e.g. women, infants, children, and adolescents, including those with special healthcare needs and underserved populations) across SD, as well as to assess the capacity of OCFS partner organizations and OCFS staff who serve families and individuals across the state. Quantitative and qualitative methods utilized included a partner survey, regional partner meetings, community input survey, youth

survey, focus groups, and fall partner meetings.

The OCFS Partner Survey was a preliminary survey designed to elicit quantitative and qualitative input from partner organizations regarding priority health and wellbeing issues that impact families and individuals they serve. The survey was developed based on existing MCH indicator data and priority health issues. Partners were also asked to share contact information for other partners who could help inform the needs assessment. The survey was disseminated electronically and informed the scope of future data collection efforts including the youth and community input surveys, regional partner meetings, and focus groups. The full report is available in application supporting documents.

Partner meetings were held in five regions across the state with a total of approximately 100 partners to discuss unique health and well-being needs of women, infants, children, and adolescents, including those with special health care needs. SD is a geographically diverse state, shaped by rural and urban communities, nine federally recognized American Indian tribes, and unique issues that impact each of these areas. To foster stakeholder engagement, it was integral that OCFS took the opportunity to engage partners in their communities and gather qualitative data.

The Youth Survey was a key data collection method used to elicit feedback from SD youth for the first time in an MCH needs assessment. This survey elicited input from 659 SD youth, grades 5-12, regarding priority health issues affecting them, including health problems, access/use of healthcare, substance use behaviors, bullying, sexual education and health, and prevention behaviors. The survey was disseminated electronically to partner organizations who serve youth, as well as via hard copy at local and state conferences targeted at SD youth. The full report is available in application supporting documents.

A Community Input Survey was a key data collection method used in the needs assessment process to seek input from community members and partners important to the process. The survey elicited input from 1,020 SD families and individuals served by OCFS programs, OCFS partner organizations, as well as concerned parents, parent/guardians of children with special health care needs, community service providers, educators, health care providers, policy makers, tribal government, and government employees who support these populations. The full report is available in application supporting documents.

Focus groups were held in four SD communities with unique populations, including women living on an American Indian reservation, co-parenting adults in a rural community in northwestern SD, single parents in eastern SD, and youth in southeastern SD. The focus groups were held to capture in-depth feedback on the health and wellbeing issues that impact families and individuals in rural and underserved communities. A summary report can be found in the application supporting documents.

Data sources utilized to inform the needs assessment included regional partner meetings, secondary data, MCH indicator data, as well as state and federal performance measures. Needs assessment data informed shared decision-making by partners and OCFS staff to identify preliminary priority needs of women, infant, children, CYSCHN, and adolescents served by the MCH program and partners. The Needs Assessment Project Team and key OCFS Advisory Committee members met in December 2019 to finalize priorities for each domain based on the needs assessment data. Each domain leader outlined chosen priorities, possible partners, suggested evidence-based strategies and how the priorities might align with National Performance Measures (NPM) or State Performance Measures (SPM). After discussing the priorities identified through the needs assessment process, the group chose NPMs and SPMs that align. Facilitators were then chosen to lead each NPM/SPM workgroup which would include external and internal partners. Each NPM/SPM facilitator met with new and existing partners to begin looking at strategy development to form the State Action Plan.

In February 2020, members of the Needs Assessment Project Team and OCFS Advisory Committee participated in Evidenced-Based Decision-Making training using Results Based Accountability framework provided by John Richards, Strengthen the Evidence for MCH Programs and Oscar Fleming, National MCH Workforce Development Center. The technical assistance provided an opportunity to create an evidence-based action plan using Evidence-Based Strategy Measures (ESM) that advance NPMs. During the training attendees analyzed the story behind the data, identified partners and what role they play, and discussed what works and what resources and activities we need to address the problems. The full Needs Assessment Report can be found here 2020 Title V Needs Assessment Report.

III.C.2.b. Findings

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

Women/Maternal Health: Findings from the needs assessment revealed many notable strengths and needs in women/maternal health. Feedback elicited from partners at the regional partner meetings recognized strengths including workforce development programs, available data, access to healthcare services, the 211 Helpline, community programs, and existing partnerships and collaboration between agencies that promote health. Needs identified specific to women/maternal health largely centered on social needs, mental health, and substance abuse, as well as access to healthcare services.

Input from the regional partner meetings, along with qualitative data from the community input survey and focus groups revealed some challenges and gaps for all women. Social needs, including lack of transportation, joblessness or having a job that does not meet the family's needs, lack of education, and poor housing conditions were noted gaps in women/maternal health outcomes. Data also revealed gaps in access to healthcare services and providers, lack of sexual health education, lack of cultural awareness and the need for improved advocacy around women's health issues (DOH, 2019).

Women's mental health and substance abuse were common themes across the state. Focus group participants were concerned about gaps in counseling services and underutilization of available services due to a lack of awareness and confidentiality. Participants also identified concerns around substance abuse, especially methamphetamine. Findings from the community input survey indicated that access to mental health services and substance abuse prevention and treatment were ranked among the top six priorities. Specifically, women who were married, who had a higher income, and were white or a race other than American Indian stated that access to mental health services was more likely to be an unmet need than women who were not married, who had a lower income, and were American Indian. While the MCH program has had limited success in increasing the number of women ages 18-44 who received a well-woman, preventative medical visit each year, SD did report a higher rate of visits in 2018 compared to the national average (77% vs. 74%, respectively). Needs assessment findings indicate the importance of such a visit as a care coordination and referral starting point for women.

Maternal attitudes and behaviors of SD mothers also reflects challenges and gaps in morbidity and health risks as outlined in 2018 PRAMS data, including:

- 67% of mothers statewide reported drinking alcohol 3 months before pregnancy, and 8% reported drinking alcohol the last 3 months of pregnancy.
- 25% of mothers statewide reported smoking the 3 months before pregnancy and 10% smoked the last 3 months of pregnancy.
- 16% of women reported depression 3 months before pregnancy, 17% reported it during pregnancy, and of those that had a postpartum visit, 13% reported symptoms indicative of postpartum depression.
- Women that were enrolled in the SD WIC program were more likely than those not enrolled in WIC to have

depression during pregnancy (26% vs. 13%) and score high on indicators for postpartum depression (21% vs. 10%) (SD PRAMS, 2018).

Current efforts to support women/maternal health include: 1) partnering with Title X and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to promote the well-woman visit, 2) partnering with the WIC program to increase the number of well-woman visit referrals made, and 3) working with one of the major insurance companies in the state to send out a reminder letter regarding well-woman visits to women of childbearing age, an evidence-based strategy.

The OCFS has not formally addressed the mental health status of its clients in community health offices across the state. However, opportunities to implement new strategies, as well as enhance the current strategies can better support this effort, ensuring an emphasis on health equity. New strategies to address this priority using MCH funds will include: 1) implementing an evidence-based behavioral health screening tool to be utilized in all OCFS sites; 2) creating a toolkit of evidence-based resources on maternal mental health/substance abuse to support referral; 3) training OCFS field staff on recognizing the symptoms of perinatal depression; and 4) the use of the selected screening tool and when/how to refer. Developing new partnerships with multi-sector, diverse partners to help address this priority need will also be key to equitability supporting women across the state, including underserved and vulnerable populations.

Adolescent Health: Notable strengths in the adolescent health domain include the following: the availability of community resources, activities, and recreational opportunities; training resources; collaboration across youth programs and non-profit organizations; youth led groups; and telehealth. Despite these identified strengths there are additional needs specific to adolescent health including a focus on mental health, substance abuse, sexual health, and health behaviors.

Much of the data identified in the needs assessment highlights poor outcomes for adolescents in SD. Specifically, both adolescent mortality and adolescent suicide rates for 10 through 19-year-olds in 2017 were some of the highest in the country at 51.7 per 100,000 and 30.0 per 100,000, respectively (DOH Vital Statistics, 2017 and MCHBG Annual Report, 2019). In addition, the youth survey identified the top five health concerns among youth age 11-18 as: 1) suicide, 2) bullying, 3) substance abuse, 4) sexual health, and 5) physical activity and nutrition. Survey data also indicated that youth felt that resources were lacking in the areas of mental health, reproductive or sexual health, and substance abuse treatment and prevention. Sexual health and suicide prevention were the two top priorities consistently noted throughout the needs assessment process (DOH, 2019).

The community input survey found similar unmet needs among the adolescent age group. Thirty-nine percent of respondents felt that access to mental health services was an unmet need. Life skills training, substance use prevention and treatment, youth voice in decisions affecting them, and safe and affordable housing were the other unmet needs with the greatest number of responses. Individuals with lower income and American Indian respondents were more likely to report that the lack of a youth voice was an unmet need among adolescents, while higher income and white respondents were more likely to state that access to mental health services was a greater need adolescents (DOH, 2019).

The youth survey asked whether participants would take a sex education course if one were offered in their community, including whether they had taken a course before. Of the participants that had already taken a sex education course, 52% of them said that they would take another class. Of those that had never taken a sex education course, 69% said that they would take a class. This reinforces a gap in education, as well as a challenge to identify how sexual health education can be offered (DOH, 2019).

Eighty-four percent of youth that responded to the Youth Survey identified suicide as one of their top five health concerns. Seventeen percent of respondents said that they had seriously considered attempting suicide. Depression and suicide also surfaced as two main mental health concerns in the adolescent focus group. Focus group participants thought that bullying and lack of healthy coping mechanisms for stress contributed to the suicide epidemic.

The following data describes the health status of adolescents in SD as it relates to suicide:

- American Indian children have disproportionately higher hospitalization rates due to attempted suicide-related injuries and the rate differences between American Indian and white children are increasing over time. Injury hospitalization rates among females has increased more rapidly and now surpasses that of males (Bai W, Specker B. Racial differences in hospitalizations due to injuries in South Dakota children and adolescents. J Racial Ethnic Disparities 6:1087, 2019).
- Adolescent suicide rate for age 15 through 19 was 29.2 per 100,000 from 2016-2018.
- Adolescent suicide rate by race and sex for ages 10-19 is shown below. White females have the lowest rate of suicide at 2.5 deaths per 100,000 while American Indian females have the highest rate at 80.2 deaths per 100,000 (South Dakota DOH, 2018).

While there are notable challenges for the adolescent domain there has been some success in addressing the needs of adolescents across the state. Specifically, data gleaned from the Youth Survey provides current baseline data specific to youth. Until now, the most recent source of youth data used to inform the adolescent health domain is from the Youth Risk Behavior Survey in 2015. New partnerships have also been established with organizations serving youth, which helps expand the reach and impact of adolescent health services and program. In addition, improvements have been made in youth immunization rates and teen birth rates. Teen birth rate for ages 15 to 19 has decreased each year from 2013 to 2018 while youth immunization rates have increased for meningococcal conjugate, Tdap, HPV, and seasonal influenza from 2017 to 2018 (DOH Vital Statistics, 2018). Moreover, we have seen an increase in the number of teachers, physicians and nurses trained in a youth suicide prevention course.

Suicide and sexual health have been on-going issues for all ages in South Dakota, but the data highlights enhanced strategies and activities are needed specific to adolescent health, including an emphasis on health equity. The MCH program will enhance services for this population and align resources related to health, wellness, and education on topics such as suicide, mental health, and sexual health. A core protective factor for both sexual health and suicide prevention are healthy relationships in adolescence. Adolescence is a time for young people to explore and develop relationships by connecting with peers, parents, teachers or a romantic partner. Relationships might be unhealthy or healthy and can be emotional, physical or sexual. A need to educate parents and adolescents on what services are available in their local communities and when to utilize services was identified during the needs assessment. Outreach to existing statewide programs and new multi-sector partners will be important to learn from and build on their successes. By fostering these partnerships, the MCH team will begin to provide a platform to address healthy relationships in adolescent and suicide prevention. In addition to learning about current programming, the MCH program needs to identify culturally appropriate strategies and services for American Indian adolescents who are disproportionately affected by these issues.

In an era where social media plays a large role in adolescent lives, enhanced strategies to address health through social media will be key. The youth survey showed that social media was one of the top three sources of health information for 48% of youth. As a result, DOH has been developing the *Cor Health SD* platform. Cor Health SD is a social media platform using Instagram and Facebook to provide educational messaging to young people and their parents. New social media messaging will be developed to enhance content shared through this platform.

The MCH program foresees an opportunity to provide programs that will include a diverse youth voice to not only assure that we are meeting the needs of SD youth but working alongside them to improve health outcomes. Beyond creating Cor Health SD, the MCH program has identified a need to develop a youth council to ensure the youth voice is included in future programming efforts.

Child Health: Strengths identified within the child domain include statewide programs and partnerships; data sharing between programs and partnerships; healthcare and dental services; cultural diversity and tribal sovereignty; resources such as food pantries and homeless shelters; mental health services; and telehealth. The community input survey noted needs included: safe and affordable housing; parenting education and support; affordable health insurance; substance use prevention and treatment; and access to healthy foods. Unmarried individuals and individuals who earned a low income stated that affordable housing was a need for improving child's health, while white respondents and respondents who reported a higher income stated that parenting education and support was the greatest unmet need. However, parenting education and support was a recurring theme with all demographics throughout the needs assessment. Qualitative feedback identified that parents want more education on topics ranging from growth and development of children to nutrition and cooking healthy meals. Lack of knowledge of available resources was commonly stressed as a barrier to achieving wellness. One respondent stated that "resources for single fathers" would be an asset (DOH, 2019).

Specific gaps identified regarding child health include: limited healthcare and dental workforce capacity; access to services (especially in rural areas); lack of policy and regulation for seat belt use; lack of daycares and preschool standards; lack of resources for parents or lack of knowledge how to access these; transportation; parenting skills/education; cultural competency; and mental health and substance abuse resources and services.

The MCH program identified opportunities to expand and enhance current efforts to support child health with an emphasis on health equity. Specifically, the program will review possible enhancements on developmental screening in the areas of promotion and staff education. The OCFS field staff has been instrumental in administering Ages and Stages Questionnaires (ASQ) as well as ASQ Social Emotional (ASQ SE) questionnaires across the state. The MCH program will continue to support Community Health Offices to administer these screenings by providing continuing education opportunities for staff, as well as strengthening the tracking and referral pathways for children with an identified need based on screening results. The SD MCH program has successfully partnered with the Learn the Signs, Act Early campaign to provide training and technical assistance to local Community Health Offices, as well as with the Part C (Birth to Three) program at both state- and local-levels for guidance on referring children with a developmental need.

The MCH program will focus efforts expanding partnerships to identify and address gaps in parenting education and support. Specifically, the program will explore ways to partner with Medicaid to look at ASQ reimbursement rates and well-child data to help identify gaps and collaborate on new activities to address these gaps.

Infant/Perinatal Health: Strengths identified within the infant domain included: programs such as Birth to 3, Cribs for Kids, and WIC; and the partnerships between statewide agencies that serve this population. South Dakota's percent of low birth weight infants and percent of preterm deliveries continues to remain lower than the national average. In 2017, the percent of low birth weight deliveries was 6.9% compared to 8.3% nationally, and the percent of preterm births was 9.3% in South Dakota compared to 9.9% nationally (DOH Vital Statistics). However, priorities that still need to be addressed regarding infant/perinatal health include social needs, access to health care services, mental health and substance abuse, and childcare.

South Dakota's successes in Infant/Perinatal Health have been shown with the percentage of infants placed to sleep

on their backs (87%, ranked 4th out of 31 states) and on a separate approved sleep surface (41.6%, ranked 1st of 31 states) (SD PRAMS, 2018). Some of the gaps that were identified through the needs assessment process included: social needs, such as transportation and affordable housing; policies that hinder data sharing; lack of Medicaid Expansion; a need for more parent education and life skills training; mental health and substance abuse treatment for mothers; access to health care services and care (specifically specialty care); affordable and accessible childcare; and cultural stigma. Another notable gap identified for the infant domain is continuing education and programming around infant sleep. Although SD's infant mortality rate has been steadily declining, the post neonatal and Sudden Unexpected Infant Death (SUID) mortality rates remain high. Data on infant mortality and sleep addresses a gap in care and the need for continued interventions:

- In 2017, the post neonatal mortality rate for infants was 2.2 deaths per 1,000 live births, compared to the national rate of 1.9.
- In 2017, the sleep-related sudden infant death (SUID) rate was 115.4 deaths per 100,000 live births, compared to the national rate of 93.0.
- In 2017, the infant mortality rate was 7.7 per 1,000 births, compared to the national rate of 5.8 (DOH Vital Statistics, 2017).
- Based on data from SD's Infant Death Review (2014-2018), 70% of infant deaths (post hospitalization) occurred in an unsafe sleep environment (DOH, 2018).

The MCH program has collaborated with partners to support implementation of programs specific to infant/perinatal, including the Association of American Retired Persons to educate grandparents on safe sleep guidelines; tribal MCH programs to provide safe sleep environments to native families in need; and East and West River Death Review teams to provide prevention recommendations to keep infants safe. However, information elicited in the Needs Assessment process identified opportunities to build and foster new partnerships to collaborate on programs and strategies that address infant/perinatal health. Specifically, new partnerships established in the process with the SDSU Extension Services, Sanford Health, Department of Social Services' Policy Strategy Department, and the Center for the Prevention of Child Maltreatment will be fostered to support implementation of key strategies. New strategies to address the post neonatal and SUID mortality rates include: safe sleep radio advertising in tribal communities; collaborating with the Safe Passage research team on culturally appropriate safe sleep education tools for Indigenous populations; and forming a statewide prevention focused committee to turn death review data into action. All these strategies will be addressed with an emphasis on health equity.

Children and Youth with Special Health Care Needs (CYSHCN): Strengths in the CYSHCN domain were identified in a 2018 survey that was conducted by the DOH and SDSU to identify needs and gaps in services for families of CYSHCN in SD. Among survey respondents that have access to family-centered care, 64.8% of families of CYSHCN reported feeling like a partner in their child's care, 69.3% reported receiving care that was sensitive to their family's values and customs, 66.9% felt their provider listens carefully to them, 63.7% felt their provider spends enough time with their child, and 65.9% reported receiving specific information they need from their provider for their child. Despite the noted strengths, the survey also revealed the unmet needs faced by CYSHCN and their families. These include difficulty in paying medical bills; distance to medical care; difficulty with scheduling or long waits for appointments; lack of insurance coverage or denial of service; and missing school and work for appointments.

South Dakota's successes in CYSHCN are seen in the 2017-18 NSCH data, which revealed SD is ranked 3rd in the nation for percent of children with special health care needs having a medical home, with a percentage of 53%, compared to the U.S. rate of 43% and significantly greater than SD's 2016-17 rate of 50%. SD is also seeing an increasing trend in the percentage of CYSHCN who report receiving care in a well-functioning system, with a slight but significant increase from 15.6% in 2016-17 to 16.3% in 2017-18 (NSCH).

Some challenges and gaps in the care of CYSHCN were also identified. Data from the 2018 DOH-SDSU survey indicated that among families of CYSHCN, only 52% received effective care coordination services compared to 62% nationally, 28% reported difficulty getting a needed referral for health care services compared to 26% nationally, and only 43% reported receiving care in a medical home, similar to the national rate. Other challenges identified in the survey included costs of care, distance to medical care, difficulty with scheduling or long wait times for appointments, lack of insurance coverage (or denial for service) and missing school or work for appointments.

The top five unmet needs identified in the community input survey among CYSHCN include: access to specialists (46%), lack of transition care (33%), parenting education and support (33%), communication between support services and health care providers (32%), and access to mental health services (24%). Parenting education and support was a greater unmet need according to higher income versus lower income individuals. A higher percent of American Indian respondents noted that lack of transition care was a greater unmet compared to white respondents (48% vs. 30%, respectively). These data highlight gaps in resources, services, and programs to address priority needs of the CYSHCN population (DOH, 2019).

Improving access to care and services for the CYSHCN population has been an ongoing priority of the SD CYSHCN program. Current efforts to address this need have been primarily focused on direct service reimbursement through the Health KiCC Program, which covers the cost of medical care, medications, and medical equipment for eligible families enrolled in the program. However, this approach only addresses a financial need and does not address the other unmet needs relating to accessing care and services, including distance to medical care, difficulty scheduling appointments, and missing school and work for appointments.

In order to more effectively address all the identified needs of this population, the CYSHCN program has been phasing out the Health KiCC Program over the past five years in order to focus time and funding on the development of new programs that will serve SD CYSHCN population statewide. The 2018 DOH-SDSU survey as well as the community input survey highlighted needs that can be addressed through expansion of diverse care coordination programs. Programs that can serve CYSHCN with very complex medical conditions that need better access to specialists that address mental and behavioral health will be the focus. A strategy to explore additional options of care coordination that can address the varied needs identified has been put in place for the next block grant cycle.

Key partnerships have been successful to address the needs of CYSHCN. Special needs car seats are being provided to families in need through a partnership with DSS Child Safety Seat Distribution Program. Through a contract with the Department of Human Services Respite Care Program, respite care is provided to families of CYSHCN across the state. The CYSHCN program also has a contract with Sanford Children's Specialty Clinic which provides operating costs to support clinics that provide a geneticist and genetics counselor to Rapid City eight clinic days per year. Strategies to enhance these partnerships include adding representatives from each partnership to the CYSHCN workgroup to collaborate on new ideas and ways we can enhance these existing partnerships and programs.

The CYSHCN program will also enhance current strategies to support coordination of the newborn screening program. SD's Newborn Screening panel is mandated by state statue and provides direct services that decrease infant morbidity and mortality in the state. MCH funding supports a newborn screening coordinator and contracted partnerships with the State Hygienic Laboratory at the University of Iowa and with Sanford Health. The State Hygienic Laboratory conducts testing on all newborn screening specimens for the state. Sanford Health provides the services of a follow-up nurse for out of normal range results, genetic counseling, and medical consultations

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

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

The DOH is an executive agency within state government. The Division of Family and Community Health (FCH) is the

public health service delivery arm of the DOH and administers MCH services. FCH consists of three offices; Disease Prevention Services, Chronic Disease Prevention and Health Promotion, and the Office of Child and Family Services (OCFS). The MCH program is part of the OCFS.

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

Women/Maternal Domain: One facilitator coordinates the state action plan activities for NPM #1 along with multi-sector workgroup members. Services for women provided with MCH funds include:

- Modified case management of high-risk pregnant women (not covered by Medicaid)
- For Baby's Sake website and Facebook page – information promoting healthy moms and healthy babies
- Developing and implementing maternal mortality prevention plans in Community Health Offices across the state
- Postpartum home or office visits (mothers not covered by Medicaid)
- Prenatal education/counseling for pregnant moms

Perinatal/Infant Domain: One facilitator coordinates the state action plan activities for NPM #5 along with multi-sector workgroup members. Services for infants provided with MCH funds include:

- Developing and implementing infant mortality prevention plans in Community Health Offices
- Newborn home or office visits (mothers/infants not covered by Medicaid)
- Cribs for Kids safe sleep kit distribution/safe sleep education for parents/caregivers
- Statewide Infant Death Review

Child Domain: One facilitator coordinates the state action plan activities related to NPM #6 along with multi-sector workgroup members. Services for children provided with MCH funds include:

- Ages and Stages Developmental Screening and related education, counseling, and anticipatory guidance for infant caregivers. Referrals as needed.
- Ages and Stages Social and Emotional Screening and related education, counseling, anticipatory guidance for infant caregivers. Referrals as needed.

Adolescent Domain: One facilitator coordinates the state action plan activities for NPM #10 and SPM #2 along with multi-sector workgroup members. Services for adolescents provided by MCH funds include:

- Program collaboration on a variety of activities as part of interagency workgroups and community-based programming designed to promote health, prevent disease and reduce morbidity and mortality among children and adolescents including abstinence, school health guidance, drug/alcohol prevention, rape prevention, and intentional/unintentional injury prevention.

CYSHCN Domain: One facilitator, the CYSHCN Director, coordinates the NPM #11 state action plan. As the direct reimbursement program, Health KiCC, is being phased out, the CYSHCN program has concentrated on a new care coordination model with Sanford Children's Hospital in Sioux Falls through a registered nurse care coordinator. This program is in its pilot year and addresses the need to improve access to specialists, decrease travel costs, and provide a medical home for CYSHCN. Additionally, the CYSHCN program partners with DSS to provide special needs car seats, DHS to provide respite care to families, and Sanford Health to provide genetic outreach clinics for the western half of the state. When a family applies for social security disability benefits for a child under age 21, the CYSHCN program provides the family with a list of programs and services they may be eligible for. The CYSHCN Director also sits on the SD Council on Developmental Disabilities whose mission is to assist people with intellectual and developmental disabilities and their families in achieving the quality of life they desire through advocacy and systems change.
The Newborn Screening program identifies babies who may have a metabolic disorder and alerts the baby's

physician to the need for further testing and special care. SD currently screens for 29 disorders either pursuant to statute or administrative rule. This program also works with hospitals to encourage screening of newborns for hearing loss prior to hospital discharge or by one month of age.

Other programs within OCFS serving the MCH population include the South Dakota Family Planning Program (SDFP), the WIC program, and the Bright Start program.

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

The OCFS provides leadership and technical assistance to assure systems are promoting the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. OCFS provides oversite to state-employed nurses, nutrition educators and dietitians for the provision of public health services in the state. This includes 193 field staff, in 7 geographic regions, and 10 Central Office staff. Linda Ahrendt, M.Ed is the OCFS and Title V Administrator and has been with the DOH for 20 years. Jennifer Folliard, MPH RDN is the OCFS Assistant Administrator and MCH Director and has been with the DOH for 5 months. Whitney Brunner, BS serves as the CYSHCN Director and has been with the DOH for 1 year. Other MCH team members and internal partners include:

- Rhonda Buntrock, OCFS Assistant Administrator-WIC program Administrator
- Peggy Seurer, OCFS Assistant Administrator – Public Health/Clinical Services
- Carrie Churchill, Home Visiting Program Manager
- Lauren Pierce, Newborn Screening Coordinator
- Sara Gloe, South Dakota Family Planning (SDFP) Program Nurse Manager
- Emily Johnson, SDFP Nurse Consultant
- Jill Munger, MCH Women/Infant Coordinator/Child Death Review
- Sarah Barclay, MCH Child/Adolescent Coordinator
- Taylor Pfeifle, Women's Health Consultant, Maternal Mortality Review
- Tim Heath, Immunization Program Director
- Mark Gildemaster, Data Statistics Manager
- Katelyn Strasser, MCH Epidemiologist
- EA Martin, SDSU contractor, MCH and home visiting epidemiology
- Derrick Haskins, DOH Communication Director

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

MCH domain leads provide training and ongoing technical assistance to DOH field staff as well as private healthcare providers who deliver MCH services and programs. The MCH team works closely with field staff on data collection for federal and state reports and program evaluation.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Title V programs have built strong partnerships both within and outside the DOH to collaborate on key programs and initiatives that impact priority populations. The physical presence of the OCFS 76 community health offices serves as a major asset throughout the state. These offices carry out coordinated programs, services, and outreach that are funded through a variety of federal, state, and local public health funding streams. These offices serve as the "local"

health department and in many rural and underserved communities this “staying” power builds trust and partnerships.

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

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

Maternal Child Health Bureau Investments: Bright Start Home Visitation Program includes OCFS as both grantee and implementing agency for the MIECHV program. Bright Start uses the Nurse Family Partnership (NFP) model in eight sites covering over 14 counties in SD. The Bright Start Home Visitation Project Director will be actively engaged with the workgroup implementing strategies under NPM 1 and NPM 5. The State Systems Development Initiative (SSDI) grant was awarded to SD in 2020 that coordinates with and directly supports the work of the MCH Title V Block Grant. SD’s SSDI grant supports an epidemiologist focused on maternal and child health, the South Dakota PRAMS, and facilitation of the identified SPM to better coordinate and disseminate data.

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

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serves participants through 76 community health offices across the state. The program works cooperatively with the Cheyenne River, Rosebud Sioux and Standing Rock tribal reservations to ensure every county in South Dakota has access to WIC services. From October 2018 to September 2019, WIC served an average of 14,896 participants per month.
Rape Prevention Education Grant (RPE) aims to decrease sexual violence by funding community-based organizations who use the public health approach to decrease sexual violence risk factors and increase sexual violence protective factors. The Sexual Violence Project Specialist for the South Dakota Network Against Family Violence and Sexual Assault will engage as an active partner on SPM 1 workgroup.

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

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

Title V Sexual Risk Avoidance Education (SRAE) is administered through a partnership with LSS and Boys & Girls Club, SRAE is utilized statewide to educate young people on sexual risk avoidance and teaches youth to voluntarily

refrain from non-marital sexual activity. The target population is 10 – 13-year old who are considered vulnerable youth. The goals of this program are to lower both Chlamydia rates and teen birth rates among young people in SD. The LSS Project Director and Boys and Girls Club Program Coordinator will engage as an active partner on the SPM 1 workgroup.

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

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

Other State Government Agencies: South Dakota Department of Social Services DOH has an MOU with SD Medicaid to provide direct healthcare services and modified case management within the 76 community health offices. The DOH and Medicaid have also established an interagency collaborative over the last year. The focus of this partnership is across all MCH domains. DSS Behavioral Health and the DOH began working together to merge resources on suicide prevention and promoting DSS' youth suicide prevention campaign - BeThe1SD. They will engage as a new active partner on NPM 7.2 workgroup. South Dakota's Office of Emergency Management partners with DOH's Office of Public Health Preparedness and Response (PHPR) and OCFS in providing emergency response efforts across the state. OCFS field staff in community health offices are assigned to a Point of Dispensing (POD) site to dispense emergency pharmaceuticals in the event of a public health emergency.

Other Programs Within the DOH: Infant Death Review (IDR), through a (MOU) between DOH and member agencies, volunteer professionals across the state conduct IDR. Two regional teams, East and West River, are made up of members from law enforcement, DSS Child Protection Services and Behavioral Health, DOH, hospital staff, fire departments, Emergency Medical Services (EMS), Forensic Pathology, Division of Criminal Investigation (DCI), Bureau of Indian Affairs (BIA), IHS, Great Plains Tribal Chairman's Health Board, and the States Attorney's offices. DOH's Office of Data, Statistics and Vital Records provides data for the review process. IDR is funded exclusively by MCH dollars.

Tribes, Tribal Organization and Urban Indian Organization: Maternal and child health services are provided in a variety of ways. A few of those include partnerships with DOH; dedicated staff within a tribe; and through a partnership with the Great Plains Tribal Chairman's Health Board. Tribal MCH Programs are informal, but long-standing, partnership with Rosebud IHS and Tribal MCH and Cheyenne River Sioux Tribal MCH are in place to provide safe sleep environments to American Indian families in need each year. The needs assessment team also noted an emerging partnership with the Sisseton-Wahpeton Oyate MCH staff, who will serve on the workgroup addressing NPM 1.Great Plains Tribal Chairman's Health Board (GPTCHB) offers public health support to s that share borders with North and South Dakota, Nebraska and Iowa. GPTCHB provides MCH services which include direct service, research, epidemiology, and technical assistance. This organization will be part of the workgroup addressing SPM 2.

Public Health and Health Professional Education Programs/Universities: SDSU Population Health Center is a formal, long-standing partner that provides technical assistance to the MCH team to develop, monitor and evaluate the program's overall objectives. They assisted with the development, execution, and evaluation of the Needs Assessment and will continue to provide technical expertise but will also serve on the workgroup that will direct State Performance Measure 2. USD Sanford School of Medicine (SSOM) and the MCH program have fostered a partnership as a formal and emerging partner who now leads the state's Early Hearing Detection and Intervention collaborative. Previously the DOH led this grant. USD also houses the state's medical school and along with SDSU jointly houses the state's only public health program.

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

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

A structured and inclusive priority-setting process was shaped by collaboration with the MCH Impact Team and OCFS partner organizations. The Needs Assessment Project Team analyzed findings from quantitative and qualitative data and developed a priority setting tool to help select preliminary priority needs by domain (women, infant, children, adolescent, and CYSHCN). Based on the data findings, the number of priority needs varied from 10 to 13 for each population domain. Each priority need was scored on a five-point scale. Criteria included significance to public health, ability to impact the issue, and capacity to address the issue.

Each tool was first disseminated to the MCH Impact Team to assist with narrowing down the priority needs prior to engaging partner organizations. Additional priority setting methods were utilized with partner organizations to help further narrow down priorities and ensure a collaborative and inclusive priority-setting process. Partner organizations, the MCH Impact Team, and the OCFS Advisory Committee were engaged in fall partner meetings to support the priority setting process.

Additional in-person/virtual meetings were held by domain (women, infants, children/CYSHCN, and adolescents) with partner organizations, OCFS Advisory Committee members, and members of the MCH Impact Team to identify two key priorities to focus on in the five-year action plans.

Priority needs identified previously were shared with meeting participants to review. The Dot Method was utilized to support priority setting during each domain meeting. Participants voted in two rounds and narrowed priorities down to two for each domain. Priority areas not selected were moved to a parking lot, understanding some of them could still be addressed and/or integrated into strategies within the identified priority areas.

Following the fall partner meetings, the MCH team and other key OCFS program staff met in-person to discuss the priorities identified and narrow down the focus to one priority per domain. This was important to ensure the priorities identified aligned with corresponding NPMs and SPMs. The seven priority needs and their corresponding NPMs and SPMs are listed in the table below.

Priority	MCH Population Domain	NPM or SPM
Mental health/Substance abuse	Women/Maternal Health	NPM 1 Well-Woman Visit
Infant safe sleep	Perinatal/Infant Health	NPM 5 Safe Sleep
Parenting education and support	Child Health	NPM 6 Developmental Screening
Mental health/Suicide prevention	Adolescent Health	NPM 7 Injury Hospitalization
Access to care and services	CYSHCN	NPM 11 Medical Home
Healthy relationships	Adolescent Health	SPM 1
Data sharing and collaboration	Cross-Cutting	SPM 2

Other common needs noted across domains included social determinants of health such as employment, housing, and transportation. These did not rank as high as other priorities in the process because the MCH program has limited resources to address these issues. Specifically, OCFS felt that the MCH program should not be the lead on addressing these needs. The OCFS does recognize their importance in the overall health of individuals and will continue to engage partners who can better address these issues.

III.D. Financial Narrative

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,476,338	$2,415,470	$2,149,068	$2,343,567
State Funds	$1,766,341	$1,695,079	$1,700,080	$1,611,368
Local Funds	$487,134	$117,472	$87,000	$149,570
Other Funds	$22,650	$0	$0	$0
Program Funds	$810,181	$1,378,312	$810,000	$1,224,994
SubTotal	$5,562,644	$5,606,333	$4,746,148	$5,329,499
Other Federal Funds	$20,613,679	$24,799,643	$20,193,754	$22,729,620
Total	$26,176,323	$30,405,976	$24,939,902	$28,059,119

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

	2021	
	Budgeted	Expended
Federal Allocation	$2,194,925	
State Funds	$514,881	
Local Funds	$40,940	
Other Funds	$0	
Program Funds	$1,100,000	
SubTotal	$3,850,746	
Other Federal Funds	$21,996,626	
Total	$25,847,372	

III.D.1. Expenditures

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

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

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

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

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

CYSHCN	$958,672
Pregnant Women/Infants	$1,925,886
Child/Adolescents	$1,716,891
All others	$144,961

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

Direct Services	$71,192
Enabling Services	$1,085,915
Public Health Services and Systems	$917,887

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

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

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

Office of Child and Family Services

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

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

Women and Infants:

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

Child and Adolescent:

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

Children and Youth with Special Health Care Needs

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

- Care coordination and development with an emphasis on evaluation.

Budgeted versus expended:

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

Form 2 C1. Title V Administrative Costs - Administrative Costs are only earned on the first $25,000 of contracts. This makes a difference in the case of SD having large contracts for communications/media and data/evaluation support.

Form 2 4. Local MCH Funds - The local funds are a percentage of local match from the local partners and during this year there was a decrease in local resources utilized and more state funds were expended.

Form 2 6. Program Income - As work shifts to a more sustainable revenue-based model, OCFS is reviewing the operations and implementation of services in local communities. As a part of this review, immunization billing has been implemented that has contributed to the increase in program income. Other income comes from services to schools, developmental screening, case management and baby care services. In addition to the MCH Needs Assessment process the Office is reviewing our business process and long-term planning. A final plan on services to local communities will be finalized in late 2020.

Significance of federal MCH Block Grant funding support:

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

Accountability:

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

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

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

Opportunities:

The infrastructure of an electronic health record platform is now operational and is being utilized by the Family Planning Program. -The platform will be expanded to include a comprehensive billing platform

for services provided in field offices such as immunizations, fluoride varnish application, developmental screening and maternal depression screening in FY21. -The expanded platform will also provide data that will inform strategy development and program improvement measures.

In FY 21 the OCFS will finalize a plan utilizing data and recommendations gathered during a detailed service assessment looking at expenses, revenue and return of investment of services provided in counties across the state. -The final plan will include tools to monitor outcomes and financial measures around service delivery.

Challenges:

The budget amounts reflect anticipated activities of program and field staff, but actual expenditures can vary based on the state economy and public health events (i.e., outbreaks, natural disasters).

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

III.D.2. Budget

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

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

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

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

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

Proposed budget for FY2021 reflects:

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

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

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

III.E. Five-Year State Action Plan

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

State: South Dakota

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

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

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

Programs for Infants & Young Children

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

Programs for Children & Adolescents

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

Programs for Pregnant & Postpartum Women

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

While the OCFS has a huge service delivery and outreach presence, it is just one piece of the efforts to serve the maternal and child population. It is partnerships with other DOH, other state agencies, and local entities that supplement our capacity to meet the needs of our MCH population. This is accomplished through both formal

(MOUs and contracts) and informal (committee/council memberships) collaboration efforts and partnerships. MCH domain leaders, funded through Title V, serve as the backbone for collaboration with interagency partners and with external community-based or research organizations. Each domain leader prioritizes strategies that are informed by data and address health inequities through collective impact.

Within the state government structure, the MCH Impact Team is comprised of 30 DOH staff and epi support who work in programs directly related to maternal and child health issues. Under this umbrella group, workgroups were established for each NPM and SPM, facilitated by the MCH domain leader. The needs assessment process created a foundation to collaborate outside of DOH. To ensure fidelity to the health equity model and life course theory, MCH domain leaders will build multi-sector partnerships and workgroups to address the priority needs of the MCH population. Through this collaboration the State Action Plans have been developed and external partners will continue to be instrumental in implementation.

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

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

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

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

In October 2019, the DOH began to explore accreditation through the Public Health Accreditation Board (PHAB). Domain teams were established to review accreditation requirements and identify gaps and weaknesses. The original timeline has established an early fall 2020 completion date for the required plans (e.g., state health assessment, state health improvement plan, workforce development plan, quality improvement plan and performance management plan). However, due to COVID-19, this effort has been temporarily suspended.

The Division of Family and Community Health is the service delivery arm of the DOH and administers MCH services and programs within the Title V Block Grant. The Office of Child and Family Services (OCFS) provides leadership and technical assistance to assure health, public health, and social systems are promoting the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. MCH domain leads provide training and ongoing technical assistance to DOH field staff as well as private healthcare providers who deliver MCH services and programs. MCH domain leads will build off of the training provided through the National Center for Education in MCH on evidenced-based practice when developing strategies relevant to the delivery of MCH services. The MCH team works closely with field staff on data collection for federal and state reports and program evaluation. These efforts will be enhanced through the development of SPM #2, *Improve data sharing with partners and the public and collaborate with new partners to enhance MCH data* which exposes a need for data interpretation training and peer learning with MCH domain leads and field staff.

MCH workforce development includes internal training/staff development opportunities. Staff orientation modules have been developed to assist new hires in acclimating to the OCFS infrastructure and program delivery. Formal needs assessments are conducted every other year to assist in identifying training needs of all OCFS staff. OCFS will be hosting a virtual conference in 2021 that will bring together staff from across the state to provide professional development and networking opportunities based on the needs identified within the assessment. In addition, as a part of our performance appraisal system there is a section devoted to continuous learning and development. Staff are to identify at least one behavior or performance expectation to develop over the coming year and define how progress will be evaluated. In addition, the state's Bureau of Human Resources provides a wide selection of trainings and team building courses that staff can opt to attend either in person or online throughout the year.

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

To develop the MCH workforce through virtual platforms, the MCH domain leaders, OCFS field staff, family leaders, and external partners will utilize the TRAIN SD learning management system (LMS) acquired by the DOH. TRAIN is

meant to house, provide, and track training with the capability of building training plans to keep track of the users' progress. The platform will be open to the public, however courses can be set up to be viewed by anyone or by a select group such as DOH staff only.

Programming throughout the DOH is supported through an initiative to improve cultural competency. A Cultural Competency Workgroup and the resulting Action Plan was developed to address needs identified by DOH staff. Various trainings were offered to DOH staff, with topics including Mental Health First Aid and Hispanic cultural awareness. Native American Cultural Awareness training was incorporated into new employee orientation. An assessment of cultural representation on DOH advisory boards and coalitions will be completed and will include recommendations for improvement, as well as resources for further education. A Cultural Competency Needs Assessment will be facilitated with DOH staff to inform three-year action planning.

Additional strategies to assist in staff retention and recruitment include:

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

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

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

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

The needs assessment brought to light the need for more engagement with external partners (outside state government), including those impacted by the programs and strategies that each workgroup will develop and implement. To build and continue to develop community-based partners and family leaders, the OCFS has developed a broad strategy for engagement leveraging our 76 community health offices. This strategy will also rely on training for OCFS personnel to develop and sustain partnerships at the local, region and state level. This strategy includes three objectives: 1) develop regional innovation labs for community and family engagement; 2) OCFS leadership will identify and begin to develop partnerships with statewide/national providers, community and family centered groups; and 3) support MCH domain leaders to create workgroups to guide the priorities identified in the needs assessment.

Communication and Outreach

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

Develop Community and Family Leaders

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

Program Development, Improvement and Evaluation

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

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

Training and Professional Development

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

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

Since its inception the State Systems Development Initiative (SSDI) Grant Program has provided a platform and resources for SD to strengthen the development and expansion of data capacity for performance measure reporting in the MCH Block Grant Program.

The SD SSDI Program conducts activities targeted to meet the greatest collective needs based on the MCH Needs Assessment to implement evidence-based approaches. The SSDI/MCH Program conducts ongoing checks throughout the grant cycles to ensure progress is being made and new challenges and gaps are identified and addressed.

The SSDI Principle Investigator (PI) establishes and maintains routine communication with the SSDI project team, MCH Impact Team, and contractors. This is accomplished by: 1) data sharing at monthly MCH Facilitator's meetings and quarterly MCH Impact Meetings; and 2) sharing data and epidemiology updates at monthly Division of Family and Community Health Administrator's meetings by the Office of Health Statistics and the epidemiology staff within the division.

Goals of the SSDI grant are:

Goal 1: Build and expand state MCH data capacity to support the Title V Block Grant program activities and contribute to data-driven decision making in MCH programs; including assessment, planning, implementation, and evaluation.

Data capacity and support has been a key part of preparing for the MCH/MIECHV needs assessment process. An MCH Epidemiologist and contracted consultant with expertise in needs assessment and health equity assisted in planning for the needs assessment and in expanding data sets to provide a clear picture of maternal and child health needs. A steering committee met regularly to provide guidance and support on data collection related to MCH domains and indicators needed for home visiting. Data collection related to needs assessment planning and implementation included domain specific data briefs, adolescent and community-based surveys, and family centered focus groups.

Goal 2: Advance the development and utilization of linked information systems between key MCH datasets in the state.

The MCH program has data sharing agreements with the DOH Office of Vital Records to review deaths in the state. Vital records provides death and birth certificates for child deaths and recently linked maternal death certificates to infant birth and death certificates. This data, along with CDC's Pregnancy Mortality Surveillance System (PMSS) data has given the DOH a starting point for reviewing causes of maternal deaths in the state. The MCH program is also working with health systems across the state on data sharing agreements that will allow medical records to be shared for the purposes of child and maternal death review. DOH is working with the Department of Social Services' (DSS) Medicaid program to link maternal death certificate and birth certificate information to Medicaid claims data. This will give the MCH program a more in-depth understanding of the women impacted by maternal mortality and severe maternal morbidity.

Goal 3: Support program evaluation activities around the NPMs that contribute to building the evidence base for the MCH Block Grant.

The greatest challenge continues to be comprehensive data dissemination, especially in the area of child and adolescent health within the MCH program. SD is in a good position to look at data and gather information around what would motivate parents to utilize a well visit and how to work with providers on evidence-based reminder/recall strategies. Data dissemination around suicide and injury prevention is critical to reducing death rates in children and

adolescents especially as it relates to disparate populations. The SSDI PI continually seeks feedback from the MCH Impact Team regarding new approaches and services and incorporates feedback into ongoing or future activities. Plans for addressing the identified barriers include having a qualified epidemiology staff that will be trained to work with MCH data as a team. This team will work with other state agencies such as DSS, for program data related to substance abuse and suicide. Through a MOU with DSS, epidemiology staff will work together to address data gaps and needs. As a team, data dissemination will be improved and spread across the DOH partner base.

The DOH contracts with South Dakota State University's (SDSU) EA Martin Program to provide detailed reports of all data that supports the MCH Block Grant submission. The data is updated for all NPMs, SPMs, ESMs, and other related objectives that support the annual report and performance reporting annually.

Other data sets that support the work of MCH are also monitored such as Youth Risk Behavior Survey (YRBS), Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Monitoring Survey (PRAMS), Pediatric Nutrition Surveillance Report (PedNSS), and Pregnancy Nutrition Surveillance Report (PNSS). These activities combined ensure the documentation of data and outcomes.

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

The DOH Division of Family and Community Health entered into a 4-year joint powers agreement with the South Dakota Department of Social Services (DSS) Division of Medical Services in 2020.

The purpose of the agreement is to promote high quality health care and services for SD Medicaid program recipients.

The agreement includes:

- Mutual objectives and responsibilities of each party;
- Services offered by each party and in what circumstances;
- Reciprocal referrals;
- Coordinating plans for health services provided or arranged for recipients;
- Payment or reimbursement;
- Provision of data; and
- Designation of a staff person on behalf of each department to act as the liaison.

There is also a memorandum of understanding between the DOH and DSS specific to the use of Medicaid claims data for the following purposes:

- Monitoring progress toward reduction of overuse and misuse of antibiotics;
- Emergency diversion planning and efforts for dental concerns;
- Chronic disease analysis to identify trends and improve quality of care; and
- Other analysis as agreed upon in writing.

Under the Social Security Act, the Commissioner of Social Security must make referrals of applicants to state programs for which the individual may be eligible for assistance/services. In SD, the applicant information is forwarded to the DOH, CYSHCN program. This program facilitates an informational mailing developed in collaboration with the Department of Human Services (DHS) and DSS addressing other state programs that could potentially provide assistance/services to the applicant.

The Medicaid Home and Community-Based Services waiver program is authorized as a part of the Social Security Act. In SD the Family Support 360 Medicaid Waiver is operated by the DHS Division of Developmental Disabilities in conjunction with DSS. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State Plan and other federal, state, and local public programs as well as the supports that families and communities provide.

The OCFS's WIC, MCH, Family Planning, CYSHCN, Newborn Screening, Baby Care, -and Bright Start Home Visiting programs, and the Office of Chronic Disease Prevention and Health Promotion have an intra-agency agreement to allow disclosure of information obtained from applicants and participants. The agreement addresses:

- Resource and referral;
- Sharing of appropriate information to ensure optimal coordination in order to minimize costs and duplication of efforts/services; and
- Sharing of pertinent health and nutrition information as deemed necessary.

In 2012, based on the recommendations of a Medicaid Solutions Workgroup, SD policymakers launched a Medicaid Health Home program to take advantage of provisions made available in the Affordable Care Act and policy guidance from the Centers for Medicare and Medicaid Services. South Dakota Medicaid, in partnership with

the health care providers and health systems in the state, implemented the Health Home program in August of 2013. The program is designed to target high cost/high need recipients in the Medicaid program and provide additional assistance at the clinic level to support increased coordination of the recipient's health care needs. Five years into implementation of the program, the state estimates the Health Home program saved $7.3 million in Medicaid spending in SFY 2018. The majority of the 6100 participants are female and the average age is 44. Additionally, the state found improvements in the overall health of the population.

The CYSHCN Program established a care coordination program within Sanford Children's Hospital in 2019 for children with complex medical conditions that have Medicaid coverage. The overarching goal of the program is to provide a coordinated, family-centered medical home for the enrolled families through case management with a registered nurse care coordinator. The program includes a comprehensive evaluation of the ongoing needs expressed by the enrolled families as well as their affiliated professionals to inform program planning.

South Dakota has one approved 1115 Waiver that impacts MCH populations "South Dakota Former Foster Care Youth" (Project Number: 1 l-W-00319/8) effective May 1, 2018 through April 30, 2023. This allows Medicaid State Plan coverage "to former foster care youth under age 26 with income up to 182 percent of the Federal Poverty Level, who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care.

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

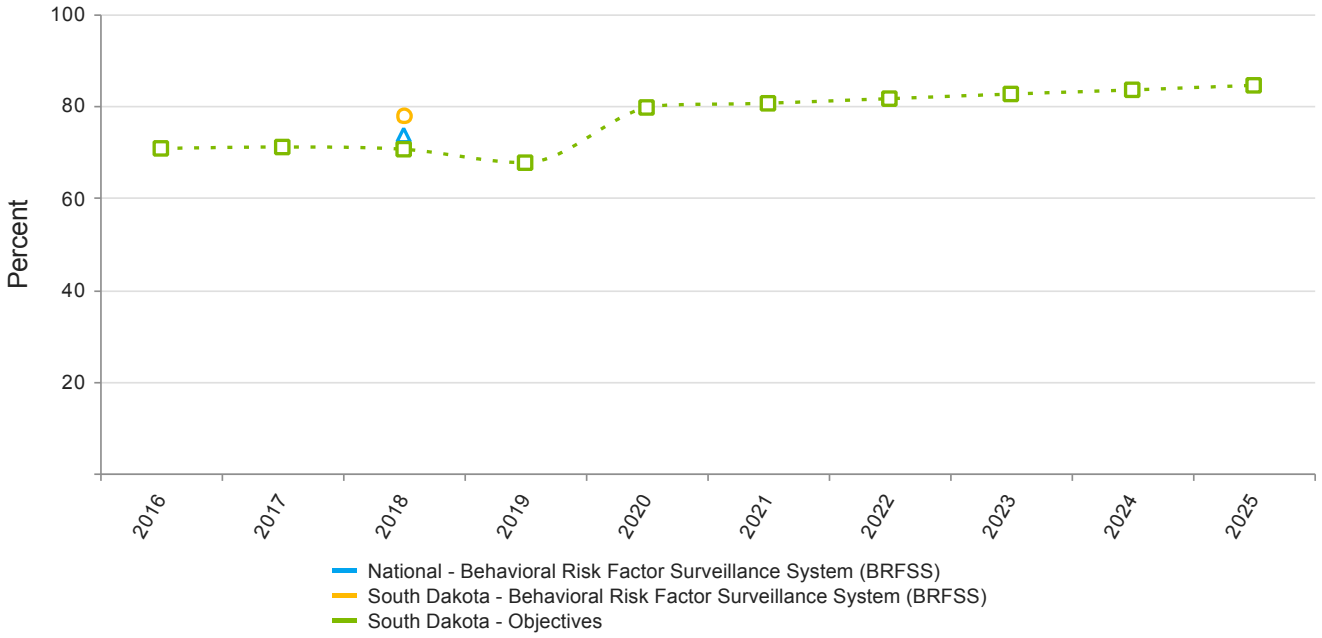
Women/Maternal Health

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-2017	45.2	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	16.4	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	6.6 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	9.4 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	25.6 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	7.8	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	7.7	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	5.5	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.2	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	255.5	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2018	8.2 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2017	1.7	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	20.4	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2018	13.0 %	NPM 1

National Performance Measures

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



Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	70.7	71	70.5	67.6
Annual Indicator	69.8	69.0	65.0	77.6
Numerator	98,560	98,280	92,476	110,174
Denominator	141,180	142,541	142,186	141,888
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	79.6	80.5	81.5	82.5	83.4	84.4

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - % of WIC clients with a positive response to PHQ 2 that received a PHQ 9 screening

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

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

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

Measure Status:	Active

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

Annual Objectives					
	2021	2022	2023	2024	2025
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
Mental Health/Substance Abuse

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

Objectives
Decrease percent of women on SD WIC program who experience postpartum depressive symptoms following a recent live birth from 20.8% (2018) to 18.7% by 2026 (PRAMS)

Strategies
1.1: Implement an evidence-based and equitable behavioral health screening tool and referral protocol within the Office of Child and Family Services (OCFS) to assess for postpartum depression.
1.2: Provide training to OCFS field staff on signs and symptoms of perinatal depression and use of an evidence based, equitable screening tool and referral pathway.
1.3: Create toolkit of resources on Maternal Mental Health/Substance Abuse and Health Equity Strategy
1.4: Develop partnerships with diverse, multisector statekholders to address maternal mental health and substance use through a health equity lens.

ESMs	Status
ESM 1.1 - % of WIC clients with a positive response to PHQ 2 that received a PHQ 9 screening	Active
ESM 1.2 - % of WIC clients whose PHQ 9 score met criteria for a referral and were referred	Active

NOMs

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

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

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

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

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

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

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

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

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

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

NOM 10 - 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

2016-2020: National Performance Measures

Women/Maternal Health - Annual Report

Improving access to insurance coverage, preventing and reducing chronic health conditions, and promoting wellness significantly affect the lives of women of all ages. Because women represent the cornerstone of a family's overall health, ensuring they have access to quality care can lead to improved health for children and families. With all of the responsibilities women have to deal with in their daily lives, well woman care can fall by the wayside. In addition, ensuring that women receive prenatal care - regular check-ups with a provider that include screening for conditions such as gestational diabetes or birth defects, monitoring for potential complications, and education to encourage healthy behaviors such as smoking cessation and healthy eating - can reduce the risk of premature delivery, low birthweight and infant mortality. Infants of women who receive late or no prenatal care are twice as likely to have a low birthweight, compared to infants of women who receive prenatal care during the first trimester.

During our 2015 MCH Needs Assessment two state priority needs were identified that were inclusive of the women/maternal health population:

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

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

- Office of Child and Family Services' (OCFS) offices (77 across the state) promoted Health Coverage Open Enrollment (November 1 – December 15, 2018) by dispersing *Get Covered South Dakota's* pamphlets to client's who did not have health coverage. The pamphlet provides instructions on how to sign up for health insurance on the Marketplace, how to get help in signing up (location of Navigators) and the location of all Community Health Centers in South Dakota (SD) that have a sliding fee scale for services and are a part of the Community Healthcare Association of the Dakotas (CHAD).
- Department of Health (DOH) partnered with Delta Dental in SD to promote oral health for new moms: Delta Dental distributed a SMILE kit to all new moms at birthing hospitals across the state. Resources included: an adult size toothbrush and a handout *Tips on Caring for Your Teeth*. Delta Dental distributed 10,861 Smile Kits in calendar year 2018.
- DOH's Tobacco Disparities Coordinator provided information to OCFS field staff on the newest programs available to clients they serve:
    - QuitLine services were made available to vaping clients
    - Added Postpartum Relapse Prevention Services for pregnant women who are using tobacco/vaping during pregnancy but trying to quit or pregnant women who have quit using tobacco products during pregnancy and don't want to relapse after they deliver.
- DOH's Tobacco Program also promoted cessation services for pregnant and postpartum women by:
    - Placing ads in SD Medical Journal (2,000 subscribers)
    - Posting Facebook ads targeting women of childbearing age
    - Mailing postcards to 4,000 postpartum women on Medicaid
    - Developing and dispensing rack cards for healthcare providers to display in their clinics
- DOH had a display at the SD Annual Perinatal Conference to share information and resources available for doctors, Certified Nurse Practitioners and nurses who work in hospitals and clinics across the state. Resources dispersed included:
    - Posters on the harms of vaping
    - Breastfeeding Friendly Business materials
    - Posters for marketing the Pregnancy Risk Assessment Monitoring Survey (PRAMS)
    - SD QuitLine information for providers
    - Information on Bright Start home visiting and the National Family Partnership model
    - Information on For Baby's Sake website and Text4baby

At the end of this reporting period the MCH Impact Team workgroup members assigned to each National or State

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

https://doh.sd.gov/documents/MCH/NPM1_2021DetailSheet_ESM.pdf

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

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

Data Statement:

The routine checkup item question on BRFSS changed in 2018 and is not comparable to previous surveys. Due to this change, it is not possible to determine whether the target was reached or whether there was significant trend. In 2018, South Dakota was ranked 8th in the nation with 77.6% of women having a preventive visit in the past year compared to a U.S. rate of 73.6%.

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

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

State Objective:

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

State Objective Data Statement:

The routine checkup item question on BRFS changed in 2018 and is not comparable to previous surveys. Due to this change, it is not possible to determine whether the target was reached or whether there was significant trend. In 2018, South Dakota was ranked 14th in the nation with 76.4% of women aged 18 through 24 years of age who had a preventive visit in the past year compared to a U.S. rate of 73.4%.

Strategies:

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

- Partnered with the SD Women, Infants, and Children's (WIC) Program to promote Well Women visits: the state WIC Breastfeeding Coordinator encouraged all WIC staff during a monthly WIC call to educate women on the importance of yearly preventive visits and to utilize the *Well Women Visit* referral in SD WIC-IT when making a referral. Well Women visit referrals increased from 200 in FY18 to 317 in FY19.
- Partnered with the Bureau of Human Resources (BHR) to promote Well Women visits: MCH team/BHR developed a letter to send to all SD state employees ages 18-39 reminding them to see their provider yearly for a preventive visit (evidence-based strategy). The letters went out in February and March of 2019 and included a list of preventive services covered at 100%. In FY19 (07/01/2018-06/30/2019) 30% of women between the ages of 18-24 submitted a claim for a preventive visit (CPT codes 99385 & 99395).
- Collaborated with the DOH Strategic Planning work group in promoting well visits for males, ages 18-34 for

National Men's Health month in June (2019) and females, ages 16-25 for National Women's Health month in May (2019) using social media.

- MCH team continues to partner with the SD Family Planning program to promote Well Women visits: SD Family Planning has 20 locations across the state each offering annual exams to clients on a sliding scale fee.
- The NPM #1(Well Women) Interagency team met in conjunction with the NPM #10 (Adolescent Well Visit) Interagency team in February 2019 to discuss ways to promote yearly well visits for adolescents and young women. Agencies represented besides DOH were BHR, Department of Social Services (DSS) Medicaid, a DSS Medical Consultant, and a Medical Consultant (Pediatrician) from Urban Indian Health and the Avera Medical Systems.
- DOH's Tobacco Program collaborates with Delta Dental to provide QuitLine information to families who have a smoker in the home. Delta Dental's Regional and Mobile clinics place a QuitLine sticker on a child's take-home paperwork when the child reports that someone in their home smokes. In 2018, Delta Dental staff saw 6,715 children for dental care and gave out a total of 564 stickers with QuitLine information.

Challenges:

- The MCH program has limited outside partners in this arena. We need to reach out to other medical groups such as the Community Healthcare Association of the Dakotas to help us promote preventive visits.

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

- BHR has a banner promoting well visits at every state employee health screening throughout the year. One hundred twenty-two screenings were offered in 26 locations. There are 26,822 employees on the SD Health Insurance Plan.
- MCH team worked with the SD WIC program to get a preconception (Well Women) message added to their *Keeping Yourself and Your Family Healthy* WIC pamphlet which is given to all women on the program. SD WIC had an average of 3,943 pregnant or postpartum women enrolled in CY18.
- A Women's Health data brief which included a section on Preconception Care was disseminated to 160 partner/stakeholders as part of the MCH Needs Assessment to encourage promotion of a Well Women visit. Data relevant to Well Women visits (BRFSS) and SD 2016 PRAMS-like data on the percent of mothers participating in health-related actions prior to pregnancy were included.
- A Facebook post titled *11 Life Changing Reasons to Get Well Women Check-ups* ran on For Baby's Sake Facebook page from 5/9/19-6/30/19. The post had a link to For Baby's Sakes' *Scheduling Annual Well Women Check-ups* and ACOG's Well Women Exam infographic. The post had a paid reach of 83,470 people.

Challenges:

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

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

- SD Family Planning developed a Power Point presentation to update OCFS field staff on the services that are offered to clients (including Well Women exams) in their clinics across the state. The Power Point will be shared at the December of 2019 regional staff meetings.
- The SD Tobacco Program updated their Program and Resource Online Facilitator (PROF) content in February of 2019 for OCFS field staff to review. Tobacco PROF includes training modules:

    - The Toll of Tobacco on SD
    - Priority Populations
    - Talking Tobacco Techniques
    - The SD QuitLine - Your Partner in Tobacco Cessation
- A Preconception Health training was presented by Dr. Jessica Rasmussen, Ob/Gyn to 56 OCFS field staff at their All Staff Conference in July of 2019. Dr. Rasmussen's presentation included a section on the risks of smoking and smoking cessation.
- NPM #1 workgroup facilitator is in the process of developing a training module for the All Women Count program so that OCFS field staff are aware of the services this program provides to low income women.

Challenges:

- Meeting the training needs of all staff in a timely manner.
- Determining the most effective way to provide training with limited budget.

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

76% completion of identified strategies.

Women/Maternal Health - Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Women's/Maternal Health Domain for the period October 1, 2020 through September 30, 2021. Priority needs identified through the Needs Assessment process in this domain were: mental health, substance abuse, access to healthcare services, and various social needs such as lack of transportation, lack of desirable employment, poor housing, and lack of education. Women's mental health and substance abuse were common themes across the state. Selected priorities and the corresponding National Performance Measure are as follows:

Priority Need: Mental Health/Substance Abuse

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

ESM 1.1: Percentage of WIC clients with a positive response to PHQ 2 that received a PHQ 9 screening.

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

2020-2021 Objectives and Strategies

Decrease percent of women on SD WIC program who experience postpartum depressive symptoms following a recent live birth from 20.8% (2018) to 18.7% by 2026 (PRAMS).

Proposed Strategies:

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

- Pilot the PHQ 2 and PHQ 9 screening tools in one large and one small OCFS field office.
- Adopt an equitable and accessible referral pathway for clients with behavioral health concerns or substance abuse issues within the OCFS.

1.2: Provide training to OCFS field staff on signs and symptoms of perinatal depression and use of an evidence based, equitable screening tool and referral pathway.

- Provide training on recognizing the symptoms of Perinatal Depression
- Provide training on use of the PHQ 2 and PHQ 9 screening tool.
- Provide training on how and when to refer clients with a positive screening result.

1.3: Create toolkit of resources on Maternal Mental Health/Substance Use and Health Equity.

- Adapt maternal mental health resources available from evidence-based sources online and in print using a health equity lens.
- Collaborate with diverse, multisector partners to identify equitable and accessible treatment options for women across the state regarding Mental Health/Substance Use.

1.4: Develop partnerships with diverse, multisector stakeholders to address maternal mental health and substance use through a health equity lens.

- Invite diverse, multisector partners and community members to participate on this work group to better understand the strengths and gaps within the systems of care surrounding mental health and substance abuse for women of childbearing age.

New Approach to Evidence- Based Strategy Measures

The detail sheets originally developed for each National and State Performance Measure in FFY17 continued to be

updated and utilized through FFY20 to capture program effectiveness. Beginning in FFY21, we will be taking a different approach to ESMs and measuring the effectiveness of our efforts based on technical assistance and training received from the MCHB Evidence Center.

New Efforts

- Screening for Maternal Depression: the MCH team will introduce depression screening for all women admitted to the SD WIC program during pregnancy and postpartum to improve health outcomes for moms and families.

- Staff Education: the MCH team will increase OCFS staff's knowledge of behavioral health and substance abuse issues and treatments to provide appropriate services and referrals.

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

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

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

There are 76 OCFS Community Health Offices located in 61 of South Dakota's 66 counties that provide public health services to this MCH population.

- Continue to support the OCFS Baby Care program to provide prenatal and postpartum education, assist low income pregnant women to obtain early and on-going prenatal care, and link women to resources that can help support healthy pregnancies.
- Form a state-wide multidisciplinary Maternal Mortality Review Committee to identify risk factors contributing to maternal morbidity and mortality and work to improve health outcomes for women and their families.

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

- Continue to partner with the EA Martin Program at SDSU to conduct the CDC's PRAMS and to utilize the findings for planning, assessing, and evaluating our programs with the goal of improving health outcomes for women and infants.

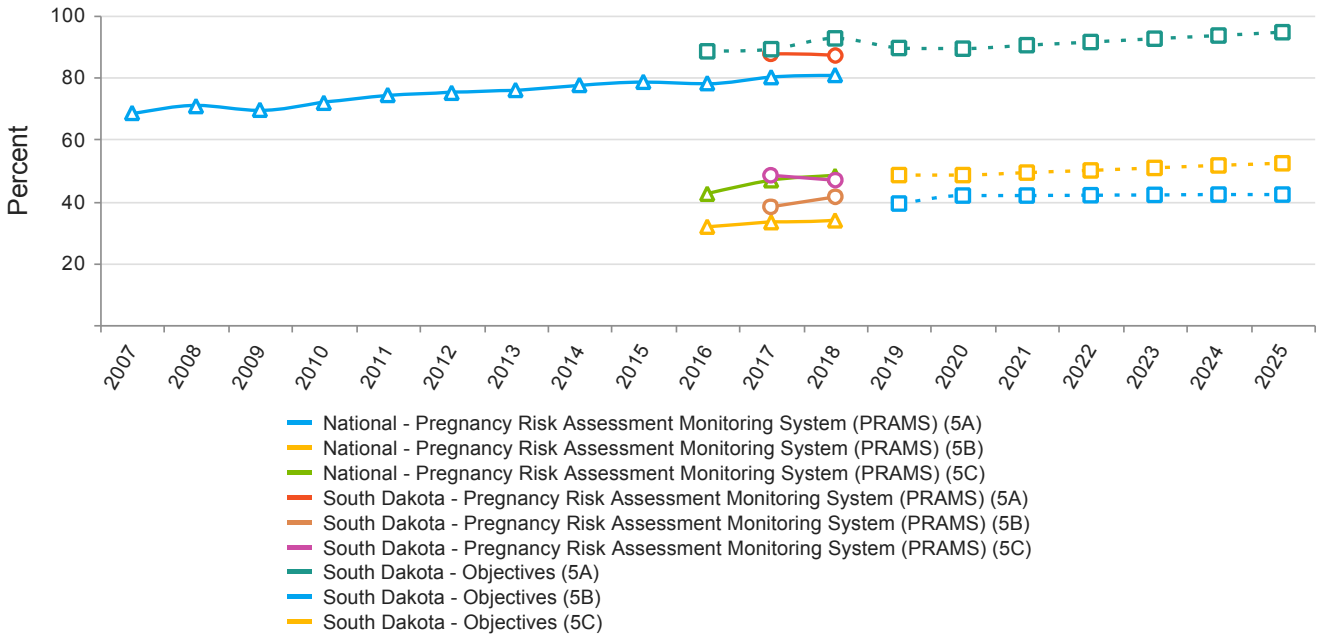
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	7.7	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.2	NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	115.4	NPM 5

National Performance Measures

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



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

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

State Provided Data				
	2016	2017	2018	2019
Annual Objective	88.2	88.9	92.4	89.3
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						
	2020	2021	2022	2023	2024	2025
Annual Objective	89.1	90.2	91.2	92.3	93.3	94.4

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

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

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			39.2
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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	41.8	41.8	41.9	42.0	42.1	42.1

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

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

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	48.4	49.2	49.9	50.7	51.5	52.2

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

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

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

Measure Status:	Active

Baseline data was not available/provided.

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

State Action Plan Table

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

Priority Need
Safe Sleep

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

Objectives
Reduce the number of SUID deaths related to unsafe sleep environment from 115/100,000 in 2017 to 84/100,000 by 2026 (NVSS)
Increase the percent of infants placed to sleep without soft objects or loose bedding from 47% in 2018 to 53% in 2026 (PRAMS)

Strategies
5.1: Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media, print, and radio.
5.2: Collaborate with diverse community partners to provide Child Death Review and disseminate findings to all South Dakotans.
5.3: Collaborate with diverse, multi-sector organizations/agencies to promote safe sleep.

ESMs	Status
ESM 5.1 - % of Child Death Review (CDR) team members who scored above 80% on a post-test	Active
ESM 5.2 - % of in-home daycares who responded to survey and indicate that they follow safe sleep guidelines	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

2016-2020: National Performance Measures

Perinatal/Infant Health - Annual Report

Promoting safe sleep practices is a public health priority. Much research has been conducted about safe sleep practices that address Sudden Infant Death Syndrome (SIDS) and suffocation risk reduction. Simple caregiving techniques can play a critical role in keeping infants safe during sleep. Parents, family members, teachers and all adults who care for an infant for one nap or many should follow safe sleep practices every nap time and every sleep time. Sleep-related preferences may be sensitive to a family's culture or personal preferences and beliefs.

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

- Reduce infant mortality

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

- Spearfish Police Department held a Sudden Unexpected Infant Death Investigation (SUIDI) training instructed by Brett Garland, SD Division of Criminal Investigation and member of the East River Infant Death Review (IDR) team, on September 4, 2019. There were 43 law enforcement officers from the western part of the state in attendance.
- Jill Munger, the facilitator for NPM #5 workgroup met with Carol Cressman, director of Sanford Children's Hospital (Sioux Falls) Pediatric and Pediatric Intensive Care units to share data from IDR. Carol dispersed the South Dakota IDR infographic to Neonatologists, Pediatricians, and nursing staff within the Sanford Medical System.
- MCH team e-mailed Neighborhood Safety Network's notice regarding the inclined sleeper recalls to all OCFS field offices (77 total). Staff were instructed to discuss with parents of infants and to post the recall where clients could see it when they came into the office.
- NPM #5 workgroup facilitator attended the Annual Perinatal Conference in Rapid City, September 2019:
    - Networked with nurse managers and nursing staff from Labor & Delivery, Postpartum and NICUs from Avera McKennan, Sanford Sioux Falls, and Regional Health (three largest hospitals in the state) All three hospitals have agreed to start utilizing DOH's *Safe Sleep Practices Can Save Lives* handout in their discharge packets. The handout includes state specific data from the 2014-2018 IDR.
    - Promoted PRAMS to all attendees and encouraged nursing staff to inform their new moms that they may be receiving the survey a few months after discharge.
    - Promoted DOH's Breastfeeding Friendly Business Initiative to support communities working together to increase breastfeeding rates as a strategy to decrease infant mortality.
- An ad was placed in SD Medicine Journal in December 2018 and January 2019 *Breastfeeding – More Than Just a Lifestyle Choice* to inform providers of the reasons many moms stop breastfeeding. Data presented in the ad was from the 2016 PRAMS-like survey. SD Medicine has approximately 2,000 subscribers.
- South Dakota State University's E. A. Martin Program released the 2017 PRAMS data related to NPM #5 in May 2019. The NPM #5 workgroup reviewed the data at their August meeting and discussed ways to continue to promote the safe sleep message to caregivers.

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

https://doh.sd.gov/documents/MCH/NPM5_2021DetailSheet_ESM.pdf

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

National Performance Measure 5:

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

Data Statement:

1. South Dakota did not reach the 2019 target of 89.3% and there was no significant change in the percentage of infants placed to sleep on their backs from 87.6% in 2017 to 87.0% in 2018. In 2018, South Dakota was ranked 4th out of 30 states for the highest percent of infants being placed on their back to sleep and the 2018 U.S. rate was 80.6%.
2. South Dakota exceeded the 2019 target of 39.2% with 41.6% of infants being placed to sleep on a separate approved sleep surface in 2018. This was a significant increase from 38.4% in 2017. South Dakota was ranked 1st out of 30 states and the 2018 U.S. rate was 33.8%.

3. South Dakota did not meet the 2019 target of 48.4% with 46.9% of infants being placed to sleep without soft objects or loose bedding in 2018. There was no significant change from the 2017 rate of 48.2%. In 2018, South Dakota was ranked 18th out of 30 states that had an overall rate of 48.1%.

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

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

State Objective:

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

State Objective Data Statement:

South Dakota reached the 2019 target of 85.1% with 85.8% of infants from other races (not non-Hispanic white or American Indian) being placed to sleep on their backs in 2018. This was a significant increase from 82.2% in 2017.

Strategies:

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

- The Family Resource Network Early Childhood Education (ECE) Center at South Dakota State University (SDSU) offered a community-based safe sleep policy class for childcare providers in the Watertown area in April 2019. This ECE also offers free on-line trainings to providers including a module *Safe Sleep Practices – Reducing the Risk of SIDS.*
- Bonny Specker, Epidemiologist with SDSU E. A. Martin Program's article *Safe Sleep Behaviors Among South Dakota Mothers and the Role of the Healthcare Provider* was accepted for publication in SD Medicine. The article is based on 2016 PRAMS data and determined that the role of the healthcare provider in talking to mothers was associated with greater compliance with some, but not all safe sleep recommendations.
- A Bright Start home visiting Facebook page is being developed by the OCFS' marketing agency. Once it is up and running safe sleep messages can be posted for home visiting clients across the state.
- Jill Munger, DOH's IDR Coordinator, presented 2013-2018 data from the Child Death Review Case Reporting System at the All Staff Conference in July (2019) to help turn data into action. The All Staff Conference includes all OCFS field and office staff from across the state, approximately 225 in number.
- The MCH team continued to support a University of South Dakota (USD) medical student's (3rd year) Pathways Scholarship project on SIDS prevention. The student has surveyed approximately 300 parents of infants at Black Hills Pediatrics to determine what information they received regarding safe sleep practices.

His next step is to survey parents at Community Health Center of the Black Hills.

- The MCH program continues to partner with USD Nursing Program in Sioux Falls to provide safe sleep classes at the Teddy Bear Den for low income families in the Sioux Falls area.

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

- The National Institute of Health's *Dads Can Help Baby Sleep Safe* posters were distributed to all field offices (77) across the state for display.
- MCH team members presented information about IDR and safe sleep at the Thiwahe Zani Okichiya Ichahwichayapi (Raising Healthy Families Together) community advisory board meeting in Pine Ridge (October 2018). Board members include representatives from IHS medical and dental services, Pine Ridge schools, SD Extension, Catholic Social Services, Pine Ridge WIC program, CASA, Delta Dental, Oglala Lakota Head Start/Early Head Start, SD School for the Deaf, IHS Midwife Clinic, Tribal Liaison for IHS, Bureau of Indian Affairs, DSS, Birth to Three, Bright Start Home Visiting, Victim Services, Sacred Shawl Society, Circle of Smiles, FACE (parenting program), and CHOICES (pregnancy prevention program for women who are in substance use treatment).
- Partnered with AARP in SD to target safe sleep messages to grandparents on their Facebook page. FB posts ran in January 2019 and reached 700 members.
- In November 2018 the MCH team created a client centered handout using 2013-2017 data from SD IDR. Copies of this *Safe Sleep Practices Can Save Lives* handout were dispersed at the Raising Healthy Families Together Community advisory board meeting in January 2019 and to members of the West River Infant Death Review Team in March 2019. The Neonatal CNP who coordinates the team arranged for the handout to be included in the discharge packets of new parents at Rapid City Regional Hospital.
- In July of 2019 the *Safe Sleep Practices Can Save Lives* handout was updated to include 2018 data. The updated version was dispersed to OCFS field staff (100+); Bright Start home visiting staff; East and West River death review team members; Pine Ridge IHS; Avera McKennan Hospital, Sanford Hospital - Sioux Falls, and Regional Hospital to include in their discharge packets to new parents.

- A new safe sleep ABCs ad (babies should sleep Alone, on their Backs, in a safe Crib) was created and ran in Black Hills Parent magazine's summer 2019 issue. Black Hills Parent is a full-size quarterly magazine with a circulation of 10,000 copies each issue (Over 3,000 copies of each issue are direct mailed to local area families with the remaining 7,000 copies distributed to schools, libraries, daycares, restaurants, hospitals, medical and dental offices, gyms, retailers, and coffee shops in the Black Hills region of SD).
- Distributed approximately 20 laminated NITHA KOZA PI KIN IYOTANWICAKILAPI HENA WAKAN PI (To Love

Our Grandchildren is Sacred) safe sleep posters to OB clinics, hospital postpartum units, and NICUs at the Annual Perinatal Conference in Rapid City September 2019.

- Safe Sleep posts on For Baby's Sake Facebook page:

for baby's sake
Healthier moms + Healthier babies

October 17, 2019

For Baby's Sake • Social Media Metrics

National Performance Measure #5
October 2018 – September 2019

Post Image	Title	Type (paid/organic)	Cumulative Reach	Average Frequency
	SIDS prevention starts with safe sleep	paid	51,770	3.76
	CPSC recall of reclined sleeper products	paid	10,404	8.15
	11 Safe Sleep Guidelines	paid	47,762	3.69
	Happy Grandparents Day	organic	700	n/a
	What Safe Sleep Looks Like (animation)	paid	106,807	4.64
	Room sharing is **safe** but bed sharing is **NOT**	paid	88,211	8.01
	Happy Pappy Father's Day safe sleep	organic	500	n/a
	Is My Crib Safe (Url Share)	paid	71,006	5.86
Cumulative Totals All Posts			**167,420**	**12.39**

Challenges:

- Lack of funding to create or use messaging for radio or television like we have done in the past.

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

- A new East River Infant Death Review team was formed in November of 2018 after the dissolution of the Regional Infant Child Mortality Review Committee. (RICMRC 1997-2018) The new team is coordinated and chaired by the SD DOH and operates with MCH funding. The first meeting was held in December of 2018. In CY 2018, the East River team met three times and reviewed 23 post-hospitalization infant deaths.
- The West River Infant/Child Death Review team met twice in CY 2018 and reviewed a total of six post-hospitalization infant deaths. The West River team is coordinated by a CNP from Regional Health Systems in Rapid City who has a contract with DOH to run the West River review. (MCH monies).
- A Preventive Death Review Committee was established by the DOH in 2019 to 1) enhance the work around infant mortality 2) review infant and child death review processes 3) discuss interest in Maternal Morality review and 4) develop a process for preventive death review that is effective and easy to use for partners and providers.
- An ad hoc Infant/Child Death Review Committee was formed in August of 2019 under the umbrella of the Preventive Death Review Committee to discuss adding statewide child death review. At present, Pennington County is the only county in the state reviewing child deaths.

Challenges:

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

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

- MCH team is in the process of developing a safe sleep process orientation for clerical in OCFS field offices. Target completion date: December 31, 2019.

Challenges:

- There is a safe sleep process orientation already in place for nurses and nutrition staff who work in OCFS field offices. Seasoned clerical have already been assisting with this process. It has been difficult to designate time developing this orientation guide with so many other safe sleep efforts taking priority.

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

- In CY 2019 the DOH partnered with the National Cribs for Kids program to distribute 1146 Pack 'n Plays to low income families in SD. SD partners and the number of Pack 'n Plays they distributed:
    - OCFS field offices: 1,023
    - Rosebud IHS and Tribal MCH: 20
    - Cheyenne River Sioux Tribal MCH: 80
    - Teddy Bear Den (Sioux Falls): 23

Challenges:

- The price of Pack 'n Plays from Cribs for Kids has gone up due to the tariffs placed on goods from China. This has decreased the number of units we can purchase for SD.

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

80% completion of identified strategies.

Perinatal/Infant Health - Application Year

In this section, South Dakota Title V Program reports on planned activities in the Perinatal/Infant Health Domain for the period October 1, 2020 through September 30, 2021. The need for continuing education for staff and strengthened programming on safe infant sleep was identified during the Needs Assessment process. Although South Dakota's infant mortality rate has been steadily declining, the post neonatal and Sudden Unexpected Infant Death (SUID) rates remain high. The selected priority and corresponding National Performance Measure are as follows:

Priority Need: Safe Sleep

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

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

ESM 5.2: Percentage of in-home daycares who responded to survey and indicate that they follow safe sleep guidelines.

2020-2021 Objectives and Strategies

Reduce the number of SUID deaths related to unsafe sleep environment from 115/100,000 in 2017 to 84/100,000 by 2026 (NVSS)

Increase the percent of infants placed to sleep without soft objects or loose bedding from 47% in 2018 to 53% in 2026 (PRAMS)

Proposed Strategies:

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

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

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

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

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

- Partner with public schools' Family and Consumer Science Class life skills training curriculum to add a safe sleep module (Dept. of Education)

- Partner with DSS/Child Care Services Early Childhood Education Centers to provide safe sleep training for non-licensed daycares
- Partner with the Sioux Falls Public Health Department and Family Childcare Professionals of SD to provide safe sleep materials to in-home daycares.

New Approach to Evidence- Based Strategy Measures

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

New Efforts

- Safe Sleep Messaging: Expand messaging to at risk populations across the state (Tribal radio).
- Improve and Expand Death Review Process: Institute a consistent death review process for review teams and expand death review to include child deaths up to age 13.
- Statewide Injury Prevention: Form a committee of diverse, multisector advocates of child safety and infant safe sleep to initiate prevention strategies across the state.
- Statewide Collaboration: Partner with other state/local agencies and community members who are passionate about this priority and can affect change.

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

- Continue to support newborn metabolic and hearing screenings to identify abnormalities and provide early intervention.
- Continue to partner with WIC and Bright Start Home Visiting Program to provide safe sleep education and distribute Pack ‘n Plays to low income families with no safe sleep environment for their infant.
- Continue to support immunizations and flu shots for infants from low-income families through OCFS field offices.
- Continue to offer infant growth and development screening in OCFS field offices for early recognition of delays and appropriate referrals to early intervention services.
- Continue to provide breastfeeding education and support in all OCFS field offices as a strategy to decrease infant mortality (decrease SIDS deaths).

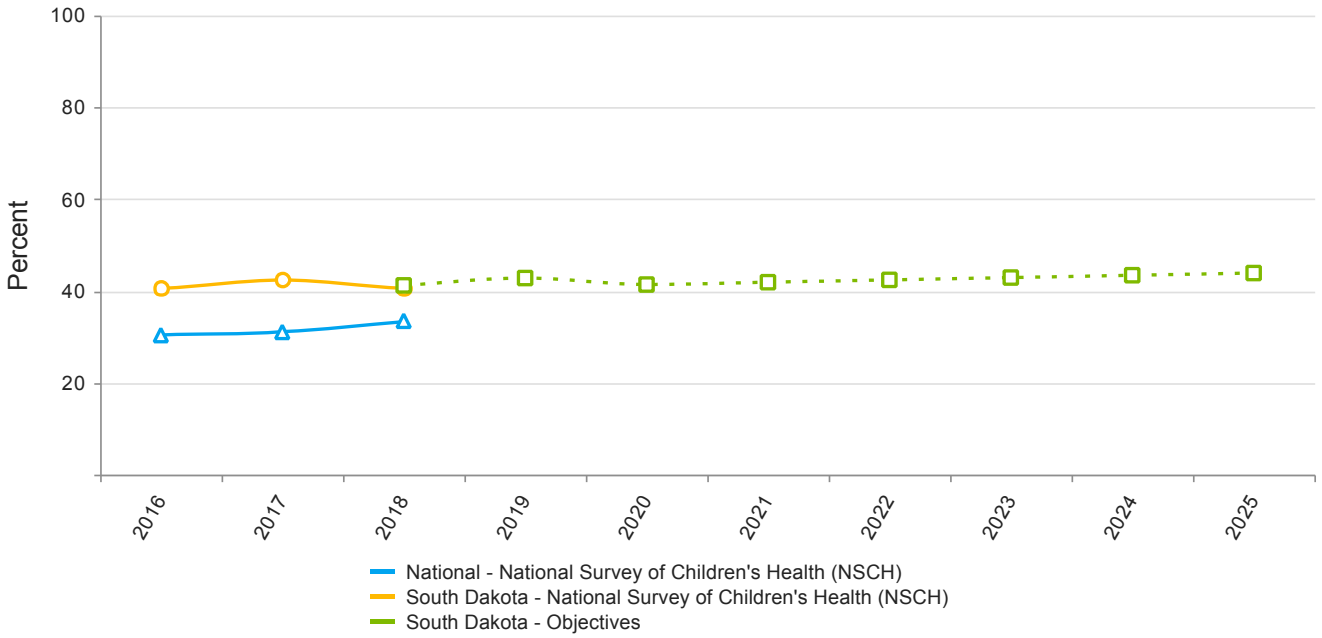
Child Health

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-2017_2018	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**	**2019**
Annual Objective			41.2	42.8
Annual Indicator		40.4	42.4	40.4
Numerator		12,135	10,542	8,655
Denominator		30,030	24,884	21,429
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	41.4	41.9	42.4	42.9	43.4	43.9

Evidence-Based or –Informed Strategy Measures

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

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

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

State Action Plan Table

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

Priority Need

Parenting Education and Support

NPM

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

Objectives

Increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year from 34.3% (2016-17) to 37.7% by 2026 (NSCH)

Strategies

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

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

6.3: Identify and address gaps in parenting education through health equity lens and provide parenting support to South Dakota parents, including vulnerable populations.

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

NOMs

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

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

2016-2020: National Performance Measures

2016-2020: State Performance Measures

2016-2020: SPM 2 - Percentage of children, ages 2-5, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		29.4	32.1	32
Annual Indicator	36.1	33.1	33.1	33.9
Numerator	1,868	2,415	2,171	3,236
Denominator	5,179	7,295	6,562	9,545
Data Source	FAD NOM 20 WIC data	PedNss	PedNSS	PedNSS
Data Source Year	2014	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Eating nutritious foods, exercising, maintaining a healthy weight and reducing risky behaviors can help prevent many chronic diseases. Efforts should be implemented to engage caregivers and parents in efforts to combat childhood obesity. Parents and caregivers usually determine the types of food available, provide recreational opportunities and promote daily physical activity. Parents also serve as role models for their children, and their health is closely tied to that of their children.

Proper nutrition, exercise, and rest are very important for children's health and development. However, a child's growth is more than just physical. Children grow, develop, and learn throughout their lives, starting at birth. Children reach milestones in playing, learning, speaking, behaving, and moving (crawling, walking, etc.). When a developmental delay is not recognized early, children must wait to get the help they need. This can make it hard for them to learn when they start school. Developmental screenings provide a quick and simple way to monitor a child's healthy development. The earlier a developmental delay or disorder is detected, the better the prognosis for the child.

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

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

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

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

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

https://doh.sd.gov/documents/MCH/NPM6_2021DetailSheet_ESM.pdf

https://doh.sd.gov/documents/MCH/SPM2_2021DetailSheet_ESM.pdf

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

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

Data Statement:

South Dakota did not reach the 2019 target of 42.8%, with 40.4% of children ages 9-35 months receiving a developmental screening using a parent-completed screening tool in 2017-18. This represents a significant decrease from 42.4% in 2016-17. In 2017-18, South Dakota was ranked 13th in the nation in percent of children receiving a developmental screening tool with a national rate of 33.5%.

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

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

State Objective:

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

State Objective Data Statement:

The 2017-18 South Dakota rate of 33.2% did not meet the 2019 target of 35.1%. This rate among children from non-metropolitan areas is lower than the overall South Dakota rate of 40.4% and there has been no significant change since 2016-17 when the rate was 34.3%.

Strategies:

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

- Incorporated training and reminders for Office of Child and Family Services (OCFS) staff to connect families to the CDC Milestone Tracker app. This included disseminating CDC Milestone Tracker app posters to every OCFS office (77 offices across the state) for display.
- Placed a provider-focused ad promoting developmental screening in the SD Medicine magazine in July 2019.
- Updated the Department of Health website with message on importance of screening and links to resources https://doh.sd.gov/family/childhood/child-development.aspx
- Released a Child Health data brief to the statewide Needs Assessment partners providing information on developmental screening rates in the state.

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

- South Dakota’s LtSAE program provided a breakout session during the 2019 OFCS all-staff conference. Sixty-five (65) staff attended.

Challenge:

- Getting the message to all OCFS field staff at the same time. Not all of the staff were able to attend the conference breakout session.

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

- Provided training on administering ASQ and ASQ SE screenings to all new staff as part of their orientation. Encouraged staff to use the Brookes Publishing ASQ/ASQ-SE newsletters for continuing education.
- Collaborated with Bright Start Home Visiting to reduce duplication of or gaps in developmental screenings and referrals for evaluation.
- Developed and disseminated a trifold developmental screening tracking card that can be ordered through the DOH central ordering system. Cards are similar to immunization tracking cards and are given to parents for their records.
- During this reporting period OCFS staff facilitated the completion of 3,388 ASQs; 3,137 ASQ SEs; and completed interventions with 548 infants and children who needed further evaluation for potential developmental delays.
- Between October 2018 and September 2019, 90% of children enrolled in DOH's MIECHV program had a completed ASQ-3 at 18 months.

ESMs

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

89% completion of identified strategies.

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

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

Data Statement:

South Dakota did not reach the 2019 target of 32.0% with 33.8% of children ages 2 to 5 years receiving WIC services with a BMI at or above the 85th percentile of children. There has been no significant trend between 2016 and 2019 and the rate in 2017 was 33.1%.

State *Objective1:*

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

State Objective 1 Data Statement:

School height/weight data for 2019 are not available. In 2018, the percentage of students 5-6 years of age with a BMI at or above the 85th percentile was 27.6% and this has not changed between 2015 and 2018. The 2017 rate was 26.7%.

State Objective 2:

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

State Objective 2 Data Statement:

South Dakota did not reach the 2019 target of 41.0% and there has been a significant increasing trend between 2016 and 2019 in the percent of American Indian children 2 through 4 years of age receiving WIC with a BMI at or above 85th percentile. The 2019 rate of 44.2% is greater than the statewide rate for all races of 33.8%. The rate in 2017 was 42.5%.

Strategies:

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

- WIC and Head Start have established an MOU to collaborate to reduce barriers for participants in both programs – such as providing services in a shared location, utilizing a common Referral/Release of Information form, and sharing of assessment data. Directors from both programs met in September 2019 to discuss the use of a shared referral/release form to streamline this process. Head Start invited WIC staff to attend their meetings in November 2019 and January 2020 to continue developing this collaboration. WIC plans to work with their MIS company to develop a report to make sharing assessment data easier for staff as well.
- The SD WIC program received the FY2017 Special Projects Grant to implement cooking classes for WIC participants in collaboration with SNAP education staff in the Mitchell area. The cooking class was provided August 2018 through August 2019.
- The SD DOH, Department of Game, Fish, and Parks, and South Dakota State University (SDSU) Extension continued the Park Rx program across the state. Currently 141 Healthcare Providers and every OCFS Community Health Office (total of 77) are participating in the Park RX program. A complete survey assessment or previous Park Prescription participants can be found here: https://healthysd.gov/park-rx-prescribe-a-day-in-the-park/
- DOH's Healthy SD Munch Code program developed a Vending and Snack Bar Munch Code toolkit and vending calculator. The Munch Code is a color coded labeling program designed to make it easier for people of all ages to choose healthier snacks on-the-go. GREEN foods and beverages are the healthiest options. You can eat a bunch! YELLOW foods and beverages have added sugar, fat, and calories. Be cautious and have just a little! RED foods and beverages are the highest in sugar, fat, and calories and the least healthy. Eat these occasionally but remember – not so much! There are 2 types of snacking environments where the Munch Code color system can be used:
    - Concession Stands – The Munch Code Healthy Concessions Toolkit provides a number of resources including a model policy for schools and community organizations. Toolkits were sent to eight organizations in 2018.

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

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

- SDSU Extension (which provides nutrition education to 7 Native American communities in SD) and the SD WIC Program have begun discussions on possible areas of collaboration in serving these communities.
- SDSU Extension Launched Double Up Dakota Bucks to help South Dakotans access more fresh fruits and vegetables on the Yankton Sioux Reservation at the Lake Andes farmers market. Double Up Dakota Bucks matches the value of SNAP dollars spent on fruits and vegetables. For every SNAP dollar spent at the Lake Andes Farmers Market the participant receives a dollar incentive to purchase more fruits and vegetables, up to $10 each visit. In addition to increasing family access to more fruits and vegetables, Double Up Dakota Bucks results in other benefits including:
    - Integration of federal nutrition and education programs

- Support for long-term dietary improvements
- Increases in farmer sales and profits
- Stimulates local economies
- Demonstrates how public nutrition assistance programs can address hunger, health and local food systems
- Links rural and urban communities in resilient economic growth

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

- WIC offices continued to utilize the Harvest of the Month curriculum to provide creative ways to increase vegetable and fruit consumption of all ages. Harvest of the Month is a downloadable educational program designed to make learning about fruit and veggies easy, tasty, and fun! This versatile set of materials can be used by parents, teachers, or educators to help kids get excited about eating more fruits and vegetables. More information can be found at: https://healthysd.gov/category/harvest+schools/
- DOH continues to provide monthly posts on https://healthysd.gov of educational articles on the Fruit and Vegetables of the Month that also list the indigenous names of the featured fruit/veggies.
- A program brochure which explains the WIC program, program eligibility, program benefits, and what to expect at your WIC appointment is in the process of being made available via a mobile application. WIC is working with a local marketing company to develop a resource tab on sdwic.org website that allows for PDF downloads.
- WIC has begun utilizing tele nutrition for follow up nutrition counseling appointments in 7 counties. The tele nutrition committee recently met and is considering expansion to other counties/offices and other types of WIC appointments. There has been discussion in regard to developing lesson plans specific for use with tele nutrition.
- The DOH and SDSU Extension led the Breastfeeding- Friendly Business Initiative to encourage worksites across the state to take an online pledge to support breastfeeding customers and employees. As of 09/30/2019 655 businesses had taken the Breastfeeding-Friendly Business Pledge and hung a 4" x 4" window cling stating *Breastfeeding Welcome Here!* Each worksite also received a kit that includes a variety of resources including the DOH Breastfeeding Support Model Policy. All materials are also available in digital format on the pledge site including the newest tool – the SD Employer Breastfeeding Accommodation Form. This form is communication tool between employer and employee to proactively work together to plan for breastfeeding accommodation needs upon return form maternity leave. https://healthysd.gov/category/breastfeeding+workplace/

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

- Through a partnership with Sanford Health's CHILD Services, 41 childcare programs received physical activity technical assistance (PATA) influencing over 3,353 children.
- The Department. of Social Services (DSS), Division of Child Care Services provided training to childcare centers on physical activity policy development and evidence-based strategies to create and environment supportive of increased physical activity.

S2.4. Promote childcare training to improve public awareness and nutrition policy – discontinued as **strategy was met**.

New Strategy: **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.

- MCH workgroup member set up speaker for Nutrition Conference in October 2019
    - Sanford FitCare – Movement Matters – The importance of Physical Activity
- Identified multiple webinars to share with WIC staff to increase knowledge on nutrition and physical activity.
- MCH workgroup member set up speakers on a variety of nutrition/cultural topics for OCFS's July 2019 All staff Conference. Some of the trainings were:
    - Engaging Families in Responsive Feeding – Florence Rivera – American Academy of Pediatrics. This session was mandatory for WIC Nutrition Educators and Registered Dietitians. The presenter discussed how responsive feeding can support picky eaters, positive mealtime behaviors and children experiencing food insecurities. It Included strategies to help support families in building a healthier, more positive eating environment.
    - Better Together: Partnerships to Support Healthy Child Nutrition – Florence Rivera – American Academy of Pediatrics. This session discussed how to support child development with healthy foods and how to partner with programs that have like goals and explore opportunities to strengthen partnerships in your community.
    - Hispanic Cultural Awareness and Best Practices for Using an Interpreter – Becky Waltner – Public Health Alliance. This session discussed how to communicate with Hispanic clients, cultural differences including views on nutrition and values when it comes to food.

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

85% completion of identified strategies.

Child Health - Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Child Health Domain for the period October 1, 2020 through September 30, 2021. In the Child Health Domain, selected priorities and corresponding National Performance Measures or State Performance Measures are as follows:

Priority Need: Parenting education and support

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

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

2020-2021 Objective and Strategies

Objective: Increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year from 34.3% (2016-2017) to 37.7% by 2026 (NSCH)

Proposed Strategies:

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

- Disseminate Trifold Developmental Screening tracking cards in DOH community health offices
- Place a provider-focused ad promoting equity in developmental screening in the SD Medicine magazine
- Provide ongoing updates through an equity lens to the DOH websites with message of importance of screening and links to resources

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

- Ensure adequate training is provided to DOH staff who administer ASQ screenings in Community Health Offices
- Provide reminders to community health office staff to connect families to the CDC Milestone Tracker app
- Identify health equity focused training opportunities and resources for community health staff
- Encourage DOH Child and Family Services staff who administer ASQ screenings to sign up for ASQ Provider email newsletter from Brookes Publishing

6.3: Identify and address gaps in parenting education through health equity lens and provide parenting support to South Dakota parents, including vulnerable populations

- Partner with Medicaid to look at ASQ reimbursement rate and well-child data to identify gaps
- Collaborate with the DOH Home Visiting program, to reduce duplication of and/or gaps in developmental screenings and referrals for evaluation between home visiting and other OCFS programs.
- Promote strongfamilies.sd.gov to South Dakota families, including vulnerable populations, as a resource for parenting education.
- Explore other parenting education resources to equitably disseminate

New Approach to Evidence- Based Strategy Measures

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

New Efforts

- Equitable promotion of developmental screening: The MCH Program will revise their provider-focused ad placed in the SD Medicine magazine promoting developmental screening to include a message on the importance of equity in developmental screening. The MCH Program will also provide ongoing updates through a health equity lens to the DOH websites promoting the importance of developmental screening.
- Staff training with emphasis on health equity: Training will be provided to DOH community health staff using the TRAIN platform. The MCH Program will identify health equity focused training opportunities for community health staff.
- Parenting education and support: The MCH Program will partner with Medicaid to look at ASQ reimbursement rates and well-child data to identify gaps. In addition to promoting strongfamilies.sd.gov as a resource for parenting education to South Dakota families, the MCH Program will look into other ways to provide parenting education, including to families who do not have access to the internet.

Ongoing Efforts Supported by MCH for the Child Domain

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

- The CYSHCN Program partners with DSS and covers the cost of special needs car seats for families referred by the Department of Social Services.

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

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

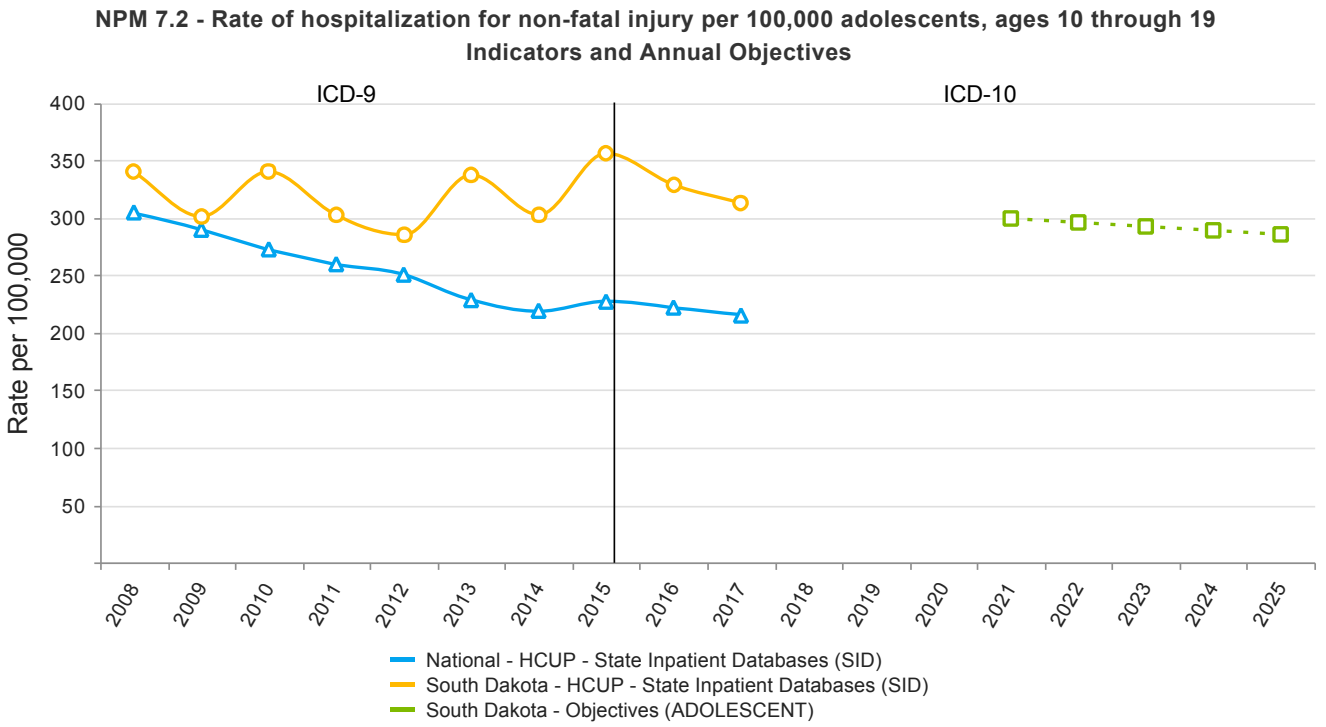
- Healthy SD: The www.healthysd.gov website has nutrition and physical activity resources that include all age groups. Particularly “Harvest of the Month” is a free curriculum for introducing fruits and vegetables to children http://www.sdharvestofthemonth.org/

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2018	20.8	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	54.8	NPM 7.2 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	29.8	NPM 7.2 NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	29.2	NPM 7.2 NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	66.8 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	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-2017_2018	11.9 %	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-2016	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-2018_2019	67.2 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2018	68.7 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2018	86.6 %	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-2018	85.3 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	20.4	NPM 10

National Performance Measures



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

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

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	299.2	295.8	292.3	288.9	285.4

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

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

State Performance Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	46.4	47.1	47.9	48.7	49.4

State Action Plan Table

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

Priority Need
Mental Health/Suicide Prevention

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

Objectives
Decrease the adolescent suicide rate among 15 through 19-year olds from 29.2 per 100,000 in 2016-18 to 10.2 in 2026 (NVSS).
Decrease the percentage of 9th-12th graders who attempted suicide in the past 12 months from 12.3% in 2019 to 11.1% in 2026 (YRBS).

Strategies
7.2.1: Promote evidence-based programs and practices that increase protection from suicide risk.
7.2.2: Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens.
7.2.3: Develop and disseminate equitable and accessible Suicide Prevention education material, resources and messaging.
7.2.4: Develop partnerships with diverse, multi-sector local and state agencies to address youth mental health and suicide prevention among all South Dakota youth.

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

NOMs

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

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

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

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

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

Priority Need

Healthy Relationships

SPM

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

Objectives

Reduce the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics from 15.2% to 7.2% (EHR NetSmart).

Reduce pregnancies to adolescents, ages 15 through 19 years old, per 1000 females (NVSS).

Strategies

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

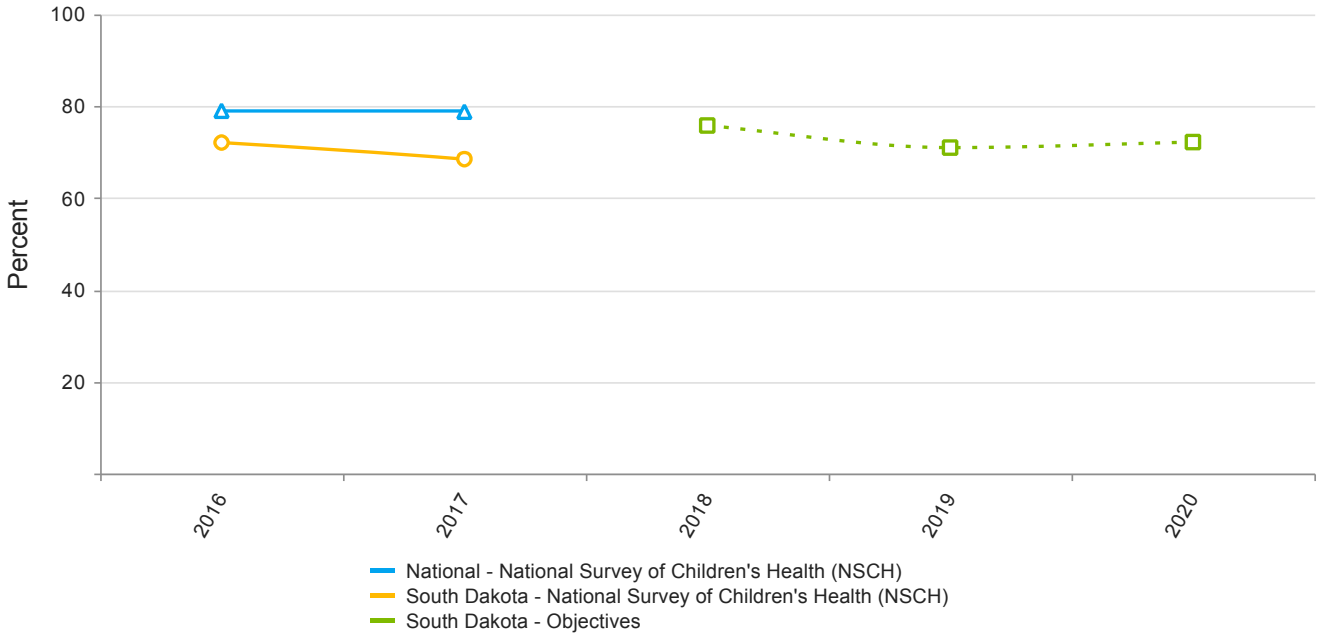
1.2: Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens.

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

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

2016-2020: National Performance Measures

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



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

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

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

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

Adolescent Health - Annual Report

Assessing physical, emotional and social development is important at every stage of life, particularly with children and adolescents. Behaviors established during childhood or adolescence, such as eating habits and physical activity, often extend into adulthood. Well-care visits provide an opportunity for providers to influence health and development and they are a critical opportunity for screening patients for suicide, mood disorders, and substance abuse and dependence.

In addition, each year, millions of children in the United States are injured and live with the consequences of those injuries. These children may face disability and chronic pain that limit their ability to perform age-appropriate everyday activities over their lifetime. These deaths and injuries need not occur because they often result from predictable events. The good news is that there are solutions that work to prevent child and adolescent injury. The challenge is to apply what we know and work together to prevent these unnecessary tragedies to children, families, and communities.

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

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

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

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

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

- Adolescent Injury Prevention: partnered with SD Office of Public Safety to develop an injury prevention toolkit to reduce adolescent injury. The toolkit provides education on car seat guidelines and encourages seatbelt use. The importance of seatbelt usage was also promoted via social media posts, infographics, phone holders, and window clings.

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

- Immunization Programs: DOH's Disease Intervention Specialists visit all enrolled vaccination clinics across the state annually to review immunization coverage rates and provide technical assistance on how to improve

coverage rates. The Immunization Program sends enrolled clinics a letter with their coverage rates, the state coverage rates, and the national rates three times a year. This serves as a reminder to keep working on improving immunization coverage.

The Office of Child and Family Services' community health nurses (OCFS) conduct an audit of all incoming Kindergarten and 6th grade student immunization records to ensure they meet the states minimum immunization requirements for school entry. The OCFS works directly with the schools to check every student's record. If a child is not up to date, the school is informed that the student needs additional immunizations. School-based clinics for influenza vaccine, adolescent Tdap, Meningococcal, and HPV vaccine are conducted by Community Health Nurses. Nurses also travel to Hutterite colonies to provide on-site vaccination clinics and promote/provide adolescent vaccines to this often vaccine hesitant population.

- A media campaign promoting influenza and all recommended vaccinations ran statewide including on tribal lands.

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

https://doh.sd.gov/documents/MCH/NPM10_2021DetailSheet_ESM.pdf

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

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

Data Statement:

There was a working change to the NSCH in 2018 that does not allow 2018 data to be compared with previous years of data. Reporting of this NPM will continue in 2019 when the original wording is restored.

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

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

State Objective 1:

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

State Objective 1 Data Statement:

South Dakota exceeded the 2019 target of 75.7% and there has been a significant increase between 2014 and 2018 in the immunization rate for >1 meningococcal vaccine among adolescents 13-17 years of age. The rate increased from 74.5% in 2017 to 85.3% in 2018. Despite this improvement, in 2017 South Dakota was ranked 27th nationally for meningococcal vaccine rate among adolescents and the U.S. rate was 86.6%.

State Objective 2:

By June 30, 2020, increase the percent of adolescents (14-18 years of age) who smoke that enroll in the Quit Line

from 0.43% (2018) to 0.50% (QuitLine and YRBS)

State Objective 2 Data Statement:

South Dakota exceeded the 2019 target of 0.50% in the percent of adolescents who smoked that enrolled in the Quitline with a 2019 rate of 0.61% compared to a rate of 0.43% in 2018. The trend between 2013 and 2019 is not significant. However, it should be noted that the 2015 YRBS data was used to estimate the number of adolescents who smoked (denominator) for the 2015-2018 estimates, but we were able to use 2019 YRBS data to estimate the number of adolescents who smoked in 2019.

Strategies:

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

- The NPM 10 interagency team met biannually to address how to disseminate adolescent health information to the public. Team members include a representative(s) from Bureau of Human Resources (BHR), SD Medicaid, DOH medical advisor, DOH medical consultant, Tobacco Prevention Program, and Communicable Diseases/Immunization Program. Results from this years' collaboration include: Medicaid and BHR data sharing, discussing and understanding key adolescent health topics that are affecting SD families, and ideas on where to disseminate Adolescent well visit materials. NPM #1 (well women) and NPM #10 met jointly to use our partner's time efficiently.
- Partnered with DSS Medicaid to add information on yearly adolescent preventive visits in their SD Medicaid Recipient Handbook updated July 2019. Information also goes out in their Annual Check-up Reminder letter to Medicaid participants that have children 11 years and older.

  Example of Well-Child Letter for 11 years-old and older can be found at:
  https://dss.sd.gov/docs/medicaid/recipients/well_child_letter_11%20and_older.pdf

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

  AWC-CH: Adolescent Well-Care Visits

  - 2017 Reported Rate was 32%
  - 2018 Reported Rate was 32%
  - 2015 National Average of reporting was 46% ** Last reported data

  IMA-CH: Immunization coverage for Adolescents

  - 2017 – Calculated but not reported
  - 2018 – 34% (without DOH SDIIS data) 57% (with DOH SDIIS data). Medicaid is looking at utilizing data from the South Dakota Immunization Information System (SDIIS) in the future
  - 2015 National Average is 67% **Last reported data

- Collaborated with SD Medical Consultant, Dr. Poppinga on key planning areas for adolescent health.
- June 2019, MCH Adolescent Coordinator met with SD's only adolescent health specialist, Dr. Barondeau to discuss what current adolescent health topics he is focusing on and to gather a greater understanding how an adolescent well visit is done at his office.

10.2. Identify and implement ways to promote yearly adolescent visit

- Continued partnering with SD Family Planning program; distributed a flier entitled “Adolescent Health Check Up” to all South Dakota Family Planning clinics.
- The DOH Community Health Offices continued to display laminated “Adolescent Health Check Up” fliers and distributed fliers to clients.
- Continued partnering with Boys & Girls Club; distributed “Adolescent Health Check Up” flier to participants and developed a display to include other information.
- South Dakota Medicine Journal published an ad entitled “Double Duty” which highlighted the difference between a sports physical versus well-child visit. The ad also addressed the importance of assessing both physical and mental health during annual checkups. South Dakota Medicine has approximately 2,000 physician subscribers.
- In September 2019, an ad titled “Well-Child Visits Cover All the Bases” was published in Black Hills Parent Magazine. The ad encouraged parents to schedule annual well-child visits for their teens and showed the difference between a sports physical vs. a well-child visit.
- In reaching out to youth with the 2020 Needs Assessment youth survey, the MCH team also distributed Adolescent Health Check-up fliers and Suicide Prevention materials to youth at SD Family, Career and Community Leaders of America Conference (April 1st, 2019), Health Occupations Students of America Conference (March 29th, 2019) and Fort Thompson Health Fair (June 6th, 2019).
- April 4th, 2019 – Grand Rounds speaker, Dr. Molly Uhlenhake spoke to providers at USD Sanford School of Medicine on adolescent health topics. The presentation was called: “Don’t Snooze on Generation Z: Addressing the Unique Health Care Needs of the Next Wave of Adolescents.” View the presentation at: https://youtu.be/7qqz_pKK0Cg
- In July of 2019, the MCH team distributed adolescent health information including the Adolescent Health Checkup flier to Family and Consumer Science Teachers across SD. Information shared included where the information can be utilized and how the information can be ordered.
- Distributed Adolescent Health Check Up fliers to our immunization partners.
- Adolescent Health Check Up flier and Well Child Visit vs. Sports Physicals infographics were added to our OCFS website and can be found at:
  https://doh.sd.gov/documents/Family/AdolescentAnnualCheckupReminder.pdf
  https://doh.sd.gov/documents/Family/AdolescentDocVisit.pdf

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

10.3. Encourage individual and family engagement.

- In April of 2018 focus group sessions were conducted in Rapid City and Sioux Falls to gain a better understanding of what parents of middle school age children felt was most important when it came 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 focus group report was completed by the end of 2018 and the MCH team utilized the information to decide on future programming and resources to provide. Activities completed based on the focus group information include:

  - Began creating the new adolescent health platform, knowing now that youth like the facts and finding out what social media platforms they are utilizing the most. Per feedback provided, key topics to address will be mental health and suicide prevention.
  - The MCH team realized that parents are wanting more information on bullying, depression and suicide

and how to give their children tools to deal with these circumstances. Parents also expressed a lack of knowledge about how to handle these tough situations their children are facing. With this information, the team is looking into how we could offer parents and teachers information.

- Parents are wanting more peer-to-peer training for their children as they felt kids listen to other kids which was confirmed during the youth focus groups. With this information the MCH team has begun looking into available peer to peer trainings. The development of a youth council will also be a strategy.

- With the help of a marketing agency, the MCH team has begun developing an Adolescent Health Platform to provide messaging to youth and parents on adolescent health topics. The platform will begin posting on Facebook and Instagram. Three key areas that will be addressed will include mental health, healthy relationships, and physical health.
- Began networking with existing youth councils to promote Adolescent well visits and to begin possible partnership for developing our youth council.

Challenge: Identifying what would be the best way to develop a youth council, one that has the best outcome for youth and reaches a diverse population.

10.4. Target messaging regarding tobacco cessation coaching for adolescents

- The SD Tobacco Control Program has been educating providers, parents, youth and young adults about the dangers of e-cigarettes through a social media campaign and print ads in SD Medical Journals and parenting magazines. The campaign focuses on the harms to youth, pregnant women, non-tobacco using adults and how to talk to adolescent about e-cigs and JUULing.
- An educational webinar on e-cigarettes and vaping is available for educators and students, which could be used in classrooms, at teacher in-services or PTA meetings. Since November 2018 the webinar has been viewed 265 times. To view: https://www.youtube.com/watch?v=RMWJOk70PIo&feature=youtu.be

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

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

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

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

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

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

10.5. Promote 6th grade vaccination requirements

- Provided the Department of Education 6th grade vaccination requirement information to distribute statewide to local school districts.
- OCFS Community Health Offices host vaccination events targeting the 11-12-year-old during the months of July and August. Strategies include: advertising special clinics via social and print media, making individual calls to families of children who are overdue for vaccinations, and sending a letter to parents of students scheduled to enter 6th grade.
- Data from the 2018 National Immunization Survey for adolescents (13-17 years old)
    - 1 or more Tdap 86.6%
    - 1 or more MCV4 85.3%
    - Up to date on HPV 49.5%

Challenge: Vaccine hesitation from families.

ESMs

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

78% completion of identified strategies.

Adolescent Health – Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Adolescent Health Domain for the period October 1, 2020 through September 30th, 2021. Priority needs identified through the Needs Assessment process in this domain were: mental health, suicide prevention, sexual health, and various others such as: bullying, access to care, life skills, lack of transportation, housing, and physical activity and nutrition. In the Adolescent Health Domain, selected priorities and corresponding National Performance Measures or State Performance Measures are as follows as well:

PRIORITY: Mental Health/Suicide Prevention

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

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

2020-2021 Objectives and Strategies

Decrease the adolescent suicide rate among 15 through 19-year olds from 29.2 per 100,000 in 2016-18 to 10.2 in 2026 (NVSS).

Decrease the percentage of 9th-12th graders who attempted suicide in the past 12 months from 12.3% in 2019 to 11.1% in 2026 (YRBS).

Proposed Strategies

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

- Provide youth Mental Health First Aid Training.
- Provide Question Persuade Refer trainings for high school staff.
- Provide teen Mental Health First Aid Training.
- Provide and promote Text4Hope - Teen Crisis Texting Support.

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

- Develop PYD training for organizations working with diverse youth on suicide prevention.
- Develop Youth Advisory Council focused on strategies and activities that emphasize healthy equity and integrating the youth voice throughout activities.

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

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

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

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

PRIORITY: Healthy Relationships

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

2020-2021 Objectives and Strategies

Reduce the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics from 15.2% to 7.2% (EHR NetSmart).

Reduce pregnancies to adolescents, ages 15 through 19, per 1,000 females (NVSS).

Proposed Strategies

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

- Provide and promote STI guidelines training to providers serving young people 10 to 24, including vulnerable/underserved youth.
- Collaborate with existing SRAE and PREP Programs serving diverse populations.

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

- Develop PYD training for organizations those working with diverse youth on healthy relationships.
- Develop Youth Advisory Council focused on strategies and activities that emphasize healthy equity and integrating youth voice throughout activities.

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

- Develop Parent – Teen Communication Messaging for Cor Health.
- Utilize TRAIN platform to disseminate trainings and materials accessible to diverse parents and organizations working with young people 10 to 24 including vulnerable/underserved youth.

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

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

New Approach to Evidence- Based Strategy Measures

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

New Efforts:

- Youth Engagement and Voice*:* Begin putting into place a system that will include the youth voice when creating programming. Continue work with and establishing relationships with youth organizations that were developed during the Title V Needs Assessment.

- Positive Youth Development (PYD): Develop a framework to follow to encourage PYD in South Dakota.

- Adolescent Platform – Cor Health SD*: Work with Hot Pink Marketing to develop messaging for new priorities and continue growing awareness of Cor Health SD Platform.*

- Suicide Prevention Training: MCH program will continue partnering with Helpline Center to bring adolescent suicide prevention trainings.
    - New Training - Teen Mental Health First Aid is an in-person training that teaches high school students about common mental health challenges and what they can do to support their own mental health.

- Parent-Teen Communication Messaging: MCH Program will begin looking at promoting efforts to increase healthy relationships between youth and their parents/trusted-adults.

- Local and State Partnership: Partner with organizations that were involved with the Title V Needs Assessment and build rapport with new organizations working with youth in the new priority areas.

Ongoing Efforts Supported by MCH for the Adolescent Domain:

- Continue to partner with HelpLine Center to offer youth suicide prevention education throughout the state of South Dakota. The HelpLine Center provides 24/7 statewide crisis line, teen crisis texting support or Text4Hope, Youth Mental Health First Aid training, and training for high school faculty on teen suicide

prevention/intervention.

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

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

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

Children with Special Health Care Needs

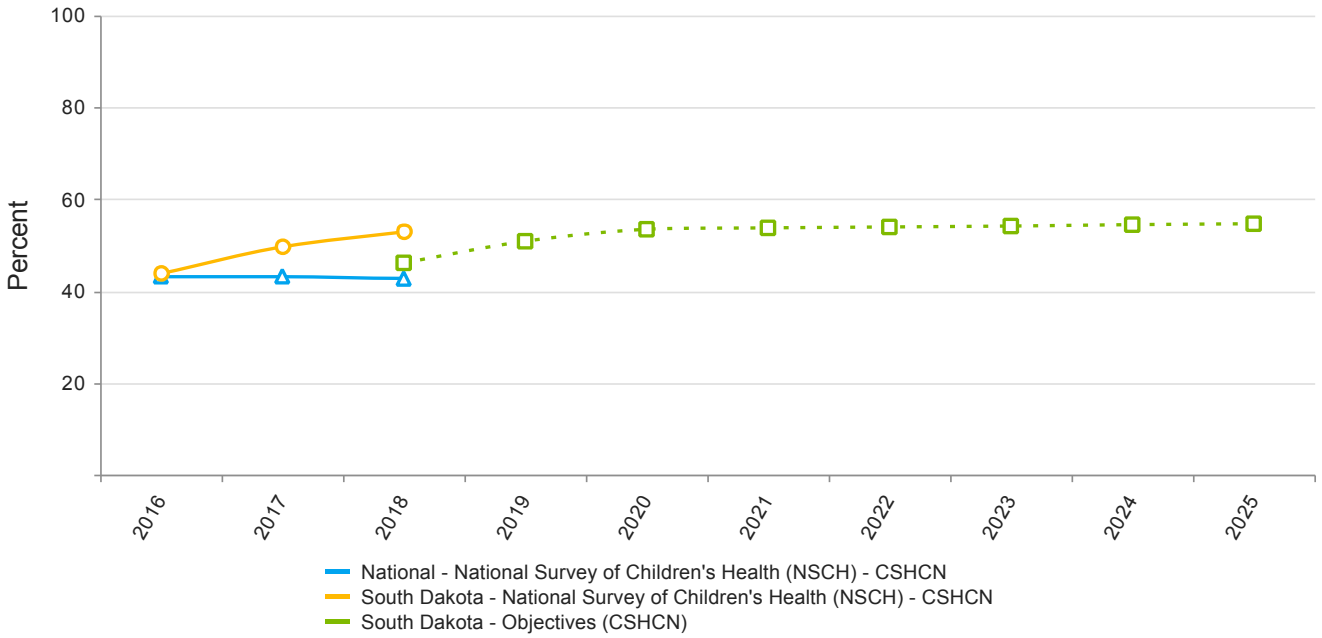
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2017_2018	16.3 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	66.8 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	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-2017_2018	2.9 %	NPM 11

National Performance Measures

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

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

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

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						
	2020	2021	2022	2023	2024	2025
Annual Objective	53.4	53.7	53.9	54.1	54.4	54.6

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

Annual Objectives					
	2021	2022	2023	2024	2025
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
Access to Care and Services

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

Objectives
Increase the percentage of CYSHCN who report receiving care in a well-functioning system from 16.3% (2017-18) to 17.2% by 2026 (NSCH)

Strategies
11.1: Enhance equitable family access to needed supports and services.
11.2: Identify and implement strategies to equitably advance medical home components for families of CYSHCN through access to family centered care coordination.
11.3: Coordinate the state newborn screening infrastructure focused on equitable testing and access to follow up services.

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

NOMs

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

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

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

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

2016-2020: National Performance Measures

Access to a pediatric medical home is associated with increased quality of care, improved health outcomes, and decreased unmet medical needs for children and youth, including children and youth with special health care needs (CYSHCN).

Family-centered care is a key component of the medical home model. For pediatric populations, family-centered care is particularly important, given that families are the primary caregivers for children and youth.

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

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

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

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

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

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

https://doh.sd.gov/documents/MCH/NPM11_2021DetailSheet_ESM.pdf

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

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

Data Statement:

Percent of children ***with*** special health care needs having a medical home: South Dakota exceeded the 2019 target of 50.8% with 53.0% of children *with* special health care needs having a medical home in 2017-18. In 2017-18, South Dakota was ranked 3rd in the nation with a U.S. rate of 42.7%. The South Dakota 2017-18 rate of 53.0% is significantly greater from the South Dakota 2016-17 rate of 49.6%.

Percent of children ***without*** special health care needs having a medical home: South Dakota did not reach the 2019 target of 54.5% with 50.9% of children *without* special health care needs having a medical home in 2017-18. In

2017-18, South Dakota was ranked 27th in the nation with a U.S. rate of 49.4%. The South Dakota 2017-18 rate of 50.9% is significantly lower than the South Dakota 2016-17 rate of 52.0%.

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

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

State Objective 1:

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

State Objective 1 Data Statement:

South Dakota exceeded the 2019 target of 16.0% with 16.3% of children with special health care needs receiving care in a well-functioning system. In 2017-18, South Dakota was ranked 24th in the nation with a U.S. rate of 13.9%. There is a significant increasing trend between 2016-17 and 2017-18.

State Objective 2:

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

State Objective 2 Data Statement:

South Dakota exceeded the 2019 target of 99.0% with 99.4% of infants whose newborn screening test results were outside the normal limits and received prompt and appropriate follow-up testing. The 2018 rate was 98.9%. There has been no significant trend between 2015 and 2019.

Strategies:

Discontinued: 11.1. Collect data specific to the needs of families of children and youth with special health care needs and the providers that serve them.

Justification: This strategy was carried out in 2018. A total of 292 families of CYSHCN were surveyed in South Dakota regarding specific health issues they faced and whether they had access to the services and supports they need. The results of the survey were used to inform program planning with the transition from direct service reimbursement to care coordination. Even though this strategy was discontinued in 2019, the CYSHCN Program continues to collect data on the services they provide.

When 11.1 was completed, the strategies that followed on the action plan table were moved up accordingly (ex. 11.2 became 11.1).

11.1. Enhance family access to needed supports and services

- Continued interagency agreement with Department of Human Services (DHS) to support respite care services across the state. Respite care can be especially important to families of CYSHCN, and through our interagency agreement with DHS, 576 children/adults were served during this reporting period.
- Contracted with Sanford Health to support the provision of genetics outreach clinics in the western part of the state. With this provision, Sanford provides the services of a geneticist and a genetics counselor by conducting 8
  1-day outreach clinics in Rapid City, SD per calendar year.
- Provided financial assistance through our direct service reimbursement program, Health KiCC to low income families to assist with the cost of medical treatment. A total of 26 clients were served through Health KiCC

during this reporting period. During this reporting period, two clients aged out of the program and one moved out of state, leaving 23 clients enrolled at the end of the grant year.
- Met with the developmental screening workgroup to discuss progress on developmental screening and areas of improvement.

Challenges:

The launch of our DOH Health Home pilot program was met with several challenges including a lack of interest from families and providers, as well as a CYSHCN Director vacancy shortly after the program launched. At the end of this grant year, only 11 families are enrolled in the program, and only 3 of these families have providers signed on to Health Home. The program was opened to families currently enrolled in our direct service program, Health KiCC, with plans for eventual expansion. Health Home was built off the framework of the Medicaid Health Home program and as such, DOH Health Home would reimburse primary care providers for core services provided to enrolled clients. Anecdotal evidence from Health KiCC clients who opted out of DOH Health Home indicated many of these clients rarely if ever see a primary care physician in favor of specialists for their frequently complex medical conditions. The program also encountered a lack of providers enrolled in the Medicaid Health Home program, a requirement to participate in DOH Health Home. In addition, the CYSHCN Director position became vacant twice in 2019, leading to a lack of continuity and oversight of the program during its critical pilot phase. As a result of the substantial challenges faced by this program, the program will be discontinued after September 30, 2020.

Our direct service program, Health KiCC, began to be phased out in 2016 due to shifting state priority needs and the transformation of the federal block grant to improve accountability of performance and impact on the health and well-being of mothers, children, and families. Health KiCC no longer takes new applicants but continues to operate for the families enrolled as we explore other opportunities to serve these families. At the end of this grant period 23 clients are being served on this program.

In response to the challenges with DOH Health Home and the move away from the direct service model, we have been focusing our efforts on the development of a two-part care coordination pilot with Sanford Health and South Dakota State University (SDSU). With this pilot, MCH funds will support a registered nurse care coordinator within Sanford Children's Hospital in Sioux Falls, SD. This hospital is the only children's hospital in the state and serves children and families all across the state. The care coordinator will implement clients' individualized care plans through appropriate linkages, referrals, coordination, and follow up to needed services and supports. Participants will be limited to South Dakota residents, and service will be prioritized to those who fall within current Health KiCC income and health condition guidelines. A strong emphasis will be put on the timely scheduling of all necessary appointments within a single day and in the same facility to combat the challenges expressed by CYSHCN families in our frontier state. The care coordinator will also serve as a point of contact for families and will monitor and evaluate the clients' ongoing healthcare needs and will submit quarterly reports to the SD MCH program containing agreed upon indicators. SDSU will provide an ongoing comprehensive evaluation of the program to evaluate the program's effectiveness at meeting the needs expressed by the enrolled families. The pilot program is set to launch in January 2020.

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

- Contracted with our SD Family 2 Family Program (Parent Connection) to address needs for training and resources. A total of 2519 individual assistance/training contacts to 665 families were provided by Parent Connection during this reporting period. This contract ended in May 2019 and was not renewed; however, Parent Connection leaders continue to serve on MCH workgroups.
- SD Parent Connect provided two training sessions for *Serving on Groups That Make Decisions*. Parents that completed the training were informed of opportunities to participate on MCH program workgroups.

- Through parent engagement and leadership efforts of the SD Early Hearing Detection and Intervention (EHDI) Collaborative (an EHDI partnership between the University of SD and the SD DOH) a core group of 4 mothers championed the first Hands & Voices (provisional) Chapter in SD. Hands and Voices is a parent-driven non-profit organization dedicated to providing education and support to families of children who are deaf or hard of hearing through various modes of communication.
- OCFS's MCH Director served as advisory board member on the *South Dakota Statewide Family Engagement Center* grant which is a five-year effort to connect families, schools and communities to help all children to be successful from cradle to career.

Challenges:

- Identifying families to participate in the Serving on Groups training and the time commitment necessary on the parents' part.
- Identifying best ways to collaborate/work with the parents as they complete the Serving on Groups training.
- High percentage (84%) of working mothers in South Dakota.(2014 American Community Survey)

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

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

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

- MCH Newborn Screening Program worked with medical consultants to review testing cutoff for presumptive positive results.
- SHL reported 95.0 % of newborn screening results for CY18 were provided to SD healthcare providers <= 7 days of age.
- Newborn Screening coordinator participated in SHL's bi-monthly partnership calls among the four state newborn screening programs; AK, IA, ND, and SD.
- Worked with medical consultants to review, revise and approve follow up recommendations regarding tandem mass spectrometry testing for cystic fibrosis, hemoglobinopathy and congenital adrenal hyperplasia.
- During this grant period, 99.4% (12,250/12,323) of the birth certificates had matching newborn screening laboratory results.
- For CY18, 709 infants had either presumptive positive or borderline newborn screening test, contact was lost with 2 infants, lost contact and 1 infant's parent/guardian refused to pursue diagnostics.

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

- During this reporting period the unacceptable specimen rate increased to 1.5%.
- During this reporting period the percentage of time-critical results reported within 5 days of birth was 94.7%
- The percentage of birth certificate's matched to the newborn screening laboratory report was 99.4% (12,250/12,323)
- The percentage of non-critical screening results reported within 7 days of birth was 93.3%
- MCH Newborn Screening program provided best practices and specimen rejection criteria education to hospitals demonstrating poor quality newborn screening specimen rates.

Challenges:

- Poor quality newborn screening specimen rates continued to increase and consistently fall above the program goal of less than 1.0% among submitters statewide. EHDI data collection has been challenged due to a lack of CDC funding support. Another challenge is that there are no state mandates regarding EHDI reporting or performance of infant hearing screening. EVRSS EHDI data indicated Pine Ridge IHS facilities had not completed hearing screenings for 6 months due to broken equipment. Infants were referred to South Dakota School for the Deaf West River Clinic for hearing screenings but only 60% of them had a hearing screening completed.

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

83% completion of identified strategies

Children with Special Health Care Needs- Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Children and Youth with Special Health Care Needs (CYSHCN) Health Domain for the period October 1, 2020 through September 30, 2021. In the CYSHCN Health Domain, selected priorities and corresponding National Performance Measures or State Performance Measures are as follows:

Priority: Access to care and services

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

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

2020-2021 Objective and Strategies

Objective: Increase the percentage of CYSHCN who report receiving care in a well-functioning system from 16.3% (2017-2018) to 17.2% by 2026 (NSCH)

Proposed Strategies:

11.1: Enhance equitable family access to needed supports and services

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

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

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

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

- Contract laboratory for newborn screening of all South Dakota births
- Partner with Sanford Health to contract medical consultants, genetics counselors, and a follow up nurse to address equitable and appropriate testing, treatment, and follow up for presumptive positive cases.

New Approach to Evidence- Based Strategy Measures

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

New Efforts

- Data collection and analysis: The CYSHCN Program will begin analyzing the data received from the Sanford Care Coordination Pilot to inform program planning and assess progress.

- Additional Care Coordination Pilots*:* The CYSHCN Program will actively pursue additional opportunities to provide care coordination in South Dakota.

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

- Linking families to resources*:* The CYSHCN Program will reach out to family organizations, medical entities, and other state organizations to create a more comprehensive list of the resources available for families of CYSHCN in South Dakota. The next step in this process will be determining how we equitably disseminate and promote these resources.

Ongoing Efforts Supported by MCH for the CYSHCN Domain

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

- The South Dakota EHDI Collaborative developed and continues to modify the tele-audiology infrastructure. Tele-audiology sites (2) are geographically located in areas of high lost to follow-up rates and sites may be modified according to usage. At these sites, infants have been identified with permanent hearing loss in a timely manner and connected with resources and support within the state such as the Birth to Three program and the South Dakota School for the Deaf.

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

- The CYSHCN Director participates in The National Community of Practice State Team meetings, which bring together state agency representatives, public and private partners, and family members focused on the mission

of supporting families of individuals with intellectual and developmental disabilities.

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

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

Cross-Cutting/Systems Building

State Performance Measures

SPM 2 - Improve data sharing with partners and the public and collaborate with new partners to enhance MCH data by increasing the number of new data sharing projects accomplished from zero to four by September 30th, 2021.

Measure Status:	Active

Baseline data was not available/provided.

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

State Action Plan Table

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

Priority Need

Data Sharing and Collaboration

SPM

SPM 2 - Improve data sharing with partners and the public and collaborate with new partners to enhance MCH data by increasing the number of new data sharing projects accomplished from zero to four by September 30th, 2021.

Objectives

Increase the number of data sharing projects accomplished from zero to four by September 30, 2021.

Increase the number of partners that we collaborate with on data projects from zero to five by September 30, 2021.

Strategies

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

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

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

2016-2020: State Performance Measures

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

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

Cross-Cutting/Systems Builiding - Annual Report

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

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

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

Within this Cross-cutting/Systems Building Domain, one State Performance Measure (SPM) was chosen and the objectives, strategies, and activities are identified within the State Action Plan framework.

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

https://doh.sd.gov/documents/MCH/SPM4_2021DetailSheet_ESM.pdf

DOH Strategic Plan Goal 5: Maximize the effectiveness and strengthen the infrastructure of the Department of Health.

State Performance Measure 4: *MCH data are analyzed and disseminated*

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

Strategies

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

- The planning phase for the 2020 MCH/Title V Needs Assessment was conducted from August 2018-December 2018. During that time, the MCH team decided to conduct a more robust needs assessment with additional data sources than previously utilized. The MCH team noted gaps in data and planned to gather more information from MCH partners, community members, and youth. The team also recognized that many vulnerable populations did not have a voice in past needs assessments and that this would be a valuable piece to understanding the health and well-being of all South Dakotans. A data collection plan was created which included both qualitative and quantitative methods.

- Maternal mortality became an increasingly important topic in MCH. SD recognized that they had limited data on maternal mortality and began identifying ways in which they could expand data capacity and review and analyze that data.

- The MCH contracted epidemiologist, Bonny Specker continued to review the Federally Available Data that

supports the MCH block grant measures including newly available SD CDC PRAMS data. MCH staff reviewed infant mortality, family planning, home visiting, and sexual violence data to gain a well-rounded perspective on MCH populations in the state.

S4.2. Identify data collection methods to address gaps

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

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

The MCH team identified the need for more robust maternal mortality data. Vital records data on maternal deaths was already being reported when a woman died 42 days or less after pregnancy. This timeframe was expanded to mirror national recommendations of reviewing records of women who died up to 1 year after pregnancy. Women's death records were also linked to birth and fetal death records to identify additional information. Data from CDC's Pregnancy Mortality Surveillance System (PMSS) was requested by SD. This data is reviewed by medical epidemiologists and is categorized as pregnancy-related or pregnancy-associated, as well as being classified by cause of death and injury relatedness. During this grant period, an ad hoc committee was formed to explore maternal morbidity and mortality in SD. This group of health care providers, legal experts, public health professionals, legislators, and others with an interest in maternal health met with the goal of ultimately forming a Maternal Mortality Review (MMR) committee. A new staff member was also hired and will be the case abstractor when the committee is ready to start reviewing cases. MMR will

help identify underlying causes of maternal mortality, women that are most impacted by these causes of death, and targeted prevention strategies.

Challenges:

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

S4.3. Implement new data collection efforts as needed

- As part of the Needs Assessment process, the MCH team used a variety of new data collection methods to identify unmet health needs. Over 70 statewide MCH partners took a survey that gave the MCH team information about the top health priorities of our partners and those that they serve. Over 650 SD youth in grades 5-12 responded to a survey that gathered information about the health needs and priorities of youth. The Needs Assessment team also disseminated a community survey and over 1,000 residents of SD responded to give feedback on the needs of MCH populations. Additionally, four focus groups from across the state were held to identify needs from specific populations including single parents, co-parents from a rural area, Native American women, and youth.

- Maternal mortality data from vital records and the CDC PMSS was analyzed. A new maternal mortality website was created on the DOH website. https://doh.sd.gov/statistics/maternalmortality.aspx? This data was presented at multiple meetings (listed in strategy 4.4) and was used to inform the needs assessment and ad hoc maternal mortality committee's work.

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

- During this reporting period, SD CDC PRAMS data was available for the first time. 2017 data was analyzed and distributed through several fact sheets, infographics, and reports listed in strategy 4.4. This new data will be valuable to our understanding of attitudes and behaviors around maternal and infant health in our state.

S4.4. Develop and disseminate fact sheets on findings

Documents:

- South Dakota Infant Death Review: 2013-2017, October 2018
- 'National Performance & Outcomes Measures and State Objectives by Life Stage Annual Report: Targets, Trends Over Time & Stratifiers': completed in May 2019
- South Dakota 2017 Pregnancy Risk Assessment Monitoring System (PRAMS), May 2019
- 2017 South Dakota PRAMS Family Planning Results, March 2019
- SSDI Minimum/Core Indicators Report, June 2019
- Summary Report of South Dakota Sexual Violence Data including state map of rape rates by county (2012-2018), July 2019
- South Dakota 2017 PRAMS WIC vs. Non-WIC Report, July 2019
- South Dakota 2017 PRAMS Survey Results: An Internal Report, July 2019

- MCH Needs Assessment: 2019 Youth Survey Report, August 2019
- 2017 PRAMS: Analysis of Breastfeeding Data Report, September 2019
- Infant Death Review Annual Report, 2018 data
- Report of first-time moms by county and Medicaid status for 2013-2017

Peer-reviewed Publications:

- Bai W, Specker B. Racial differences in hospitalizations due to injuries in South Dakota children and adolescents. Journal of Racial and Ethnic Health Disparities 6:1087-1094, 2019. DOI:10.1007/s40615-01900611-x
- Specker BL, Minett M, Beare T, Poppinga N, Carpenter M, Munger J, Strasser K, Ahrendt L. Safe sleep behaviors among South Dakota mothers and the role of the health care provider. South Dakota Med, ***in press***
- Specker B, Wey HE, Minett M, Beare T. Pregnancy survey of smoking and alcohol use in South Dakota American Indian and white mothers. American Journal of Preventive Medicine 55:89-97, 2018. DOI:10.1016/j.amepre.2018.03.016

Presentations:

- Students working on the SD 2014 and 2016 PRAMS-like surveys and the 2017 CDC SD PRAMS presented posters at the Avera/SDSU Research Symposium in Brookings, October 2018:
  - Short E, Binkley T, Minett M, Beare T, Specker B. Relationship between maternal dieting behavior and health-related attitudes before and during pregnancy. Presented at the Avera-SDSU Research Symposium, Brookings, Oct 24, 2018
  - Crawford A, Minett M, Beare T, Binkley T, Specker B. Relationship between exercise and other health outcomes in South Dakota mothers. Presented at the Avera-SDSU Research Symposium, Brookings, Oct 24, 2018
  - Wormer R, Minett M, Binkley T, Beare T, Specker B. Stressful events before pregnancy and health outcomes: Lessons from SD mothers. Presented at the Avera-SDSU Research Symposium, Brookings, Oct 24, 2018
- 'PRAMS-like Survey and Preconception Care in South Dakota' Annual South Dakota Nursing Association Meeting, October 2018, Brookings, SD (Beare)
- 'South Dakota Rape Prevention Education Annual Data Report & Program Evaluation' – South Dakota Sexual Violence Prevention Steering Committee, October 2018, Pierre, SD (Specker)
- 'Safe Sleep Practices in South Dakota, 2016', South Dakota Perinatal Conference, Sioux Falls, October 2018 (Specker)
- 'South Dakota Needs Assessment Kick-Off Webinar' January 2019, Zoom (MCH Team)
- 'Maternal and Child Health Data' Needs Assessment Partner Meetings, Rapid City, Pierre, Sioux Falls, March 2019 (Strasser)
- 'South Dakota PRAMS', Zoom presentation to Tribal WIC offices, interagency tribal organization (ITO) & DOH, March 2019
- 'Title V/ Maternal Child Health Needs Assessment' Needs Assessment Tribal Partner Meeting Sisseton, June 2019 (Strasser)
- 'Infant Mortality' OCFS All-Staff Conference, July 2019, Pierre, (Munger)
- 'Trends in South Dakota Maternal Mortality' OCFS All-Staff Conference, July 2019, Pierre (Strasser).
- 'DOH OCFS Community Needs Assessment Survey Results', MCH Impact Working Groups, Pierre, September 2019 (Specker)

One-pagers:

- Infant, Child, Youth, and Women Data Briefs, March 2019
- 2017 Infant Death Review Infographic, March 2019
- Women, Infant & Children (WIC) in South Dakota, 2014 & 2016, October 2018
- Breastfeeding in South Dakota, 2014 & 2016, October 2018
- South Dakota birth rates by age (2010-2017) and difference in teen birth rates per 1,000 between SD and US, 2010-2017
- Breastfeeding, South Dakota PRAMS, 2017, August 2019
- Maternal Mental Health, South Dakota PRAMS, 2017, August 2019
- Cigarette Smoking, South Dakota PRAMS, 2017, September 2019
- Infant Sleep Practices, South Dakota PRAMS, 2017, September 2019
- Oral Health, South Dakota PRAMS, 2017, September 2019
- Women's Health and Alcohol Use, South Dakota PRAMS, 2017, September 2019

Cross-Cutting/Systems Building – Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Cross-Cutting/Systems Building Domain for the period October 1, 2020 through September 30th, 2021. In the Cross-Cutting/Systems Building Domain, selected priorities and corresponding National Performance Measures or State Performance Measures are as follows:

Priority: Data sharing and collaboration

SPM 2: Improve data sharing with partners and the public by increasing the number of new data sharing projects accomplished from zero to four by September 30th, 2021

ESM: 2.1. Number of partners that responded to the data use survey

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

2020-2021 Objectives and Strategies:

Objective:

1. Generate a minimum of 2 reports annually by September 30th, 2021.

2. Increase the number of partners that DOH collaborates with on data projects from zero to five by September 30th, 2021.

Proposed strategies:

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

- Send a survey to partners to learn about current data accessibility and preferences for data sharing in the future.
- Create an external data dashboard with MCH data from diverse sources (DOH and other secondary data that support MCH) that highlights disparities.
- Highlight MCH data on inequities in a bi-monthly MCH newsletter that is sent to the MCH partner list from the needs assessment.

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

- Create a new infant mortality report that incorporates infant death review and vital records data. Highlight disaggregated data and share with partners.
- Update MCH data briefs by domain to reflect new NPMs and health inequities within these domains.

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

- Collaborate with DSS to analyze Medicaid data for causes leading to maternal mortality and severe maternal morbidity. Identify vulnerable populations to target prevention methods.
- Form multidisciplinary SD Maternal Mortality Review Committee by identifying partners who represent vulnerable populations and hold bi-annual reviews.

New Approach to Evidence- Based Strategy Measures

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

New Efforts:

- Data use survey: One theme that was consistently noted through the MCH Needs Assessment was a need for

enhanced data sharing and collaboration. Across sectors and population domains, partners frequently noted challenges in accessing data, understanding the context of MCH data, sharing data, and collaborating on new data projects. This survey will provide DOH with information on how data is currently accessed and preferences for data sharing in the future.

- MCH data dashboard: Enhancing data visibility and accessibility is a top priority for not only MCH but for SD Department of Health. One of the guiding principles on DOH's strategic plan is supporting data-driven innovation. A new MCH data dashboard would provide partners and the public with up-to-date, relevant MCH data points in a centralized location. It would also serve as a communication piece between the population domains and MCH performance measures.
- MCH newsletter: An MCH newsletter was initiated during the needs assessment as a communication tool to partners. The continuation of this newsletter would allow for certain data pieces specific to health inequities to be featured quarterly.
- Infant mortality report: The infant mortality report was last updated in 2017. Over the last 10 years, South Dakota has seen a steady decline in 3-year averages for infant mortality. However, increased data through infant death review has indicated that the state still has work to do to promote and improve safe sleep conditions for infants, especially among Native American infants.
- MCH data briefs: During the needs assessment, data briefs with MCH data by population domain were sent to partners to give them a baseline of current data. A new activity would be to update these briefs around the newly chosen performance measures with a focus on health inequities. This could serve as a quick data snapshot for partners or the public and explain the current work around each measure.
- Maternal Morbidity and Mortality Medicaid Project: The SD Department of Social Services will be working on a new project supported by IBM to collaborate on maternal mortality and severe maternal morbidity data. This new data will give the DOH further insight into the population most affected by severe maternal morbidity and mortality and lead to enhanced prevention efforts
- SD Maternal Mortality Review Committee: Further prevention efforts around the topic of maternal mortality and morbidity will come from a SD Maternal Mortality Review Committee (MMRC). The DOH aims to have the SD MMRC established by the end of 2020 and begin reviewing deaths in 2021. This multidisciplinary group will provide recommendations for prevention of maternal mortality that can be implemented through MCH.

III.F. Public Input

The Department of Health (DOH) made the FY 2021 MCH block grant priorities and action plan available for public review and comment via the DOH website and targeted outreach to over 100 partners. MCH Impact Team members, as well as the Needs Assessment Advisory committee, were asked to share with any partners that would be involved in MCH activities and initiatives. These team members and partners then in turn shared the summary via Facebook pages, websites, listservs, newsletters, and email. A few of the partners reached were SD Parent Connection and the families they serve, Infant Death Review team members, Newborn Metabolic Screening program partners, Newborn Hearing Screening program partners, parent focus group participants, Birth to 3 Early Intervention families and providers, Dept. of Social Services Child Care Services, Personal Responsibility Education Program partner, and Developmental Disabilities Council members. In addition, the summary was provided to DOH field offices to display for clients to request, review, and provide comments on the state plan. The public comment posting can be found here https://doh.sd.gov/news/MCH-comment.aspx.

The DOH received three responses to the request for public comment. One comment focused on support for the Department of Human Services Family Support 360 Program, which houses the respite care program supported in part through CYSHCN. Two comments requested the addition of oral health as a national priority measure for the South Dakota block grant application.

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

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

III.G. Technical Assistance

Within the next five-year plan, the MCH team leadership will explore the opportunity for training to address health equity, family partnership development and continued assistance to support evidenced-based or informed practice. In the next year, the MCH team will be trained on a framework like Collective Impact to develop multi-sector partnerships outside of state government. This will be critical to the success of strategies for each NPM and SPM. Training will also be provided on cultivating family engagement and developing leaders as crucial to sustaining our goals and objectives.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Medicaid-DOH MOU 6-2020.pdf

V. Supporting Documents

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

Supporting Document #01 - YouthSurveyReport2019.pdf

Supporting Document #02 - OCFS_PartnerReport_2019.pdf

Supporting Document #03 - CommunitySurveyReport2019.pdf

Supporting Document #04 - ChildHealth_DataBrief_2019.pdf

Supporting Document #05 - OCFS_NeedsAssessment_FocusGroupFindings.pdf

VI. Organizational Chart

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

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: South Dakota

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,194,925	
A. Preventive and Primary Care for Children	$ 719,740	(32.7%)
B. Children with Special Health Care Needs	$ 692,180	(31.5%)
C. Title V Administrative Costs	$ 75,000	(3.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,486,920	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 514,881	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 40,940	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,100,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,655,821	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 3,850,746	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 21,996,626	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 25,847,372	

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 88,700
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 149,723
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 213,314
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 261,690
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 245,053
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,150,952
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 110,048
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 999,404
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 18,730,977
Department of Justice > Office of Violence Against Women > DOJ Sexual Assault Training	$ 46,765

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,149,068		$ 2,074,993	
A. Preventive and Primary Care for Children	$ 687,702	(32%)	$ 678,205	(32.6%)
B. Children with Special Health Care Needs	$ 644,721	(30%)	$ 652,116	(31.4%)
C. Title V Administrative Costs	$ 85,962	(4%)	$ 74,659	(3.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,418,385		$ 1,404,980	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,695,079		$ 1,609,382	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 117,472		$ 39,373	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,378,312		$ 1,153,643	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 3,190,863		$ 2,802,398	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 5,339,931		$ 4,877,391	
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)	$ 20,487,960		$ 21,996,626	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 25,827,891		$ 26,874,017	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 159,943	$ 88,700
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 149,723
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,428	$ 213,314
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 276,251	$ 261,690
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,010,338	$ 1,150,952
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 110,048
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 245,053
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,284,000	$ 999,404
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 17,000,000	$ 18,730,977
Department of Justice > Office of Violence Against Women > DOJ Sexual Assault Training		$ 46,765

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Indirect costs are only earned on the first $25000 of contracts	
2.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: In FFY19 used less local resources and more state resources were expended.	
3.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Program income revenues were greater than budgeted.	

Data Alerts: None

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

State: South Dakota

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 261,820	$ 246,909
2. Infants < 1 year	$ 359,340	$ 338,738
3. Children 1 through 21 Years	$ 719,740	$ 678,205
4. CSHCN	$ 692,180	$ 652,116
5. All Others	$ 86,845	$ 84,366
Federal Total of Individuals Served	$ 2,119,925	$ 2,000,334

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 479,000	$ 478,902
2. Infants < 1 year	$ 862,000	$ 861,337
3. Children 1 through 21 Years	$ 1,039,000	$ 1,038,686
4. CSHCN	$ 307,000	$ 306,556
5. All Others	$ 61,000	$ 60,595
Non-Federal Total of Individuals Served	$ 2,748,000	$ 2,746,076
Federal State MCH Block Grant Partnership Total	$ 4,867,925	$ 4,746,410

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: South Dakota

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 71,192	$ 71,192
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 71,192	$ 71,192
2. Enabling Services	$ 1,175,863	$ 1,085,914
3. Public Health Services and Systems	$ 947,870	$ 917,887
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		$ 31,720
Physician/Office Services		$ 4,052
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 5,746
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 4,061
Laboratory Services		$ 25,579
Other		
Targeted Case Management		$ 34
Direct Services Line 4 Expended Total		$ 71,192
Federal Total	$ 2,194,925	$ 2,074,993

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 1,736,423	$ 1,736,423
3. Public Health Services and Systems	$ 1,065,975	$ 1,065,975
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 2,802,398	$ 2,802,398

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

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

State: South Dakota

Total Births by Occurrence: 12,223 **Data Source Year: 2019**

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	12,152 (99.4%)	312	20	20 (100.0%)

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

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Infant Hearing Screening	11,734 (96.0%)	244	26	10 (38.5%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

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

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Infant Hearing Screening - Referred For Treatment**
	Fiscal Year:	**2019**
	Column Name:	**Other Newborn**

Field Note:
The number referred for treatment is less than the number of confirmed cases. This is due to the 2019 data not yet being complete. Additionally, referral to early intervention service data is not available to the DOH.

Data Alerts: None

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

State: South Dakota

Annual Report Year 2019

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

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,474	30.0	0.0	67.0	3.0	0.0
2. Infants < 1 Year of Age	96	30.0	0.0	67.0	3.0	0.0
3. Children 1 through 21 Years of Age	12,079	26.0	0.0	70.0	4.0	0.0
3a. Children with Special Health Care Needs	1,282	42.0	0.0	56.0	2.0	0.0
4. Others	10,332	9.0	0.0	84.0	7.0	0.0
Total	23,981					

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

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	11,893	Yes	11,893	66	7,849	1,474
2. Infants < 1 Year of Age	12,574	No	12,224	99	12,102	96
3. Children 1 through 21 Years of Age	253,386	Yes	253,386	54	136,828	12,079
3a. Children with Special Health Care Needs	45,001	Yes	45,001	51	22,951	1,282
4. Others	616,740	Yes	616,740	37	228,194	10,332

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2019**
	Field Note: Prenatal health review clients plus MCH case managed clients plus post-partum visits to women not risk assessed during pregnancy.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2019**
	Field Note: Infants vaccinated at Community Health Offices.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: Individuals vaccinated at Community Health Offices. Due to data limitations this data is for ages 1-24.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: Children with chronic conditions provided direct financial assistance plus child/families provided respite care services plus children provided special needs car seats plus children/families provided health education/referral assistance/care coordination via Family 2 Family provider.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: Adults vaccinated at Community Health Offices.	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2019**
	Field Note: Reflects those provided a direct or enabling service.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2019**
	Field Note: 2800 Parent/Infant Bright Start Welcome boxes (boxes discontinued after January 2019 when new Administration took office) plus 3256 letters sent to new mothers with Medicaid during reporting year plus 1800 PRAMS surveys sent to women during reporting year divided by federally provided 11893 pregnant women.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2019**
	Field Note: 12,153 infants receiving at least one newborn screen divided by 12,224 total births. This data does not include hearing screenings.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: 137,605 reached within Immunization Program divided by federal 253,386.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: NSCH 2017-18 shows 16.6% of SD children are CYSHCN so number of all children immunized in #3 137,605 times 16.6% equals 22,842. 22842 divided by federally available 45,001.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: 229,285 reached within Immunization Program divided by federal 616,740.	

Data Alerts: None

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

State: South Dakota

Annual Report Year 2019

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	11,228	7,984	403	628	1,581	202	10	395	25
Title V Served	4,591	2,240	260	490	1,211	128	20	242	0
Eligible for Title XIX	4,176	1,854	260	214	1,708	99	39	0	2
2. Total Infants in State	12,109	8,781	321	684	1,429	223	11	660	0
Title V Served	12,109	8,781	321	684	1,429	223	11	660	0
Eligible for Title XIX	5,240	2,471	349	263	2,002	99	55	0	1

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

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

State: South Dakota

A. State MCH Toll-Free Telephone Lines	2021 Application Year	2019 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 305-3064	(800) 305-3064
2. State MCH Toll-Free "Hotline" Name	Bright Start	Bright Start
3. Name of Contact Person for State MCH "Hotline"	Jennifer Folliard	Scarlett Bierne (see note 2)
4. Contact Person's Telephone Number	(605) 367-5374	(605) 773-4439
5. Number of Calls Received on the State MCH "Hotline"		884

B. Other Appropriate Methods	2021 Application Year	2019 Annual Report Year
1. Other Toll-Free "Hotline" Names	National Suicide Prevention Lifeline and Text4Hope	National Suicide Prevention Lifeline and Text4Hope (See note 3)
2. Number of Calls on Other Toll-Free "Hotlines"		4,371
3. State Title V Program Website Address	doh.sd.gov/family	doh.sd.gov/family
4. Number of Hits to the State Title V Program Website		74,544
5. State Title V Social Media Websites	See note 1b for list	See note 1a for list
6. Number of Hits to the State Title V Program Social Media Websites		135,917

Form Notes for Form 7:

1a. Social Media Websites Annual Report Year 2019
www.MunchCode.org (42 page views) *
www.Facebook.com/MunchCodeSD (this page is unpublished/no longer reported on)
www.ForBabySakeSD.com (15,418 page views)
www.Facebook.com/ForBabySakeSD (19,497 page consumptions)
http://doh.sd.gov/family/wic (3,792 page views)
http://doh.sd.gov/family/pregnancy/family-planning.aspx (1643 page views)
www.SDWIC.org (91,912 page views) **
https://www.facebook.com/SouthDakotaWIC/ (3,613 page consumptions)
*page views down significantly from 2018 due to loss of CDC federal funding for this project. Remaining content from this site has been moved to healthysd.gov (URL below)
**48,130/91,912 views are on the knowledge base side, meaning they are staff visits as opposed to consumer visits

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

2. Scarlett Bierne, previous MCH Director, was the contact person for the State MCH Hotline during the annual report year and through February 12, 2020. In April 2020 Jennifer Folliard became MCH Director and contact person for the hotline.

3. The SD Helpline Center crisis texting line was renamed "Text4Hope" in annual report year 2019.

Form 8
State MCH and CSHCN Directors Contact Information

State: South Dakota

1. Title V Maternal and Child Health (MCH) Director	
Name	Jennifer Folliard
Title	MCH Director
Address 1	4101 W 38th St
Address 2	STE 102
City/State/Zip	Sioux Falls / SD / 57106
Telephone	(605) 367-5374
Extension	
Email	jennifer.folliard@state.sd.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Whitney Brunner
Title	CYSHCN Director
Address 1	600 E Capitol Ave
Address 2	
City/State/Zip	Pierre / SD / 57501
Telephone	(605) 773-4749
Extension	
Email	whitney.brunner@state.sd.us

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

Form Notes for Form 8:

None

Form 9
State Priorities – Needs Assessment Year

State: South Dakota

Application Year 2021

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

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: South Dakota

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

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	45.2	6.3	51	11,285
2016	39.5	5.9	45	11,398
2015	39.4	6.9	33	8,385
2014	46.8	6.5	52	11,122
2013	45.5	6.5	50	10,988
2012	33.1	5.5	36	10,873
2011	36.3	5.8	39	10,742
2010	40.7	6.2	43	10,554
2009	56.5	7.3	61	10,796
2008	40.8	6.2	44	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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2018	16.4	5.2	10	60,921

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 6 - Notes:

None

Data Alerts: None

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

Data Source: CMS Hospital Compare

Multi-Year Trend

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

Legends:

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	255.5	45.9	31	12,134
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
2017	115.4	30.9	14	12,134
2016	122.2	31.6	15	12,275
2015	218.9	42.2	27	12,336
2014	114.0	30.5	14	12,283
2013	130.6	32.7	16	12,248
2012	90.9	27.4	11	12,104
2011	92.9	28.0	11	11,846
2010	118.5	31.7	14	11,811
2009	134.1	33.5	16	11,934

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - 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
2018	8.2 %	1.0 %	913	11,086
2017	8.3 %	1.0 %	919	11,073

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - 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
2017	1.7	0.4	19	11,354
2016	1.8	0.4	21	11,528
2015	1.6	0.4	14	8,555
2014	1.6	0.4	18	11,255
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	1.3	0.4	14	10,849
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR
2008	NR	NR	NR	NR

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 11 - Notes:

None

Data Alerts: None

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

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

NOM 12 - Notes:

None

Data Alerts: None

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

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

NOM 13 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

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

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	29.8	4.2	51	171,187
2015_2017	24.1	3.8	41	170,094
2014_2016	23.4	3.7	40	171,242
2013_2015	14.5	2.9	25	171,823
2012_2014	19.1	3.3	33	172,681
2011_2013	17.4	3.2	30	172,774
2010_2012	24.3	3.8	42	172,983
2009_2011	29.3	4.1	51	173,766
2008_2010	33.2	4.4	58	174,643
2007_2009	35.1	4.5	62	176,399

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	29.2	4.1	50	171,187
2015_2017	30.0	4.2	51	170,094
2014_2016	28.0	4.1	48	171,242
2013_2015	29.1	4.1	50	171,823
2012_2014	22.6	3.6	39	172,681
2011_2013	22.0	3.6	38	172,774
2010_2012	20.8	3.5	36	172,983
2009_2011	24.2	3.7	42	173,766
2008_2010	28.6	4.1	50	174,643
2007_2009	24.9	3.8	44	176,399

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.3 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	16.6 %	1.5 %	35,046	211,653
2016_2017	16.1 %	1.3 %	33,876	210,513
2016	15.7 %	1.4 %	32,704	208,339

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.1 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	16.3 %	3.9 %	5,708	35,046
2016_2017	15.6 %	3.8 %	5,296	33,876
2016	9.6 %	1.9 %	3,144	32,704

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.2 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	1.3 %	0.4 %	2,259	173,786
2016_2017	1.5 %	0.5 %	2,649	171,841
2016	2.0 %	0.8 %	3,263	166,826

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.3 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	6.5 %	1.1 %	11,164	172,611
2016_2017	6.5 %	1.0 %	10,997	170,388
2016	7.0 %	0.9 %	11,719	166,311

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.4 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	66.8 %	6.6 %	12,005	17,965
2016_2017	60.9 %	5.9 %	10,629	17,449
2016	51.8 %	7.0 %	8,075	15,596

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 18 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	93.7 %	1.0 %	197,336	210,705
2016_2017	93.7 %	0.9 %	196,224	209,466
2016	92.7 %	1.1 %	191,296	206,419

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 19 - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	17.1 %	0.5 %	1,156	6,771
2014	17.1 %	0.5 %	884	5,179
2012	14.8 %	0.4 %	1,190	8,020
2010	17.3 %	0.4 %	1,363	7,884
2008	16.1 %	0.4 %	1,121	6,946

Legends:

Indicator has a denominator <50 and is not reportable

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2017_2018	11.9 %	2.3 %	10,969	91,796
2016_2017	13.6 %	2.3 %	11,680	86,126
2016	13.0 %	2.2 %	10,488	80,613

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 20 - Notes:

None

Data Alerts: None

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

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	5.2 %	0.7 %	11,133	214,180
2017	6.1 %	1.0 %	12,936	212,391
2016	4.3 %	0.8 %	9,120	213,902
2015	7.4 %	1.3 %	15,401	209,556
2014	7.3 %	1.2 %	15,285	209,494
2013	7.3 %	1.0 %	14,974	205,982
2012	3.9 %	0.8 %	7,869	204,137
2011	5.7 %	0.8 %	11,454	202,877
2010	7.1 %	1.2 %	14,562	204,414
2009	6.7 %	0.9 %	13,342	199,435

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, 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
2018	69.1 %	3.9 %	12,556	18,166
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 width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	67.2 %	2.2 %	136,681	203,394
2017_2018	64.4 %	2.0 %	128,145	198,957
2016_2017	63.2 %	2.4 %	125,737	199,014
2015_2016	70.8 %	2.0 %	139,014	196,236
2014_2015	64.4 %	2.4 %	124,290	192,937
2013_2014	68.5 %	2.1 %	131,211	191,596
2012_2013	73.2 %	3.3 %	140,455	192,009
2011_2012	58.2 %	2.6 %	107,634	184,949
2010_2011	53.7 %	4.6 %	100,976	188,037
2009_2010	56.5 %	2.6 %	95,462	168,959

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

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

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	68.7 %	2.9 %	39,413	57,365
2017	63.2 %	3.2 %	35,462	56,124
2016	55.9 %	3.4 %	30,966	55,423
2015	46.0 %	3.2 %	25,628	55,733

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	86.6 %	2.2 %	49,689	57,365
2017	79.5 %	2.8 %	44,628	56,124
2016	79.4 %	2.9 %	43,986	55,423
2015	72.4 %	2.9 %	40,325	55,733
2014	75.0 %	3.0 %	41,570	55,439
2013	70.0 %	3.3 %	38,650	55,198
2012	65.9 %	3.3 %	35,845	54,368
2011	54.4 %	5.2 %	29,467	54,183
2010	52.5 %	3.2 %	29,225	55,702
2009	39.6 %	3.4 %	22,002	55,527

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	85.3 %	2.2 %	48,920	57,365
2017	74.5 %	2.9 %	41,838	56,124
2016	65.7 %	3.2 %	36,400	55,423
2015	55.5 %	3.2 %	30,918	55,733
2014	57.0 %	3.4 %	31,618	55,439
2013	51.7 %	3.4 %	28,523	55,198
2012	40.0 %	3.5 %	21,743	54,368
2011	37.4 %	4.8 %	20,280	54,183
2010	30.9 %	3.0 %	17,198	55,702
2009	24.9 %	2.9 %	13,838	55,527

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	20.4	0.9	565	27,707
2017	22.6	0.9	614	27,226
2016	25.1	1.0	681	27,149
2015	26.5	1.0	720	27,214
2014	26.7	1.0	735	27,483
2013	29.4	1.0	812	27,650
2012	33.5	1.1	929	27,747
2011	34.3	1.1	964	28,066
2010	34.8	1.1	975	28,045
2009	38.7	1.2	1,092	28,228

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 23 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	13.0 %	1.2 %	1,435	11,037
2017	14.3 %	1.2 %	1,604	11,203

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were 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
2017_2018	2.9 %	0.7 %	6,216	211,542
2016_2017	3.1 %	0.7 %	6,559	210,083
2016	2.3 %	0.7 %	4,772	207,703

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: South Dakota

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

Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	70.7	71	70.5	67.6
Annual Indicator	69.8	69.0	65.0	77.6
Numerator	98,560	98,280	92,476	110,174
Denominator	141,180	142,541	142,186	141,888
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	79.6	80.5	81.5	82.5	83.4	84.4

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective	88.2	88.9	92.4	89.3
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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	89.1	90.2	91.2	92.3	93.3	94.4

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			39.2
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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	41.8	41.8	41.9	42.0	42.1	42.1

Field Level Notes for Form 10 NPMs:

None

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

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

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	48.4	49.2	49.9	50.7	51.5	52.2

Field Level Notes for Form 10 NPMs:

None

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

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

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	41.4	41.9	42.4	42.9	43.4	43.9

Field Level Notes for Form 10 NPMs:

None

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

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

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	299.2	295.8	292.3	288.9	285.4

Field Level Notes for Form 10 NPMs:

None

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

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

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	53.4	53.7	53.9	54.1	54.4	54.6

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: South Dakota

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

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

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: South Dakota

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	46.4	47.1	47.9	48.7	49.4

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Improve data sharing with partners and the public and collaborate with new partners to enhance MCH data by increasing the number of new data sharing projects accomplished from zero to four by September 30th, 2021.

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - Percentage of children, ages 2-5, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		29.4	32.1	32
Annual Indicator	36.1	33.1	33.1	33.9
Numerator	1,868	2,415	2,171	3,236
Denominator	5,179	7,295	6,562	9,545
Data Source	FAD NOM 20 WIC data	PedNss	PedNSS	PedNSS
Data Source Year	2014	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

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

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

Field Level Notes for Form 10 SPMs:

None

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

State: South Dakota

ESM 1.1 - % of WIC clients with a positive response to PHQ 2 that received a PHQ 9 screening

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

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

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

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

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

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

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

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

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure that all women are aware of the importance of annual well women visits.

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			100
Annual Indicator			76.2
Numerator			48
Denominator			63
Data Source			DOH detail sheets
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.3 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure implementation of infant safe sleep practices.

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			100
Annual Indicator			80
Numerator			48
Denominator			60
Data Source			DOH detail sheets
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 6.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to improve early identification and referral of developmental delays.

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			100
Annual Indicator			88.9
Numerator			32
Denominator			36
Data Source			DOH detail sheets
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

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

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

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure access to a medical home.

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			100
Annual Indicator			83.3
Numerator			30
Denominator			36
Data Source			DOH detail sheets
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: South Dakota

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Improve young peoples' (10 to 24 years) relationships by increasing education and support, STI prevention, and pregnancy prevention.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td># of individuals answering “very true” to the entry survey question: “I would talk to a trusted adult (for example, a family member, teacher, counselor, coach, etc.) if someone I am dating or going out with makes me uncomfortable, hurts me, or.....</td></tr>
<tr><td>Denominator:</td><td>total # of individuals who completed the above question on the entry survey</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>SRAE and PREP entry survey</td></tr>
<tr><td>Significance:</td><td>Relationships are an important part of adolescent development. Adolescence is a time for young people to explore and develop relationships by connecting with peers, parents, teachers, or a romantic partner. These relationships might be healthy or unhealthy, and can be emotional, physical, or sexual. A comprehensive approach of covering education and support for healthy relationships, STI prevention, and teen pregnancy prevention is key to achieving healthy relationships in adolescence.</td></tr>
</table>

SPM 2 - Improve data sharing with partners and the public and collaborate with new partners to enhance MCH data by increasing the number of new data sharing projects accomplished from zero to four by September 30th, 2021.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increased data sharing and collaboration
Definition:	**Numerator:** Number of data sharing projects **Denominator:** N/A **Unit Type:** Count **Unit Number:** 7
Data Sources and Data Issues:	Count of the number of new data sharing projects completed by the DOH and partners on this SPM
Significance:	Data sharing and collaboration are evidence-based strategies for improving health equity. Disaggregated data that is available to communities can lead to a better understanding of local conditions and help monitor progress toward achieving health equity. Linking data sets and sharing resources across sectors will lead to a more robust understanding of the health of South Dakotans. Data sharing and collaboration were common themes during the needs assessment process across all population domains, thus making it ideal for the cross-cutting state performance measure.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - Percentage of children, ages 2-5, receiving WIC services with a BMI at or above the 85th percentile (overweight or obese)
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Promote positive child and youth development to reduce morbidity and mortality</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td># of children aged 2 to 5 years receiving WIC with a BMI at or above 85th percentile (overweight or obese)</td></tr>
<tr><td>Denominator:</td><td># of children aged 2 to 5 years receiving WIC</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>NWS-10.1: Reduce the proportion of children aged 2 to 5 years who are considered obese</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>PedNSS</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

2016-2020: SPM 4 - MCH data are analyzed and disseminated
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Improve state and local surveillance, data collection, and evaluation capacity
Definition:	**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 1.1 - % of WIC clients with a positive response to PHQ 2 that received a PHQ 9 screening
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Address mental health in women by measuring the percentage of WIC clients with a positive response to PHQ 2 that received a PHQ 9 screening.
Definition:	**Numerator:** # of WIC clients with a positive response to PHQ 2 that received a PHQ 9 screening **Denominator:** # of positive PHQ 2 generated from the WIC assessment **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	code added to the state's Time Keeping System for a PHQ 9 screening
Significance:	A Pregnancy and Postpartum WIC Assessment provides a critical opportunity to identify mental health needs and improve subsequent maternal and perinatal outcomes by providing appropriate referrals to address mental health issues.

ESM 1.2 - % of WIC clients whose PHQ 9 score met criteria for a referral and were referred
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Address mental health in women by measuring the percentage of WIC clients whose PHQ 9 score met criteria for a referral and were referred
Definition:	**Numerator:** # of WIC clients whose PHQ 9 score met criteria for a referral and were referred **Denominator:** # of WIC clients whose PHQ 9 score met criteria for a referral **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Statistics kept by Community Health Offices
Significance:	A Pregnancy and Postpartum WIC Assessment provides a critical opportunity to identify mental health needs and improve subsequent maternal and perinatal outcomes by providing appropriate referrals to address mental health issues.

ESM 5.1 - % of Child Death Review (CDR) team members who scored above 80% on a post-test
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Determine the effectiveness of training provided to CDR team members by measuring the % of team members who scored above 80% on a training post-test.
Definition:	**Numerator:** # of CDR team members who scored above 80% on a post-test **Denominator:** # of CDR team members who took post-test **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Manual tally of post-test scores
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 5.2 - % of in-home daycares who responded to survey and indicate that they follow safe sleep guidelines NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Collaborate with diverse, multi-sector organizations/agencies to promote safe sleep by providing safe sleep materials to in-home daycares and measuring the % of in-home daycares who respond to a survey and indicate they follow safe sleep guidelines
Definition:	**Numerator:** # of in-home daycares who respond to survey and indicate they follow safe sleep guidelines **Denominator:** # of in-home daycares who respond to survey **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Survey distributed to in-home daycares
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 6.1 - % of Community Health Offices that distribute tracking cards
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Provide parenting education on developmental screening by providing trifold developmental screening tracking cards at Community Health Offices
Definition:	**Numerator:** # of Community Health Offices that distribute tracking cards **Denominator:** # of Community Health Offices **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Reporting from Community Health Offices
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. Parenting education on the importance of developmental screening is critical to increase screening rates and improve child outcomes.

ESM 7.2.1 - # of students trained in teen Mental Health First Aid
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	Address suicide prevention and mental health in adolescents by promoting evidence-based programs and practices that increase protection from suicide risk
Definition:	**Numerator:** # of students trained in teen Mental Health First Aid **Denominator:** N/A **Unit Type:** Count **Unit Number:** 300
Data Sources and Data Issues:	# of class participants reported by training facilitator to have completed the teen mental health first aid curriculum
Significance:	New evidence-based curriculum for youth that teaches high school students how to identify, understand and respond to signs and symptoms of mental health or substance abuse.

ESM 11.1 - % of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Improve access to care and services for CYSHCN by measuring the effectiveness of the Sanford Care Coordination Program.
Definition:	**Numerator:** # of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services **Denominator:** # of families enrolled in care coordination services **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	pre-care coordination and post-care coordination surveys of clients provided by South Dakota State University Population Health
Significance:	The AAP specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard 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 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure that all women are aware of the importance of annual well women visits.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Promote preconception/inter-conception health and promote oral health
Definition:	**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.

2016-2020: ESM 5.3 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure implementation of infant safe sleep practices.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

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

2016-2020: ESM 6.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to improve early identification and referral of developmental delays.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

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.

2016-2020: ESM 10.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to increase the percent of adolescents with an annual preventive medical visit.
2016-2020: NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

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.

2016-2020: ESM 11.2 - The degree to which the South Dakota Title V program has implemented evidence-based or informed strategies to assure access to a medical home.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

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

Form 11
Other State Data

State: South Dakota

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

Form 11 Data