

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **SD**

APPLICATION YEAR: **2005**

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Copies of the assurances and certifications are maintained in the State Maternal and Child Health (MCH) program's central office. To receive a copy of the assurances and certifications, contact:

Kayla Tinker, Administrator
Office of Family Health
South Dakota Department of Health
615 East Fourth Street
Pierre, South Dakota 57501-1700
(605) 773-3737
kayla.tinker@state.sd.us

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This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

State performance measures were developed based on the state's comprehensive needs assessment. The Department of Health (DOH) made the FY 2005 MCH block grant available for public review and comment via the DOH web site at www.state.sd.us/doh. A summary of the plan was put out on the web site on May 6, 2004 with comments due back to the DOH by July 2, 2004. Information on how to obtain a complete copy of the application for review was made also provided on the web site. No written comments were received. In South Dakota, the MCH program interacts daily with the MCH population and related providers. This allows the MCH program to respond to any identified areas of need and build those recommendations into the annual plan prior to the block grant being available for public review.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

South Dakota is one of the least densely populated states in the nation with 754,844 people living within its 75,955 square miles for an average population density of 9.9 people per square mile (2000 Census). Over half (34) of the state's 66 counties are classified as frontier (population density of less than six persons per square mile) while 29 are considered rural (population density of six or more persons per square mile but no population centers of 50,000 or more). Three counties are classified as urban (have a population center of 50,000 or more). Of the state's total population, 88.7 percent are White (of which 99.3% are White alone, not Hispanic or Latino), 8.2 percent are Native American and the remaining 3.1 percent are classified as some other race.

Many of the Indian reservation counties in South Dakota are considered to be the poorest in the nation, with Shannon County being the poorest.

/2003/ According to the 1990 Census, 15.9 percent of South Dakotans live below 100 percent of the federal poverty level (FPL) compared to 13.1 percent for the nation. Over 40 percent (40.9%) of South Dakotans live under 200 percent of the FPL compared to 30.9 percent for the U.S. When looking at poverty levels for counties on Indian reservations in the state, these numbers are significantly higher.
/2004/ According to the 2000 Census, 13.2 percent of South Dakotans live below 100 percent of the federal poverty level (FPL) compared to 12.4 percent for the nation. Over 33 percent (33.1%) of South Dakotans live under 200 percent of the FPL compared to 29.6 percent for the U.S. Poverty rates for counties on Indian reservations in the state are significantly higher.

/2002/ Over one-quarter (28.5%) of the state's population are children (under the age of 18) while 7.8 percent of the population is under the age of five. Forty two percent of the state's female population is considered to be of childbearing age (aged 15 through 44). South Dakota resident pregnancies totaled 11,005 in 1999 (26 of those were to women not in the 15-44 year age range).

/2003/ Over one-quarter (26.8%) of the state's population are children (under the age of 18) while 6.8 percent of the population is under the age of five. Just over forty one percent (41.5%) of the state's female population is considered to be of childbearing age (aged 15 through 44). South Dakota resident pregnancies totaled 10,947 in 2000 (33 of those were to women not in the 15-44 year age range).

/2004/ South Dakota resident pregnancies totaled 10,086 in 2001 (34 of those were to women not in the 15-44 year age range).

//2005/ South Dakota resident pregnancies totaled 11,570 in 2003 (26 of those were to women not in the 15-44 year age range). //2005//

Pregnancies were estimated by totaling resident births (pregnancies producing at least one live birth), fetal deaths and abortions.

Access to primary care physicians is limited in the state. According to a survey conducted by the DOH Office of Rural Health, there were 1,246 active physicians licensed in South Dakota in 2000. Of those, 56.7 percent practiced in an urban location (defined as the three most populous counties -- Minnehaha, Lincoln and Pennington), 30.3 percent practiced in a large, rural area (the next 11 most populous counties) and 12.9 percent practiced in a small rural area (all other counties). Of the 1,246 licensed physicians, 576 are considered primary care physicians (i.e., family practice -- 281, internal medicine -- 155, pediatrics -- 57, OB/GYN -- 55, or general practice -- 28). There are also 305.15 FTE primary care midlevel practitioners (i.e., physician assistants, nurse practitioners, and nurse midwives) located in the state. Over two-thirds of the state is designated by the federal government as a Health Professional Shortage Area.

/2002/ South Dakota has 49 community hospitals (excluding federally financed and specialty hospitals), 18 federally qualified health centers (FQHCs), 55 rural health clinics (RHCs), and 19 Indian health centers.

/2003/ South Dakota has 51 general community hospitals, of which 27 are critical access hospitals, as well as five IHS hospitals and three VA hospitals. There are 22 federally qualified health center (FQHCs) sites, 57 rural health clinics, and 19 Indian health centers.

//2005/ There are 546 FTE primary care physicians and 214 FTE primary care midlevel

practitioners in South Dakota. There are 34 CAHs, 24 FQHCs and 56 licensed rural health clinics in South Dakota. //2005//

As discussed above, the economic status of individuals in the state, particularly the Native American population, is a major barrier to access to services. Another factor to consider is transportation to access services. For some, this means traveling great distances (over 50 miles) to see a primary care provider, and even further to see a specialist. On the Indian reservation, this problem is further complicated by the lack of a reliable transportation system.

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

Medicaid Managed Care -- The Medicaid Managed Care program is designed to improve access to medical care as well as improve the quality of care received. Recipients are required to receive covered services from a primary care provider (PCP) and/or have medically necessary specialty services prior referred/authorized by their PCP. Eligibility categories that must participate in the managed care program include: (1) Supplemental Security Income (SSI) recipients; (2) TANF-eligible families, or qualified low income families; (3) low income children; and (4) pregnant women. Approximately two-thirds of the state's Medicaid population participate in the program.

Children's Health Insurance Program (CHIP) -- CHIP provides free health insurance to children under age 19 who meet certain eligibility guidelines. CHIP covers doctor appointments, hospital stays, dental/vision services, prescription drugs, mental health care, and other medical services. CHIP provides health insurance coverage to uninsured children whose family income is up to 200% of the FPL (\$35,200 for a family of four). Children who already have private health insurance may also be eligible for CHIP to pay deductibles, co-payments and other medical services not covered by their private policy. Census Population Survey (CPS) data for 1998 estimate that South Dakota has 13,000 uninsured children under age 19 whose family income was at or below 200% of FPL. Since CHIP was implemented in July 1998, DSS outreach efforts have reduced that number by 9,000 (69%) through increases in both CHIP and Medicaid. There are currently 45,618 children receiving assistance -- of which 3,516 children are covered under CHIP and 42,102 children are covered under Medicaid. /2003/ Since the inception of CHIP on July 1, 1998, DSS outreach efforts have increased the number of children with health insurance coverage. The 2001 Annual Report of the State Children's Health Insurance Plan Under Title XXI of the Social Security Act reported that there were 34,890 children enrolled (Medicaid and SSI) on 06-30-98 which was the last quarter prior to CHIP implementation. At the end of the 4th Quarter of FFY '01 (ending 09-30-2001) there was a total enrollment of 54,564 children (total Medicaid and CHIP children including children on SSI). /2004/ At the end of the 4th Quarter of FFY '02 (ending 09-30-2002) total enrollment was 59,479. **/2005/ At the end of FFY '03 (ending 09-30-03) total enrollment was 62,733. //2005//**

In early 2001, the DOH was one of 20 states to be awarded a State Planning Grant (SPG) through the Health Resources and Services Administration (HRSA) to conduct a one year, in-depth analysis of the most effective methods for providing access to affordable health insurance coverage for all uninsured South Dakotans.

/2002/ At the end of the grant period, a report will be submitted to the Secretary of the U.S. Department of Health and Human Services detailing South Dakota's plan to provide access to health insurance coverage for all uninsured South Dakotans. The grant offers a unique opportunity to study the state's uninsured population and devise realistic options to address this important public health issue.

/2003/ The state contracted with The Lewin Group, a Washington, D.C. area research firm to conduct the study during the summer and fall of 2001. It included statewide telephone surveys of more than

20,000 households and also of 401 South Dakota employers. Eight focus group interviews were also conducted with selected high-risk population such as farmers and ranchers, Native Americans, and low-income households. Key findings of the study include: (1) 8.1 percent of South Dakotans are without health insurance; (2) only 4.4 percent of children under age 19 were without health insurance; (3) more than one-quarter of the uninsured were without health insurance for one year or less - however, about 42 percent were without coverage for five years or more; (4) 80 percent of those surveyed report high premium costs as a major obstacle to securing coverage; (5) uninsurance varies by geographic region - the lowest rate was in the southeast region (7.1%) while the highest rates were in the south central (10.6%) and northwest (12.1%) regions of the state; (6) 84.3 percent of the uninsured are either employed or the dependent children or spouses of the employed; (7) about 55 percent of private employers in South Dakota offer health insurance to their employees, with recruiting and retaining employees the primary reason; (8) on average, employers pay 81 percent of the worker's insurance premium, and 39 percent of his/her dependent premium; and (9) about 18 percent of surveyed employers in the state are self-insured, accounting for approximately 61 percent of the workforce.

/2004/ A task force was appointed in August 2002 to take the findings of the Lewin Report and develop recommendations for addressing the issue of uninsured South Dakotans. While legislation did not pass during the 2003 legislative session, discussions by the Legislature on several risk pool bills did lay the groundwork for a special session which was called by Governor M. Michael Rounds on June 27, 2003. The Legislature passed legislation creating a risk pool to provide health insurance coverage for South Dakota residents who lose their existing medical health insurance through no fault of their own. The risk pool will become effective on August 1, 2003 and replaces the requirements that were put in place to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) guarantee issue provisions and will help stabilize the individual insurance market in the state.

/2005/ As of June 1, 2004, there were 462 individuals enrolled in the risk pool. Since the risk pool was implemented, the individual insurance market in South Dakota has stabilized and several companies have entered the individual insurance market in South Dakota. //2005//

/2004/ The state's public health preparedness and response efforts for a bioterrorism event or other public health emergency are directed by the DOH Office of Public Health Preparedness and Response. The DOH is utilizing a portion of the bioterrorism funding it is receiving to strengthen the public health infrastructure in South Dakota. DOH field staff providing MCH services are benefiting from this funding through improvements in computer and communication systems. Most of the nurses on the MCH staff have been vaccinated as part of the department's smallpox vaccination plan and would be available to respond to such an outbreak.

Systems development for women, infants, children, adolescents, and CSHCN is an integral part of the MCH planning process. This includes analyzing of current programs and services, identifying gaps in services, establishing appropriate goals and objectives, collaborating with partners, and establishing methods for monitoring and evaluating programs and services to ensure that goals and objectives are met.

/2004/ The MCH team used the CAST 5 self assessment tool with facilitation assistance provided by Karen Van Landeghem in early 2002. This process helped the MCH team examine performance related to the core public health functions and identify specific capacity building needs. The MCH program used this process to examine existing capacity and assist programs in aligning efforts within an overall system and population-based approach. Results of the CAST 5 process clearly point to needs in data capacity and infrastructure building. Smaller MCH team workgroups have been established to start to address these two needs identified.

A MCH Assessment, Planning and Monitoring Process has been initiated utilizing the MCH Team. The process is data driven, with the starting point of assessing the needs of the MCH population groups using Title V health status and system capacity indicators, performance measures, and other quantitative and qualitative data. The process focuses on needs, priorities, targets, and activities -- not specific programs or individuals. When completed the process will have addressed the above for

all MCH population groups.

The MCH Team began the process with the child and adolescents population group. The Team discussed national and state performance measures, determining if objectives were met or unmet. Health system capacity and health status indicators, and data sets used were analyzed. Additional data sources to assist in assessment of this population group were identified. Ongoing and emerging issues impacting this population group were also identified. As a result of this process, a matrix was developed that identified needs, data sources, performance measures and indicators relevant to the needs, linkage to HP 2010 Objectives, gaps in data or data needs, and identification of a lead agency. The MCH Team then determined level of responsibility relative to the MCH Program. This process allowed for prioritization of the needs of this population group and the role of MCH in addressing them. Current activities and new or proposed activities were discussed to meet the needs, as prioritized.

This process is ongoing. The following steps will be implemented formally for each population group and then continue in conjunction with the state's budget process and MCH Block Grant application requirements -- Assess Needs, Examine Capacity, Select Priorities, Set Targets, Identify Activities, Allocate Resources, Monitor and Evaluate.

B. AGENCY CAPACITY

The DOH is charged with the protection of the public health by appropriate measures set forth and authorized by state law. The DOH is designated as the sole state agency to receive, administer and disburse federal Title V monies. South Dakota Codified Law (SDCL) 34-1-21 authorizes the DOH to adopt rules to administer the Title V program relating to MCH and CSHCN services. Administrative Rules of South Dakota (ARSD) 44:06 provides guidance on the delivery of children's special health services (CSHS) and outlines general operation of the program, eligibility requirements, providers, family financial participation, claims, and scope of benefits. SDCL 34-24-17 requires all infants born in the state to be screened for the metabolic diseases of phenylketonuria (PKU), hypothyroidism and galactosemia and ARSD 44:19 contains the rules regulating screening for these diseases.

Within the DOH, the Division of Health and Medical Services (HMS) is the health care services delivery arm of the DOH and administers MCH services. HMS consists of four offices and the State Epidemiologist.

OFFICE OF FAMILY HEALTH (OFH)

OFH administers the MCH Block Grant for the DOH. OFH staff provide training and ongoing technical assistance to DOH field staff as well as private health care providers who deliver MCH services. Staff are responsible for the development of policies and procedures relevant to the delivery of MCH services for pregnant and postpartum women, infants, children, adolescents, and CSHCN. OFH works closely with field staff on data collection needed for federal and state reports as well as for program evaluation.

The CSHS program directs care coordination services for children with chronic illness, disabling conditions and other special health care needs. CSHS also coordinates diagnostic and consultative outreach pediatric specialty clinics and provides financial assistance for specified conditions and procedures on a cost share basis.

/2004/ Telemedicine clinics have also been implemented at the Pierre, Aberdeen and Rapid City sites to further enhance access to specialty care.

The Perinatal program provides direction and technical assistance for primary and preventive care for women and infants including risk assessment and care coordination of pregnant women, perinatal education, prenatal/Bright Start home visits, developmental screenings, immunizations for infants/toddlers, sudden infant death syndrome (SIDS), and newborn metabolic and hearing screenings.

The DOH has utilized both MCHB Universal Newborn Hearing Screening funds as well as CDC Early Hearing Detection and Intervention (EHDI) funding to establish newborn hearing screening programs in all hospitals in the state that deliver babies. The Newborn Hearing Screening Program provides technical assistance and training to hospitals in the state regarding newborn hearing screening. The program has worked closely with the Office of Data, Statistics and Vital Records to develop the Electronic Vital Records and Screening System (EVRSS) which is a centralized system that incorporates web technology to improve the current vital records system as well as newborn metabolic and hearing screening data collection processes. Statewide implementation of EVRSS began on February 11, 2003. This will help assure minimal loss to follow-up by monitoring the status and progress of infants through the system in an effort to further achieve the state's goal of screening by one month of age, evaluation from a diagnostic audiologist by three months of age, and early intervention by six months of age.

/2004/ To continue the development of the program, facilities are being trained on their role in the Newborn Hearing Screening Program. For infants who do not pass their first two screenings, they are referred to their medical doctors for a medical and evaluation and a diagnostic audiologist for an auditory evaluation. All of the results from these evaluations are to be entered by the appropriate facility into EVRSS. The intention of centralizing all of this information is to have the capability of following and tracking infants to insure proper and appropriate intervention in a timely manner.

The Public Health Nutrition program is responsible for developing and managing nutrition activities for the DOH. The State Nutritionist serves as a spokesperson on issues that affect the nutritional health of the state and recommends appropriate nutrition interventions.

/2005/ The State Nutritionist position was transferred to the Office of Health Promotion and continues to coordinate MCH nutrition activities. //2005//

The Women, Infants and Children (WIC) program provides nutrition education, supplemental nutritious food and referrals for pregnant, breastfeeding and post-partum women, infants and children up to age five. Clients must meet income eligibility and be at nutritional risk.

The Family Planning program offers men and women of childbearing age reproductive health education, contraceptive counseling and methods, physical examinations, and sexually transmitted disease (STD) counseling, testing and treatment. Payment for family planning services is based on a sliding fee schedule according to family size and income.

Through a Title X Research and Development grant originally received in FY 2000, the DOH has developed a partnership with Youth and Family Services (YFS) in Rapid City to increase male involvement in family planning and reproductive health. Long term goals of the project are increased responsibility of males to use contraceptives if sexually active, reduced unintended pregnancy rates and improved overall health of the community. The intended impact is increased self-responsibility related to sexual behavior and increased awareness and knowledge of reproductive health issues among male youth exposed to educational, clinical and counseling services.

/2003/ YFS staff began serving young males in March 2000.

/2005/ During CY 2003, YFS provided education and advocacy services to 474 young males under the collaborative partnership. In October 2003, YFS received \$250,000 in funding for their project directly from DHHS Office of Population Services. //2005//

Through Title X special initiative funding, the DOH has also increased the availability of family planning services through partnerships with Urban Indian Health (UIH) in Aberdeen, Pierre and Sioux Falls. Although family planning services are available in these communities, it was found that clients referred from Urban Indian Health were not always finding their way to the Title X clinic. In addition, UIH has not been able to maintain a pharmacy within their agencies. Through this partnership, the DOH will provide prescription and non-prescription birth control methods listed on the DOH Family Planning formulary and UIH will provide counseling, education and medical services required by Family Planning. In addition, partnerships with selected FQHCs in Elk Point, Alcester and DeSmet are being developed in order to increase the availability of Title X family planning services in rural communities.

//2005/ These partnerships with UIH and the FQHCs served a total of 207 men and women in need of family planning services. //2005//

OFFICE OF HEALTH PROMOTION (OHP)

OHP coordinates a variety of programs designed to promote health and prevent disease. The All Women Count! Breast and Cervical Cancer Control program coordinates statewide activities to promote early detection of breast and cervical cancer. The program pays for screening tests for women who are underinsured and meet age and income guidelines. The All Native Women Count! program provides services at the Sioux San IHS Hospital to Native American women residing in Pennington County. The Cancer Registry program ensures the coordination of cancer reporting in the state.

The All Women Count! Chronic Disease Screening program reimburses health care providers for screening, diagnosis and patient education for diabetes and cardiovascular disease. The Diabetes Control Program ensures that people with diabetes are diagnosed and entered into the health care system, provides educational materials, promotes screening for gestational diabetes, and provides blood glucose monitors to pregnant women with diabetes.

The mission of the Diabetes Prevention and Control Program is to design, implement, and evaluate public health prevention and control strategies that improve access to and quality of diabetes education for all persons with diabetes in South Dakota; to reach those communities most impacted by the burden of diabetes; and to deliver a broad range of public health activities that will reduce death, disability, and costs related to diabetes and its complications.

The Child and Adolescent Health Program coordinates a variety of programs designed to promote health, prevent disease and reduce morbidity and mortality among children and adolescents, including school health guidance, intentional and unintentional injury prevention (i.e., bicycle/ helmet safety, car safety, consumer product safety information, and suicide prevention).

//2005/ This program was transferred to the Office of Family Health. //2005//

The Coordinated School Health Program provides technical guidance and services to schools and is jointly administered with the Department of Education (DOE).

//2002/ The Tobacco Control Program which was recently transferred to the DOH oversees tobacco prevention and education activities for the state.

//2003/ The Tobacco Control Program coordinates state efforts to prevent young people from starting to use tobacco products, help current tobacco users quit, and reduce non-smokers' exposure to second-hand smoke. A toll-free Quit Line (1-866-737-8487) has been established that links smokers who are trying to quit to over-the-phone professional counseling sessions. Quit-smoking products and materials are also provided to those who participate in the Quit Line counseling sessions. The Tobacco Control Program is also working with four pilot communities in the state to help evaluate the effectiveness of different tobacco control approaches (i.e., use of effective school-based curriculums, encouraging tobacco-free policies, forming local coalitions to address prevention needs of citizens, promoting smoking cessation programs, and reducing exposure of children and teens to tobacco products and promotions).

//2004/ The Tobacco Control Program (TCP) continues to provide statewide telephone-based cessation services, serving over 17,000 people to date, including pregnant females and youth. The TCP sponsored more than 40 different community coalitions working on tobacco prevention at the local level, as well as a statewide conference to provide technical assistance to the coalition members. The TCP helped to develop a model for implementing proven prevention education lessons into existing middle school classrooms without overwhelming any one subject area, or sacrificing fundamental educational needs. Results from the first year of implementation are very positive for this model.

//2003/ The DOH recognizes oral health as a critical component of overall public health and had utilized the services of a contract to access dental consultant services during the early and mid 90's.

In the fall of 2001, the DOH made the commitment to allocate resources and an FTE to an oral health position to be located in the Office of Health Promotion. The department is currently actively recruiting to fill this position.

/2004/ The Oral Health Coordinator position was filled in August 2002.

/2004/ In February 2003, the DOH hired a Cardiovascular Health program coordinator who is responsible for collaborating with partners across the state to develop a statewide cardiovascular health plan.

OFFICE OF COMMUNITY HEALTH SERVICES AND PUBLIC HEALTH ALLIANCE (OCHS/PHA)

This office provides professional nursing and nutrition services and coordinates health-related services to individuals, families and communities across the state. Services include education and referral; immunizations; developmental screenings; management of pregnant women; WIC; family planning; nutrition counseling and education; screenings for vision, hearing, blood pressure, blood sugar, and hemoglobin; and many more. In most counties, these services are delivered at state DOH offices. In 12 Public Health Alliance sites, the office coordinates the delivery of services through contracts with local county governments and private health care providers.

The office also administers the Bright Start Home Visitation Program in Sioux Falls and Rapid City. The Bright Start Home Visit program works with expectant mothers and is being piloted in Rapid City and Sioux Falls. The typical client is a first-time mom, under the age of 19, unmarried, with limited education and resources, and who has no family or other support system. Regular home visits help these at-risk women improve their life choices, which makes it more likely that their baby will be born healthy. The visits also give expectant parents a chance to learn how to care for their child in a positive home environment. Bright Start nurses work with women during their pregnancies and for the first three years of the child's life. They assess child/maternal health, family needs and offer education on parenting, health, safety, nutrition, and early childhood development. Another key role is linking families with primary health care and community resources such as mental health services, alcohol and drug treatment, job training, literacy services, and other services that may be needed. The visit schedule is intensive and designed to offer key support at critical times. Bright Start nurses visit expectant mothers every week for the first four weeks, then every other week for the rest of the pregnancy. Once the baby is born, the visits are weekly for the first six weeks and every other week until the baby is 21 months old. The visits continue on a monthly basis until the baby's second birthday, and are then based on need until the baby turns three. The DOH home visitation nurses started to see families in June 2000.

/2002/ From June 1, 2000 to May 31, 2001, nurses provided 2,074 home visits to 244 pregnant women.

/2003/ From October 1, 2000 to September 30, 2001, nurses provided 2,628 home visits to 266 pregnant women.

/2004/ From October 1, 2001 to September 30, 2002, nurses provided 2,384 home visits to 328 families.

/2005/ From October 1, 2002 to September 30, 2003, nurses provided 2,634 home visits to 338 families. //2005//

The Bright Start website (<http://www.state.sd.us/bright/>) and toll-free phone number (1-800-305-3064) provide information to assist parents or caregivers in nurturing a child's healthy development. An Ages and Stages information book helps parents know what they can generally expect of their child at a specific age. Activities to stimulate development (physical, intellectual, emotional, social) are included with the ages and stages information as well as suggestions for age-appropriate books and music.

OFFICE OF DISEASE PREVENTION (ODP)

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

training for the public, schools and health care providers, and assistance with health care costs for those with HIV disease. The program also provides tuberculosis clinics and contracts with the private medical sector for evaluation, treatment and follow-up of TB cases. ODP also conducts disease outbreak investigations for the state.

STATE EPIDEMIOLOGIST

The State Epidemiologist integrates epidemiologic services throughout the department and provides support, technical assistance and guidance as needed.

State Systems Development Initiative (SSDI) grant dollars are used to assist the MCH and CSHS programs in building State and community infrastructure that has resulted in comprehensive, community-based systems of care for the children and their families served by the programs. FY2000 and 2001 SSDI dollars have been used to focus efforts on improving the completeness and accuracy of data for the Title V MCH block grant needs assessment indicators and performance measures through the use of community assessments, hospital discharge data, Behavioral Risk Factor Surveillance System (BRFSS), ICDS, and Perinatal Health Risk Assessment Survey.

As a result of subjective information about an increasing problem with child obesity in South Dakota, the DOH in cooperation with DOE, school nurses and physical education/health teachers, developed a method to collect height and weight data for school-aged children in the state. The first survey was conducted during the 1998-1999 school year with data received for over 16,000 students from 110 schools. A report of the information gathered with recommendations for students, parents, teachers, administrators, school food service, and communities was sent to participating schools in March 2000 and was also made available on the DOH website.

/2002/ The survey was conducted again for the 1999-2000 school year with data received for 15,062 students in 86 schools. Data were analyzed using the new CDC growth chart standards with a report sent to participating schools in May 2001 and again made available on the DOH website. Collection of measurements continued for the 2000-2001 school year.

/2003/ Data collection and analysis of school height and weight information continued for the 2001-2002 school year and planning has begun for the 2002-2003 school year.

/2004/ For the 2002-2003 school year 140 schools participated with over 20,500 students.

/2005/ The DOH provided 198 balance beam scales and wall-mounted measuring boards to schools to help improve data quality and allow additional schools to participate. Data was collected for the 2003-2004 school year and will be collected again in 2004-2005. //2005//

A workgroup of various state programs (i.e., MCH, WIC, Head Start, chronic disease, school nutrition programs, Coordinated School Health, Child Care (including after-school programs) and Game, Fish and Parks recreational programs) interested in combating child obesity was also started in late 1999.

/2003/ Starting in the summer of 2001, the DOH utilized CompCare Technical Assistance through Health Systems Research, Inc. (HSR) to analyze child obesity in the state. The Child Obesity Workgroup served as the first advisory group for the project until a more specific Child Obesity Advisory Committee was formed in March 2002. The advisory committee includes primary care providers, dietitians, health educators, IHS, DOE, Medicaid, parish nursing, and DOH staff. A mail survey was developed and sent to pediatricians, family practice physicians, physician assistants, public health nurses, dietitians, chiropractors, and health educators. Surveys are to be returned by the end of June 2002.

/2004/ Information from the CompCare survey and the school height and weight efforts is being utilized with existing programs and partnerships. A "For Professionals" link has been added to the DOH Nutrition webpage with additional resources for health and nutrition professionals. Methods, partnerships, and funding for new efforts to combat child and adolescent obesity are being explored.

/2005/ In August 2003, South Dakota participated in the National Governors Association's Policy Academy on Chronic Disease Prevention and Management. The goal of the NGA workgroup is to improve the health of South Dakotans by increasing physical activity and improving nutrition in order to decrease the incidence of chronic disease. In addition to the

NGA workgroup, the South Dakota Health Care Commission has formed a Disease Management/Promotion of Healthy Behaviors Subcommittee to work at the community level to encourage healthy behaviors through changes in environment and policies at the local level. //2005//

C. ORGANIZATIONAL STRUCTURE

The DOH is an executive-level department with the Secretary of Health appointed by, and reporting to, the Governor. The mission of the South Dakota Department of Health (DOH) is to prevent disease and promote health, to ensure access to necessary, high quality care at a reasonable cost and to efficiently manage public health resources. South Dakota is working to improve access to quality, affordable health care through an incremental approach aimed at controlling costs, expanding access to health care and promoting networking among health care providers in the delivery of care.

The DOH is organized into three divisions - Health and Medical Services, Administration, and Health Systems Development and Regulation. As was mentioned above, HMS is the health care service delivery arm of the DOH. A detailed description of HMS offices and activities is provided under Agency Capacity.

The Division of Administration provides centralized support to DOH programs including financial management, computer systems, communications, health planning, legislative coordination, grant writing, and research. The division also provides oversight of the state correctional health care system. The Data, Statistics and Vital Records (DSVR) unit provides technical assistance for the development, implementation and evaluation of data collection activities. DSVR has an FTE to oversee data collection and analysis activities for the Preventive Health and Health Services (PHHS) Block Grant as well as the MCH Block Grant. DSVR maintains the vital records system for the state including births, deaths, marriages, divorces, and fetal deaths and issues certified copies of such records. The State Public Health Laboratory provides testing, consultation and expert testimony in support of local, state and federal government agencies and the general public.

The Division of Health Systems Development and Regulation (HSDR) administers regulatory programs related to health protection, health care facilities and emergency medical services (EMS) including the traditional public health areas of sanitation and safety, inspection and licensure of public facilities and Medicaid/Medicare survey and certification of health care facilities and providers. HSDR is also responsible for coordinating EMS training, certifying ambulance personnel and inspecting and licensing ambulance services. The Office of Rural Health (ORH) works to improve the delivery of health services to rural/medically underserved communities with an emphasis on access. Specific program examples include recruitment of health professionals, assistance to health care facilities, development and use of telemedicine applications, and general information and referral.

/2003/ The DOH recently established an Office of Public Health Preparedness and Response within HSDR to provide coordination and assessment of bioterrorism and public health preparedness activities for the DOH.

/2004/ On April 17, 2003, the EMS Program was moved to the newly formed Department of Public Safety.

Copies of DOH organizational charts are available from the MCH Program Administrator.

D. OTHER MCH CAPACITY

Preventive and primary care services to the MCH population are provided through OCHS/PHA. OCHS/PHA provides direction to state-employed nurses, nutrition educators and dietitians for the provision of community health services in the state.

/2002/ Field staff providing primary preventive services for mothers, infants and children include 12.13 FTE for mothers and infants and 7.98 FTE for children and adolescents. Another 6.65 FTE provide family planning services in the state.

/2003/ Mothers and Infants - 9.08 FTE; Children and Adolescents - 7.9 FTE; Family Planning - 7.46

FTE.

/2004/ Mothers and Infants - 6.63 FTE; Children and Adolescents - 5.56 FTE; Family Planning - 5.56 FTE.

/2005/ Mothers and Infants - 7.0 FTE; Children and Adolescents - 7.6 FTE; Family Planning - 5.5 FTE. //2005//

/2002/ The service delivery system for CSHCN is a regional system with 12.9 FTE (including nursing, dietitian and social work) staff providing services at offices in Pierre, Sioux Falls, Aberdeen, and Rapid City.

/2003/ 18.4 FTE

/2004/ 18.8 FTE

/2005/ 18.6 FTE //2005//

Services are provided in a community-based manner that enable families to receive appropriate consultation and care planning as close to home as possible. Pediatric specialty clinics are held in each of the four offices. In addition, pediatric specialists, dietitians, registered nurses, and social workers function as a multi-disciplinary team with families to assist them in meeting the needs of CSHCN. The CSHS service delivery system represents a unique private-public partnership between the DOH and numerous hospitals and physicians across the state.

/2002/ OFH and OHP central office program staff dedicated to providing program direction to specific MCH program areas include: 1.7 FTE for child and adolescent health, 1.6 FTE for perinatal health, 1.5 FTE for family planning services, and 0.9 FTE for CSHS.

/2003/ Child/Adolescent Health - 1.6 FTE; Perinatal Health - 1.9 FTE; Family Planning - 1.9 FTE; CSHS - 0.68 FTE.

/2004/ Child/Adolescent Health - 1.94 FTE; Perinatal Health - 1.97 FTE; Family Planning - 1.6 FTE; CSHS - 0.68 FTE.

/2005/ Child/Adolescent Health - 1.3 FTE; Perinatal Health - 1.5 FTE; Family Planning - 1.7 FTE; CSHS - 1.8 FTE. //2005//

Kayla Tinker, RN, is the Administrator of OFH and also serves as the MCH Program Administrator. Kayla has served in this capacity since December of 1999. Prior to this position, Kayla served as the Administrator of the Office of Public Health Alliance for three years and was a community health nurse supervisor for the DOH for over six years. Nancy Hoyme is the MCH Program Coordinator and also serves as the Administrator of the Children Special Health Services Program - a position she has held since November of 1993. Prior to this position, Nancy worked as a care coordination specialist for the DOH Children's Special Health Services Program.

/2005/ As of July 9, 2004, the MCH Program Coordinator/CSHS Program Administrator position is vacant. The position has been announced at it is anticipated it will be filled by September 1, 2004. //2005//

Everett Putnam has been with the DOH since December of 1988 as a statistician and currently serves as the MCH State Data Contact. More detailed biographies for these positions are available upon request from the MCH Program Administrator. Other MCH team members include the following:

- Linda Ahrendt, School Health
- Darlene Bergeleen, Administrator, Office of Community Health Services
- Kristin Biskeborn, State Nutritionist
- Terry Disburg, Newborn Hearing/CSHS Nursing Consultant
- Bev Duffel, Family Planning Director
- Sandi Durick, Office of Rural Health
- Julie Ellingson, Oral Health
- Sherrie Fines, Child and Adolescent Health Coordinator
- Lucy Fossen, Metabolic Screening/CSHS Nursing Consultant
- Kathi Mueller, Administrator, Office of Data, Statistics and Vital Records
- Nancy Shoup, Perinatal Nursing Consultant

- Susan Sporrer, Division of Administration
- Colleen Winter, Administrator, Office of Health Promotion

Through a contractual arrangement, South Dakota Parent Connection, Inc. provides parent consultant and training services for the CSHCN program. Parent Connection identifies and recruits parents of CSHCN to provide mentoring and peer support to other families with CSHCN. They provide a family perspective to CSHCN program staff regarding programs and policies and procedures, maintain a statewide database of support parents and groups, provide parent-to-parent training, and link parents throughout the state with trained supporting parents in as community-based manner as possible. This relationship was formalized in 1999 and continues to expand, as well as enhance family involvement of the CSHCN program.

Parent Connection is a non-profit Parent Training and Information Center formed by parents, educators and service personnel to provide information and training to parents of children with special needs throughout the state. Their Board of Directors consists of a minimum of fifty percent parents. Parent Connection employs a full-time Parent to Parent Coordinator who works with the state's CSHCN program.

E. STATE AGENCY COORDINATION

South Dakota's public health system includes the DOH, community health centers (CHCs), IHS, and tribal health representatives. While many states use local health departments to deliver public health services, in South Dakota these services are delivered by the DOH and funded primarily with federal or state resources. There is only one local health department in the state located in Sioux Falls. However, its primary function is to inspect food and lodging establishments.

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

IHS delivers services to the Native American population on the state's nine reservations. There are IHS hospitals in Eagle Butte, Pine Ridge, Rapid City, Rosebud, and Sisseton. On many of the reservations, tribally-appointed community health representatives also provide services.

//2002/ The DOH also has ongoing communication with the Northern Plains Healthy Start Project. Local staff participate on local consortia and central office staff have attended statewide consortia meetings to share information, problem solve and network. Healthy Start also provides representation on a variety of DOH perinatal workgroups.

//2003/ Due to lack of funding, the Northern Plains Healthy Start Project has not been active during the past year. It is the DOH understanding that this project has recently obtained funding and will begin operations again.

//2004/ Northern Plains Healthy Start has just recently hired a new project officer and the MCH program is working to reestablish communication with the project.

//2005/ The Family Planning Program has contacted the Healthy Start program to discuss how the two programs can partner to reduce unintended pregnancy and lengthen the interval between pregnancies. The Family Planning program coordinated a training on birth control methods for Healthy Start staff. //2005//

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

coordination of high-risk pregnant women, referral mechanisms, outreach for Medicaid, and CHIP.

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

The South Dakota Tobacco Education Project is a broad-based, statewide coalition of youth organizations and health groups whose mission is to enable communities to control tobacco use, with the main objective of preventing tobacco addiction among South Dakota's youth. Chaired by a family physician from Rapid City, the coalition works closely with the state's Prevention Resource Centers to promote the development of local coalitions; provide education on reducing youth access to tobacco; provide technical assistance to schools, agencies and interested groups and individuals; provide resource development, including dissemination of current research; and work with community coalitions on awareness programs and other activities.

The DOH collaborates with DHS Divisions of Mental Health and Alcohol and Drug Abuse to address issues affecting children and adolescents and their families such as suicide, tobacco use, FAS, and HIV prevention. DOH staff provide assistance and representation on the Division of Alcohol and Drug Abuse Advisory Council Safe and Drug-Free Schools application reviews and the Mental Health Planning and Coordination Advisory Council's Children Subcommittee.

/2002/ The DOH is working with DHS to implement the provisions of the new FAS reporting law. Over the next several months, staff will be working with the SD State Medical Association (SDSMA), SD Association of Healthcare Organizations (SDAHO), USD School of Medicine, SD Academies of Pediatrics and Family Practice, SD Center for Disabilities (formerly University Affiliated Programs or UAP), and other interested parties to promulgate rules to specify how reports will be made and the content and timeliness of such reports.

/2003/ The DOH has drafted administrative rules for the collection and reporting of diagnosed and suspected cases of FAS. The proposed rules provide definitions as well as reporting requirements (including what constitutes a case of FAS). The rules will be effective on July 31, 2002.

/2004/ As a result of the administrative rules promulgated in 2003, DOH implemented the mandatory FAS reporting law and has received reports of diagnosed and suspected cases of FAS throughout the year. DOH continues to educate reporting individuals and entities on the law. The first year of data will be analyzed during the upcoming months.

/2005/ The DOH continues to gather reports of suspected and diagnosed FAS. Currently the numbers in the system are too small for any broad analysis. The DOH continues to work with physicians to make them aware of the reporting requirement. //2005//

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

DHS and the Social Security Administration (SSA) have an expanded joint powers agreement with the DOH to assure that SSI child beneficiaries under age 18 are provided appropriate outreach, referral, disability determination, and rehabilitation services. Expansion of the agreement enables increased

collaboration with DHS to promote coordination and delivery of services for children with severe emotional disturbances or developmental disabilities. The CSHS program manager is the DOH Title V liaison with DHS and SSA.

South Dakota receives funding from CDC for a Coordinated School Health Program (CSHP) to support a collaborative relationship between DOE and DOH in an effort to help local schools implement and coordinate comprehensive school health programs directed toward the three CDC priority areas of nutrition, physical activity and tobacco. DOH and DOE have a MOA that outlines areas of responsibility and requirements to implement the program and have developed a very effective relationship that allows for maximum use of financial and staffing resources.

/2002/ As part of the Coordinated School Health Program, the DOH and DOE are working jointly on an application for supplemental funding to the Coordinated School Health Cooperative Agreement from CDC to address physical activity in schools/communities. The funding is focused on children aged 9-13 and is to be utilized to develop sustainable physical activity programming in the school/community.

/2003/ The Coordinated School Health Program received supplemental funding to address inactivity in youth ages 9-13. The DOH Childhood Obesity Workgroup assisted in planning for the grant and for targeting a variety of groups for physical activity training opportunities. Mini-grants were given to seven community/school groups to enhance and expand physical activity opportunities outside of the school day. The Coordinated School Health Program also received supplemental funding for School Food Safety.

/2005/ CSHP provided training to an additional six school districts interested in organizing a Coordinated School Council in their local school district. With the additional councils, South Dakota has 19 coordinate school health councils addressing chronic disease prevention in schools. CSHP collaborated with Game, Fish and Parks to offer the "Fantastic Fourth Grade Field Trip" to fourth grade teachers at no cost. Each teacher receives a packet of information including core content based lessons and physical activity options while visiting the park. The first ever "South Dakota Healthy School Awards" will be given in three categories elementary, high school and district wide that exemplify healthy programs and policy. //2005//

The DOH has a long-standing collaborative relationship with the Center for Disabilities within the USD School of Medicine's Department of Pediatrics. The South Dakota Leadership Education Excellence in Caring for Children with Neurodevelopmental and Related Disorders (LEND) is a program of the Center for Disabilities that works to improve the health status of infants, children and adolescents with neurodevelopmental and related disabilities. The LEND program provides one year of specialized training which focuses on the interdisciplinary training of professionals for leadership roles in the provision of health and related services to infants, children and adolescents with neurodevelopmental and related disabilities and their families. The program augments graduate studies in the disciplines of audiology, health administration, medicine, nursing, nutrition, speech-language pathology, occupational therapy, pediatric dentistry, physical therapy, psychology, and public health social work. Both the Title V MCH director and CSHS director serve on the LEND advisory group. In addition to LEND, MCH and the Center for Disabilities collaborate on a number of training and other interagency projects.

Recognizing that oral health is a major part of total health and that South Dakota is experiencing a shortage of dental professionals, oral health advocates throughout the state formed the South Dakota Oral Health Coalition. The Coalition is a network of supporters including legislators, social workers, child advocates, dental professionals, dental insurers, health professionals, various state agencies, IHS, community health centers, and educational institutions. This diverse group advocates for policies and funding for effective programs to address the oral health needs of South Dakota's most vulnerable populations. Their mission is to promote the quality of life by facilitating the availability of accessible oral health services. The Coalition has been working to address the pervasive issues of oral health disparities with emphasis on the three priority issues of workforce stabilization and expansion, access to dental care, and education/prevention.

/2005/ The Oral Health Coalition was awarded a Healthy Tomorrows Grant to fund and create an "interface" project to improve the oral health of South Dakota children by enhancing the

role of primary care medical providers in preventing dental disease. The goal of the project is to increase the number of Medicaid eligible children ages 1-5 who have access to oral health care by 25%. The project will use a train-the-trainer format using selected South Dakota dentists to train 95% of the state's 57 pediatricians and 80% of the non-dental primary health care professionals on early childhood caries, risk assessment and oral health promotion. The MCH director is part of the advisory board overseeing the project. //2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

HSCI #01: The rate of children hospitalized for asthma (10,000 children less than five years of age).

See Health Systems Capacity Indicator form (Form 17).

HSCI #02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

In South Dakota, the goal is to increase the adequacy of primary care for Medicaid enrollees. Between 1995 and 1998, the percent of infants enrolled in Medicaid who received at least one initial or periodic screen increased dramatically from 68 percent to 83 percent. This increase may be attributed to improvements in access to primary health care services in rural areas and increased public awareness of rural providers. See Health Systems Capacity Indicator form (Form 17) for further detail.

HSCI #03: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

See Health Systems Capacity Indicator form (Form 17).

HSCI #04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Adequate prenatal care is vital for the success of the pregnancy and well-being of the infant and mother. The DOH goal is to increase the adequacy of prenatal care utilization among South Dakota mothers. The percent of South Dakota women receiving adequate prenatal care has increased since 1996. See Health Systems Capacity Indicator form (Form 17). A need has been identified to gather additional data from providers on their practices and beliefs regarding prenatal care.

HSCI #05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the state.

The DOH goal is to eliminate the disparities of pregnancy health outcomes between those receiving Medicaid and those not receiving Medicaid. A sample of 400 Medicaid births was selected from the Medicaid paid deliveries for each of the calendar years 1996 through 2000.

The average number of Medicaid paid deliveries over the time span 1996 through 2000 was approximately 3,500. A sample size of 350 would provide a sampling error of approximately + 5%. Assuming that not all records would be matched to the birth file, a sample of 400 was linked to the birth certificates for each year to obtain the Medicaid birth data. Non-Medicaid data is the prorated difference between the "Medicaid" and "All" categories. During the four-year reporting period, approximately one-third of all births in South Dakota were Medicaid-paid births. While the percentage of low birth weight non-Medicaid babies increased slightly, the percentage of low birth weight status among the Medicaid babies decreased.

/2002/ Over the four-year reporting period (1995-1998), the percent of all pregnant women entering care during their first trimester increased slightly from 81.7% to 82.6%.

/2003/ In 1999, 83.3% of pregnant women entered care during their first trimester. This percentage decreased to 78.5% in 2000.

/2004/ In 2001, 78.3% of pregnant women entered prenatal care during their first trimester.

/2005/ In 2002 77.6% of pregnant women initiate prenatal care in the first trimester.

The percentage of women with Medicaid who had first trimester care was significantly below the non-Medicaid women every year. The 2003 Perinatal Health Risk Assessment Survey indicated that 8.6% of mothers responded they were waiting to qualify for Medicaid. //2005//

In South Dakota, the percentage of non-Medicaid mothers receiving adequate prenatal care was significantly higher than the percentage of Medicaid mothers for each of the reporting years.

/2002/ The disparity, however, was decreasing steadily from a 16 percent gap in 1995 to a 6 percent difference in 1998.

/2003/ This gap has remained consistent in 1999 and 2000.

/2004/ This gap remained consistent again in 2001.

See Health Systems Capacity Indicator Reporting Form (Form 18) for further detail.

HSCI #06: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

See Health Systems Capacity Indicator Reporting Form (Form 18).

HSCI #07: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

See Health Systems Capacity Indicator form (Form 17).

HSCI #08: The percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) program.

The DOH collaborates with SSA and DHS programs serving children with chronic and disabling medical conditions, severe emotional disorders or developmental disabilities and promoted outreach and access to rehabilitative services, mental health services, medical care, and service coordination. An ongoing joint powers agreement between the DOH, DHS and SSA assures that SSI child beneficiaries and potential beneficiaries under the age of 18 years are provided appropriate outreach, referral, disability determination, and rehabilitation services.

The DOH provides care coordination services, information and referral, and outreach specialty clinics to SSI beneficiaries. During SFY 2002 (July 2001-June 2002), a total of 650 transmittals and 166 redeterminations were received from Disabilities Determination Services.

See Health Systems Capacity Indicator form (Form 17) for further detail.

HSCI #09A: The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

See Health Systems Capacity Indicator Reporting and Tracking Form (Form 19).

HSCI #09B: The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

See Health Systems Capacity Indicator Reporting and Tracking Form (Form 19).

HSCI #09C: The ability of State to determine the percent of children who are obese or overweight.

See Health Systems Capacity Indicator Reporting and Tracking Form (Form 19).

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The DOH priority needs are based on the needs assessment completed for the FY 2001 South Dakota MCH Block Grant application. Priority needs in South Dakota cross the four levels of the public health services pyramid. The DOH has identified the following MCH priority needs: (1) reduce unintended pregnancies; (2) reduce infant mortality; (3) improve pregnancy outcomes; (4) reduce morbidity and mortality among children and adolescents; (5) improve adolescent health and reduce risk taking behaviors (i.e., intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization); (6) improve the health of, and services for, CSHCN through comprehensive services and support; (7) improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CSHCN; (8) improve state and local surveillance and data collection and evaluation capacity; and (9) reduce childhood obesity.

The priority setting process is an ongoing and evolving process. Systems development for women, infants, children, adolescents, and CSHCN is an integral part of the MCH planning process and includes analyzing of current programs and services, identifying gaps in services, establishing appropriate goals and objectives, collaborating with partners, and establishing methods for monitoring and evaluating programs and services to ensure that goals and objectives are met. As was mentioned earlier, the MCH team has used the CAST 5 self assessment tool to examine existing capacity and assist programs in aligning efforts within an overall system and population-based approach and smaller workgroups have been established to start to address the identified needs in data capacity and infrastructure building.

The MCH team also initiated a MCH Assessment, Planning and Monitoring Process which is data driven, with the starting point of assessing the needs of the MCH population groups using Title V health status and system capacity indicators, performance measures, and other quantitative and qualitative data. The process focuses on needs, priorities, targets, and activities -- not specific programs or individuals. The MCH Team began the process with the child and adolescents population group. The Team discussed national and state performance measures, determining if objectives were met or unmet. Health system capacity and health status indicators, and data sets used were analyzed. Additional data sources to assist in assessment of this population group were identified. Ongoing and emerging issues impacting this population group were also identified. As a result of this process, a matrix was developed that identified needs, data sources, performance measures and indicators relevant to the needs, linkage to HP 2010 Objectives, gaps in data or data needs, and identification of a lead agency. The MCH Team then determined level of responsibility relative to the MCH Program. This process allowed for prioritization of the needs of this population group and the role of MCH in addressing them. Current activities and new or proposed activities were discussed to meet the needs, as prioritized.

B. STATE PRIORITIES

As a result of the MCH assessment, South Dakota has developed seven performance measures that relate directly to identified priority needs. Priority needs in South Dakota, as well as the respective performance measures and activities that address these needs, cross the four levels of the core public health services pyramid -- direct services, enabling services, population-based services, and infrastructure building services.

As a result of on the Assessment, Planning and Monitoring Process referenced above, the MCH team identified three state performance measures to delete as state-designated performance measures: (1) percent of high school youth who self-report taking a drink in the past 30 days; (2) rate of death to adolescents aged 15-19 caused by motor vehicle crashes; and (3) percent of adolescents with disordered eating. The assessment process indicated inadequate data to measure progress in addressing these issues from performance measure perspective for youth drinking and eating disorders. The death rate for adolescents caused by motor vehicle crashes is now a health systems

capacity indicator and the team felt this was a better way to monitor the issue. It should be noted that deletion of these three performance measures does not indicate that the MCH program does not believe these are areas of concern. The MCH program will continue activities to address these issues impacting the health status of adolescents.

SPM #01: Percent of women who smoked prior to pregnancy and report they stopped during pregnancy.

Smoking during pregnancy increases the risk of miscarriage, stillbirth and preterm/low birthweight infants. Improved pregnancy outcomes have been demonstrated when women significantly decrease or stop smoking during pregnancy. Activities related to this performance measure will impact infant mortality in the state.

SPM #02: Percent of women who report not drinking alcohol upon knowledge of pregnancy.

Damage to the fetus from alcohol consumption can occur early in pregnancy, often prior to confirmation of pregnancy by a health professional. Therefore, intervention to modify or eliminate the behavior is crucial. Alcohol consumption during pregnancy may lead to intrauterine growth retardation, mental retardation, maxillary hypoplasia, reduction in width of palpebral fissures, and microcephaly. Activities related to this performance measure will promote better pregnancy outcomes and reduce infant and child mortality and morbidity. A similar performance measure was used in the past but it was modified this year to more accurately reflect a direct health care service. This change was made due to the fact that alcohol consumption is generally episodic in nature rather than a daily occurrence such as smoking. The WIC or Baby Care population are individuals for whom a risk reduction or client plan of action can be developed and should aid them in their desire to limit or eliminate risky behaviors. For some clients, the impact may not be evident in this pregnancy since the damage may have already been done. The hope is that for some, the impact may be found in the next pregnancy by providing education and enhancing knowledge in this pregnancy.

//2005/ This state performance measure has been discontinued. //2005//

SPM #03: Identify issues and trends that may impact access to health care for CSHCN and their families.

Title V has a responsibility to provide and promote family-centered, community-based, coordinated care for CSHCN and facilitate the development of community-based systems of services for these children and their families. Lack of meaningful consumer participation in systems development and care coordination activities can result in fragmentation or duplication and serious gaps between service delivery systems. To successfully identify and meet the needs of children and families, consumer input and involvement must be sought and incorporated into systems of care for CSHCN. Responsive systems of care will promote better outcomes and improve health status.

//2005/ This state performance measure has been discontinued. //2005//

/2004/ SPM #04: The rate (per 1,000 births) of children under age 1 who die as a results of Sudden Infant Death Syndrome.

//2005/ SPM #02: The rate (per 1,000 births) of children under age 1 who die as a results of Sudden Infant Death Syndrome.//2005//

SIDS is occurring over three times as much in the Native American population than in the White population. One of the most important things to help reduce the risk of SIDS is to place healthy babies on their back. Education is an important piece to help reduce SIDS deaths among infants in the state. Activities related to this performance measure will impact infant mortality related to SIDS in the state.

/2004/ SPM #05: Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.

/2005/ SPM #03: Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.//2005//

Unintended pregnancies are associated with maternal health risk behaviors, low use of preventive health measures including early prenatal care, child abuse, and dependency on welfare. There is a greater risk for complication and poor pregnancy outcomes including infant mortality, birth defects and low birth weight infants.

/2004/ SPM #06: Percent of high school youth who self-report tobacco use in the past 30 days.

/2005/ SPM #04: Percent of high school youth who self-report tobacco use in the past 30 days.//2005//

Smoking is responsible for one in six adult deaths in the U.S. and is the single most preventable cause of death. According to the 2003 YRBS, 60% of respondents have tried cigarette smoking with 18% of respondents having smoked a whole cigarette prior to age 13. Thirty percent of respondents smoked a cigarette during the past 30 days and 62% who have smoked during the past 12 months reported they have tried to quit smoking. Fifteen percent of respondents had used chewing tobacco or snuff during the past 30 days.

/2004/ SPM #07: Percent of children and adolescents who are overweight or obese.

/2005/ SPM #05: Percent of school-aged children and adolescents who are overweight or obese.//2005//

Obesity is a risk factor for many chronic medical conditions including cardiovascular disease, hypertension, diabetes, degenerative joint disease, and psychological problems. Overweight can result from excessive energy intake, decreased energy expenditure or impaired regulation of energy metabolism. Activities include development of a system to assess and monitor obesity in school-aged children.

/2005/ SPM #06: Percent of children age 2-5 who are overweight or obese.

Obesity is a risk factor for many chronic conditions including cardiovascular disease, hypertension, diabetes, degenerative joint disease, and psychological problems. Overweight can result from excessive energy intake, decreased energy expenditure or impaired regulation of energy metabolism. Weight-for-height during early infancy predicts weight-for-height during late infancy and childhood. //2005//

/2005/ SPM #07: Percent of infants who are breastfed at least 6 months.

Breastfeeding provides the most complete nutrition for infants and has many benefits to both mother and infant including decreased new cases and severity of diarrhea, respiratory infections, and ear infections. Infants who are breastfed have less overweight and the overweight rate is improved the longer the infant is breastfed. //2005//

As mentioned above, identified priority needs cross the four levels of the service pyramid. Certainly, one-on-one direct service interventions will improve health status and reduce adverse outcomes. Since enabling services facilitate and enhance direct services, activities in both levels of the pyramid will address the state's priorities. There are several priority needs that primarily impact the population-

based service level. Again, in order to accomplish improvement in the state's priorities, there must be educational and service interventions at both the direct and enabling service levels. Conversely, effective interventions at the direct and enabling service levels require the accompaniment of population-based education and other activities.

All the state priority needs have elements of infrastructure building services. The development of an interagency collaborative infrastructure is critical to reducing barriers to care and improving health outcomes. Improved state and local surveillance, data collection and evaluation capacity facilitates data-driven decision making regarding allocation of resources and strategies to address the priority needs. Coordination, quality assurance, standards development, and monitoring must accompany interventions to reduce barriers to care and improve and assure appropriate access to health services focused on families, women, infants, children, adolescents, and CSHCN.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

Partnered with Sioux Valley Clinical Laboratories (SVCL) for the provision of newborn metabolic screening laboratory services in South Dakota for mandated disorders and optional screening under the Newborn Metabolic Screening Program.

Updated information links and resources on the DOH Newborn Metabolic Screening website.

Conducted ongoing site visits and phone contacts with hospitals and physician offices offering technical assistance regarding newborn metabolic screening.

Collaborated with SVCL to provide follow-up on infants with indeterminate or abnormal specimens.

Provided follow-up to those infants without metabolic screening results through ongoing matching of birth certificates and lab reports.

Conducted follow-up with the facility of birth or physician on infants with pending screens.

Referred infants diagnosed with a metabolic disorder to CSHS to be referred and followed by the pediatric endocrinologist, dietitian, social worker, and nursing staff.

Utilized the Electronic Vital Records and Screening System (EVRSS) for data collection and monitoring.

Provided mechanism for optional hemoglobinopathy screening to be performed upon physician request.

Partnered with SVCL to provide mechanism for optional screening, the supplemental screening (Supp NBS), and hemoglobinopathy screening upon physician order.

b. Current Activities

Making improvements to the newborn metabolic screening data collection system to improve effectiveness in identifying babies that need further testing and follow-up.

Screening infants for congenital hypothyroidism, galactosemia, and phenylketonuria (PKU), and identify infants needing follow-up for indeterminate, abnormal, or never tested results.

Performing quality assurance activities to verify notification of indeterminate and abnormal test results.

Providing optional screening for hemoglobinopathy disorders and Supplemental (optional) screening via an arrangement with the state designated laboratory and Baylor University Medical Center to detect metabolic disorders through tandem mass spectrometry.

Distributing brochure explaining the Newborn Metabolic Screening Program to hospitals, physician, and other health care providers in the state.

Maintaining and updating the website, including links to SVCL, Baylor University Medical Center's Supplemental Screening web page, and other resources to allow families and clinicians to easily obtain information on metabolic screening.

Collaborating with the department's Vital Records and Statistics Program to link birth and death certificates with the Newborn Metabolic Screening Program through the Electronic Vital Records Screening System (EVRSS).

Updating as needed the Newborn Metabolic Screening Program manual and distribute to all hospitals and clinics in the state.

Ongoing referral of infants diagnosed with a metabolic disorder to CSHCN Program for follow-up care coordination and treatment.

Monitoring participation percentage of Supp NBS optional screening with the mandated disorders.

Conducting site visits as needed to birthing facilities and laboratories to provide technical assistance with screening process.

Developing education materials specific to hemoglobinopathy screening for providers and parents.

c. Plan for the Coming Year

Screen all infants born in South Dakota for inheritable disease/metabolic disorders as required by law. Collaborate with health care providers, hospitals and SVCL to make information available as needed to parents/guardians of newborns regarding the necessity and benefits of screening. Compare submitted laboratory reports with the birth records and follow-up with hospital of birth or physician of infants who do not have testing completed or have abnormal results.

Refer newborn infants identified with positive screening results for follow-up testing and any needed medical treatment. Continue to implement, review and update protocols for follow-up on abnormal test results.

Evaluate and enhance, as necessary, data collection methods in order to meet reporting requirements.

Monitor participation of optional testing for metabolic disorders and evaluate the appropriateness of adding disorders to the screening program.

Prepared educational materials for parents/providers regarding metabolic disorders, the Newborn Metabolic Screening program, mandated testing, and other optional screening.

Provide ongoing evaluation of the Metabolic Newborn Screening program.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

a. Last Year's Accomplishments

Continued to work with South Dakota Parent Connection to promote family involvement in the care of CSHCN, maintain a database of mentor parents and provide parent education and sibling of CSHCN workshops.

b. Current Activities

Collaborating with South Dakota Parent Connection regarding parent training opportunities, parent mentors, FILE record system, and other activities to support parents in decision making.

Networking with parent groups, private sector and other agencies and programs to promote family involvement in their CSHCN's care.

Seeking input from parents of CSHCN via discussions at clinic visits, home visits, child and family intake and assessment, and networking activities.

Through arrangement with SD Parent Connection, providing financial support (including technical assistance, reimbursement for travel and child care costs) for parent training and support activities.

c. Plan for the Coming Year

Collaborate with SD Parent Connection, Center for Disabilities, Children's Care Hospital and School, and other entities on projects to assist families of CSHCN, including but not limited to, a record keeping FILE system for families, development and use of fact sheets about various programs and conditions, and training opportunities for providers and parents.

Collaborate with SD Parent Connection to: (1) identify and recruit parents of CSHSN for the provision of peer support and mentoring; (2) provide a family perspective to CSHS staff; (3) maintain statewide database of support parents, groups and programs within the state and provision of this information to parents; and (4) provide parent-to-parent training and support.

Collaborate with South Dakota Parent Connection on surveys and discussion groups to gather information from parents regarding National Performance Measures.

Identify family members of CSHSN to utilize for staff inservice and other trainings of professionals serving CSHCN and their families.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

a. Last Year's Accomplishments

Provided care coordination, clinical services and/or financial assistance to children with chronic medical conditions and disabling illness and their families through CSHS.

b. Current Activities

Conducting diagnostic and consultative specialty outreach clinics at the CSHS regional office sites. CSHCN clients not eligible for financial assistance are also seen in specialty clinics and either the child's family and/or appropriate third party payer are billed.

Providing care coordination services to children with chronic medical conditions and disabling illness. CSHS utilizes a multi-disciplinary team consisting of pediatric subspecialists, nurses, social workers, and dietitians to work with the primary care physician in the provision of care coordination and follow-up for CSHCN and their families. All children served through CSHS are required to identify a physician/health care provider who accepts responsibility for their primary care. Staff assist in the linkage with a medical home if one does not exist.

Partnering with the state Medicaid program in the provision of high-level care coordination of CSHCN, thus allowing for exemption from Medicaid Managed Care.

Maintaining ongoing relationships with physicians through networking activities and follow-up care of individual children to facilitate coordination of care for CSHCN.

c. Plan for the Coming Year

Collaborate with medical providers, ORH, SDAHO, SDSMA, CHAD, and Academies of Pediatrics and Family Practice to promote medical home and family-centered, community-based care for CSHCN.

Collaborate with the Center for Disabilities, Parent Connection, Family Support, and other entities regarding awareness of the importance of a medical home for CSHCN.

Collaborate with South Dakota Parent Connection on surveys and discussion groups to gather information from parents regarding National Performance Measures.

Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

a. Last Year's Accomplishments

Assisted in the identification and referral of numerous CSHCN and their families and facilitated their application to Medicaid, SCHIP and SSI.

b. Current Activities

Providing financial assistance on a cost share basis according to family size and income for physician visits, hospitalizations, prescription medications, laboratory testing, radiology testing/procedures, and inpatient and outpatient treatment relative to specified conditions and procedures.

Assisting in the identification and referral of numerous CSHCN and their families and facilitate their applications to Medicaid, SCHIP and SSI.

Linking families to other resources that can assist families "fill the gaps" if there are needs not

being met by their public or private health care coverage.

c. Plan for the Coming Year

Revise and update the Joint Powers Agreement with DHS, SSA and DOH to facilitate action on transmittals from Disability Determination Services.

Collaborate with DHS (Divisions of Mental Health, Developmental Disabilities, and Vocational Rehabilitation), SSA, DSS (Medicaid and SCHIP), and DOE (Birth to 3) to assist in the provision of coverage and services for CSHCN.

Develop and maintain ongoing communication with the major insurance carriers in the state, initiate provider agreements as appropriate, and facilitate understanding of the needs of CSHCN.

Collaborate with South Dakota Parent Connection on surveys and discussion groups to gather information from parents regarding National Performance Measures.

Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

a. Last Year's Accomplishments

Received referrals during the fiscal year from physicians, schools, parents, hospitals, and other agencies.

Assisted in the provision needed services for specialty care and/or primary care follow-up for CSHCN during the fiscal year in their home community.

b. Current Activities

Continuing to formalize identification and referral process and improve coordination of care for CSHCN through linkages with other agencies, programs and providers.

Providing pediatric specialty outreach and telemedicine clinics at Aberdeen, Pierre and Rapid City regional offices.

c. Plan for the Coming Year

Network and coordinate with local medical and related service providers to facilitate early identification and referral of CSHCN.

Collaborate with South Dakota Parent Connection on surveys and discussion groups to gather information from parents regarding National Performance Measures.

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

Assisted youth and families with transition to adult services in conjunction with care coordination activities.

b. Current Activities

Assisting adolescent CSHCN and their families in identifying and addressing their needs related to transition to all aspects of adult life through care coordination activities.

c. Plan for the Coming Year

Provide additional training to CSHS staff regarding the issues related to transition to adult care and the services available.

Collaborate with South Dakota Parent Connection on surveys and discussion groups to gather information from parents regarding National Performance Measures.

Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

a. Last Year's Accomplishments

Served as a "selectively" universal vaccine provider. Distributed diphtheria, tetanus, acellular pertussis, Haemophilus influenza B, measles, mumps, rubella, polio, and hepatitis B vaccines for children 18 years of age and younger and varicella to children 12-24 months and children entering kindergarten. Prevnar was made available to all age-appropriate VFC-eligible children.

Maintained the South Dakota Immunization Information System (SDIIS). There are currently 234 public and private providers using SDIIS in 64 counties in South Dakota. Currently there are approximately 392,000 records and over 2.4 million individual immunizations recorded in SDIIS.

Partnered with DSS to assess the immunization status of children receiving public assistance through TANF and Medicaid and immunized those who were due/overdue for vaccinations.

Maintained the WIC/Immunization Program linkage to improve the assessment and administration referral for immunizations for any infant/child seeking services through OCHS/PHA offices.

Recognized providers who achieved the 90% immunization goal at the 2003 Awards of Excellence luncheon. Fourteen clinics (with more than 50 clients age 19-35 month) received the "Golden Syringe Award" for reaching and consistently maintaining a 90% immunization coverage goal for 2 year olds. The largest clinic in the state received the "Silver Syringe Award" for having the most improved immunization rate. Fifty four clinics (with 50 or fewer clients aged 19-35 months) received certificates for consistently maintaining immunization coverage rates at 90% or higher for 19-35 month olds.

Completed audits of immunization records to assure appropriate immunization levels of children in Day Care/Head Start centers which found that 95% of day care clients and 93% of Head Start clients were age-appropriately immunized.

Completed assessments of immunization records for all kindergarten and transfer students in South Dakota schools to assure compliance with state immunization requirements for school entry which found that 97.1% had the immunizations required by law to enter school.

Provided technical assistance and resources to 10 local community immunization coalitions which educate the community and sponsor activities to increase age-appropriate immunization.

Conducted a retrospective immunization survey of all two year olds by county and found 81% of children were age-appropriately immunized. This is the highest vaccination rate since the tracking began and has increased from 64% since 1994.

Conducted immunization coverage level assessments of two-year-olds using the SDIIS Central Registry. The immunization coverage level of South Dakota two-year-olds has increased from 57% in July 2000 to 80% in June 2003 (based on those providers utilizing SDIIS).

Provided vaccine education to physicians, nurses, and other health care professionals regarding childhood immunizations through videotapes, "Pink Books", mailings, presentation, phone

b. Current Activities

Utilizing state funds to purchase varicella vaccine to support the state's childhood varicella immunization initiative.

Utilizing local field staff to serve on local community immunization workgroups to assess immunization needs and facilitate development of plans to immunize children.

Continuing as a "selectively" universal vaccine provider and distribute federally-funded vaccine free of charge through ODP. Special arrangements are made for receipt of varicella and Prevnar based upon insurance status. Utilizing OCHS/PHA nurses to administer vaccine and coordinate numerous activities to raise public awareness about the importance of immunizations.

Converting the current SDIIS to a web-enabled system that will be more user-friendly.

Distributing immunization materials to hospitals, clinics, DOH field offices, day cares, schools, Head Starts, and other interested organizations.

Collaborating with DSS to assess immunization status of children receiving public assistance through TANF and in the general Medicaid population of children under age two.

Assuring access to immunizations for infants and children receiving home visits through Bright Start.

Collaborating with DSS Office of Child Care Services to add a "Parent Guide to Childhood Immunization" to the Bright Start Welcome Boxes that are sent to new parents.

Continuing to develop and refine local agency plan to improve the assessment, administration and referral for immunizations. The local plan focuses on the WIC/immunization linkage and any infant/child seeking services through OCHS/PHA offices.

Reviewing immunization PSAs to air on radio and television to educate families on the importance of having their child immunized.

Collaborating with the Immunization Program to promote childhood immunizations in the state.

Providing technical assistance and resources to 10 local immunization coalitions.

Conducting annual retrospective survey of two-year olds as well as annual audits of

immunization records for all kindergarten and transfer students, licensed day care centers, and Head Starts.

Collaborating with Delta Dental, SDDA, and the DOH Oral Health program to assess the immunization status of children receiving services through the South Dakota Dental Care Mobile and providing those immunizations that are necessary to bring children up-to-date (excluding varicella).

c. Plan for the Coming Year

Utilize state funds to purchase varicella vaccine to support the state's childhood varicella immunization initiative.

Serve on local community immunization workgroups to assess immunization needs and facilitate development of plans to immunize children.

Continue as a "selectively" universal vaccine provider and distribute federally-funded vaccine free of charge through ODP. Special arrangements will be made for receipt of varicella and Prevnar based upon insurance status.

Distribute immunization materials to hospitals, clinics, DOH field offices, day cares, schools, Head Starts, and other interested organizations.

Collaborate with DSS to assess the immunization status of children receiving public assistance through TANF and in the general Medicaid population of children under age two.

Assure access to immunizations for infants and children receiving home visits through Bright Start.

Continue to develop and refine local agency plan to improve assessment, administration and referral for immunizations. The local plan focuses on the WIC/immunization linkage and any infant/child seeking services through OCHS/PHA offices.

Collaborate with DSS to add "Parents Guide to Childhood Immunization" to the Bright Start Welcome Boxes that are sent to new parents.

Review immunization public services announcements to air on radio and television to educate families of the importance of having their child immunized.

Provide technical assistance and resources to 10 local immunization coalitions.

Conduct annual retrospective survey of two-year olds as well as annual audits of immunization records for all kindergarten and transfer students, licensed day care centers, and Head Starts.

Collaborate with Delta Dental, SDDA, and the DOH Oral Health program to assess the immunization status of children receiving services through the South Dakota Dental Care Mobile and provide those immunizations that are necessary to bring children up-to-date (excluding varicella).

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

a. Last Year's Accomplishments

Funded five abstinence education projects. Two projects targeted middle and high schools to

provide abstinence education to youth and three programs provided youth development-based programming to young girls in after-school programs.

Developed an abstinence page on the DOH website (www.state.sd.us/doh) to provide abstinence education.

Provided abstinence curriculum developed by the Black Hills Special Services to the National Abstinence Clearinghouse. If approved, the curriculum would be available to other abstinence education programs.

Provided family planning services to 5,021 adolescents age 19 and under during CY 2003. Of those, 555 were adolescent males (age 19 and younger). Forty-seven percent of adolescents seen were 17 years of age or younger.

Provided community/school education services related to reproductive health to 10,431 adolescents.

Partnered with the Winner community and the Tripp County Public Health Alliance to provide a program for girls in middle school. During the 2002-2003 school year, between 42 and 50 girls attended each monthly sessions.

Continued the Title X Family Planning project for Male Involvement and Research Development in partnership with Youth & Family Services in Rapid City. The Wise Guys curriculum was presented to 474 boys aged 8-16 in a variety of settings.

b. Current Activities

Negotiating new and monitoring existing contracts to provide abstinence education across the state.

Continuing to collaborate with the Title X Family Planning Program on services to adolescents including counseling, education, medical exams, STD screening, and contraceptive supplies.

Providing community/school education programs related to reproductive health to adolescents and parents as requested.

Establishing a new partnership with the Boys and Girls Club of South Dakota through special funding from Region VIII Title X Family Planning Office to conduct a Male Involvement and Research Development Project.

c. Plan for the Coming Year

Collaborate with the Title X Family Planning Program to provide family planning services to adolescents including counseling, education, medical exams, STD screening, and contraceptive supplies.

Provide community/school education programs related to reproductive health to adolescents and parents.

Collaborate with the Department of Corrections to assure juveniles under their supervision are provided education and services necessary to prevent unintended pregnancy.

Provide youth development information and materials that discuss the importance of increasing the protective factors among youth and their relationship to decreasing risk factors among youth to all abstinence grantees.

Continue to provide technical assistance to address teen pregnancy and its related risk factors upon request.

Provide technical assistance as requested to address teen pregnancy and its related risk factors.

Participate as members of the Department of Education Comprehensive School Health State Advisory Committee and Interagency Workgroup. The committee is comprised of individuals representing schools and organizations through the state that work with school age children and youth.

Support an abstinence education project through the granting of funds to local youth serving organizations across the state to increase, enhance and improve abstinence education.

Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

a. Last Year's Accomplishments

Developed an oral health informational booth which was used at the South Dakota Diabetes Conference in April 2003 and the South Dakota School Nurses Conference in July 2003.

Distributed 1,400 oral health informational messages to Head Start, Early Head Start, day care providers, WIC, and Early Childhood Enrichment (ECE) programs.

Provided the DOH regional managers with oral health materials to be used by CHN staff in bulletin board displays.

Visited local elementary schools with dental information for third graders during National Children's Dental Health Month (NCDHM).

Partnered with the South Dakota Dental Association on a press release during NCDHM to encourage parents to develop early healthy dental habits for their children.

Developed an oral health link on the DOH website (www.state.sd.us/doh).

Partnered with the Office of Rural Health to conduct two community dental needs assessments for the Dental Tuition Reimbursement program.

b. Current Activities

Partnering with the State Library to prepare a list of children's dental books to promote NCDHM.

Partnering with WIC and the DSS ECE program to distribute 5,500 infant toothbrushes/gum massagers along with educational materials about the importance of early oral health care.

Providing "train the trainer" oral health education to 30 Head Start and Early Head Start staff as well as the DOH regional managers and 90 CHNs.

Supporting the Outreach Dental Clinic in Watertown which utilizes University of Minnesota dental students to provide dental services to individuals without a dental home. In November 2003, five dental students provided \$34,000 in dental services to 80 patients.

Updating the DOH oral health webpage as needed.

Partnering with the Office of Rural Health to conduct community dental needs assessments for the Dental Tuition Reimbursement Program.

Visiting local elementary schools during NCDHM.

Finalizing and distribute the South Dakota Oral Health Survey Report 2002-2003.

Serving on the advisory board for the South Dakota Ronald McDonald Delta Dental Care Mobile. The care mobile is a 40-foot mobile dental clinic that will provide dental care to underserved children across the state. The DOH is financially supporting Care Mobile staff and coordinating and evaluating oral health educational materials to be distributed to patients.

Collaborating with the Tobacco Control Program to reduce spit tobacco use.

Participating in health fairs for fifth grade students to provide oral health supplies and educational brochures.

Utilizing the oral health informational booth at various events, conferences, health fairs, etc.

c. Plan for the Coming Year

Participate on the Oral Health Coalition steering committee which addresses the following priorities - Education/Prevention, Work Force Development, and Access to Care. The DOH chairs the Education/Prevention workgroup.

Facilitate oral health discussions and planning with partners including SDDA, Delta Dental, Medicaid, Head Start, Office of Rural Health, CHAD, IHS, WIC, and other health professionals regarding options for improving access to oral health care for underserved children in South Dakota.

Facilitate education/training opportunities to update DOH field staff in offices throughout the state (including WIC), community health centers staff, Head Start staff, day care providers, and other health providers on oral health issues.

Work with SDDA to distribute information to dental and medical professionals about encouraging achievement of oral health-related performance measures, HP 2010 and collection of data to measure progress towards these objectives.

Continue discussions with Medicaid, Delta Dental, SDDA, and Office of Rural Health regarding options for improving access to oral health care for children in South Dakota.

Collaborate with the Tobacco Control Program to reduce spit tobacco use.

Collaborate with the Public Health Nutrition and Coordinated School Health programs to provide "train the trainer" sessions for childcare providers.

Continue to partner with Delta Dental on the Care Mobile project to provide services to underserved children.

a. Last Year's Accomplishments

Collaborated with the Office of Highway Safety (OHS) to support special needs child safety seats in South Dakota.

Coordinated with regional CSHS offices to distribute special needs car seat to children whose medical conditions require special seating for safety purposes.

Provide technical assistance on child passenger safety seats and booster seats to local DOH staff, schools and communities.

Collaborated with OHS to promote National Child Passenger Safety Week (NCPSW) by distributing information materials to over 1,500 contacts in the state as well as dissemination of a public service announcement. The theme of NCPSW was to encourage the four steps of child passenger safety -- infant rear-facing, forward facing, booster seat and seatbelts.

Collaborated with OHS on child passenger check points and shared this information with local CHN offices in the state.

Continued to collaborate with OHS and other partners to educate the public on the primary child restraint law for children and youth 18 years of age and under and the importance of using booster seats for children aged 4-8.

Distributed "Ford Boost America" booster seats in Pierre, Sioux Falls, Aberdeen and Spearfish.

Continued to encourage CHS staff to discuss child passenger safety and seatbelt information with parents during well child assessments, home visits, prenatal classes, and health education classes.

Represented the DOH on the OHS Roadway Committee.

Maintained the injury web page on the DOH website (www.state.sd.us/doh).

b. Current Activities

Participating on the Roadway Safety Committee in the development and implementation of the "Office of Highway Safety Plan for South Dakota".

Collaborating with OHS on child passenger safety/check points and sharing this information on with local CHN offices.

Providing information to CHS staff to discuss child passenger safety and seat belt information with parents during well child assessments, home visits, prenatal classes, and health education classes.

c. Plan for the Coming Year

Participate on the Roadway Safety Committee in the development and implementation of the "Office of Highway Safety Plan for South Dakota".

Collaborate with OHS on child passenger safety/check points and share this information on with local CHN offices.

Provide information to CHS staff to discuss child passenger safety and seat belt information

with parents during well child assessments, home visits, prenatal classes, and health education classes.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

Continued to collect breastfeeding initiation rates for the state and by individual hospital via the Newborn Screening Program. Sent letters to hospitals with their individual rates and materials on how to increase and support breastfeeding.

Loaned 175 electric breast pumps to MCH and WIC clientele to encourage continued breastfeeding. WIC also provides program participants with manual breast pumps as needed.

Served as an active member of the Breastfeeding Coalition which is made up of lactation consultants, USD School of Medicine, Cooperative Extension Services, and other interested parties. Collaborated with the Breastfeeding Coalition to promote World Breastfeeding Week's theme "Breastfeeding: Healthy Mothers, Healthy Babies". Obtained a Governor's proclamation for World Breastfeeding Week.

Set up Breastfeeding Coalition's display at the SDSU Nutrition Seminar.

b. Current Activities

Continuing to collect breastfeeding initiation rates for the state and by individual hospital via the Newborn Screening Program. Send letters to hospitals with their individual rates and materials on how to increase and support breastfeeding.

Providing electric breast pumps to MCH and WIC clientele to encourage continued breastfeeding. WIC also provides program participants with manual breast pumps as needed.

Serving as an active member of the Breastfeeding Coalition which is made up of lactation consultants, USD School of Medicine, Cooperative Extension Services, and other interested parties. Collaborating with the Breastfeeding Coalition to promote World Breastfeeding Week with the them of "Exclusive Breastfeeding -- The Gold Standard: Safe, Sound, Sustainable". Obtain a Governor's proclamation for World Breastfeeding Week.

Educating mothers in the Bright Start home visiting, WIC, and perinatal programs on the benefits of breastfeeding and providing support and encouragement to initiate and continue breastfeeding.

Revising the Breastfeeding Self-Study Packet that is used to provide initial and ongoing training to DOH staff who provide breastfeeding counseling. The packet also includes information for support staff to enable them to promote breastfeeding and create a positive breastfeeding environment.

Setting up the Breastfeeding Coalition's display at the SDSU Nutrition Seminar.

Identifying a breastfeeding coordinator for each DOH OCHS office.

c. Plan for the Coming Year

Continue representation on the South Dakota Breastfeeding Coalition to provide a networking

system for breastfeeding education and promotion.

Educate mothers in the Bright Start home visiting, WIC and perinatal programs on the benefits of breastfeeding and provide support and encouragement to initiate and continue breastfeeding.

Enhance partnerships with Medicaid and other health professionals to encourage more women to breastfeed.

Continue to provide and update breastfeeding information on the DOH website.

Collaborate with WIC to develop, purchase and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.

Collect breastfeeding initiation data via the newborn metabolic screening program. Analyze the data and provide hospitals with breastfeeding initiation rate data specific to their facility as well as information on ways to improve breastfeeding rates for their facility.

Set up Breastfeeding Coalition's display at the SDSU Nutrition Seminar.

Partner with CDC Nutrition and Physical Activity Program and OCHS to develop local coalitions to address breastfeeding environment and support in communities.

Partner with CDC nutrition and physical activity programs to provide resources to educators of prenatal and breastfeeding classes.

Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

a. Last Year's Accomplishments

Continued to collaborate with hospitals to ensure that all babies born in South Dakota are screened for hearing impairment before the age of 1 month, evaluation from a diagnostic audiologist by three months of age, and intervention by six months of age.

Facilitated periodic meetings of the Advisory Committee on Newborn Hearing Screening, either in person or via DDN.

Continued to make available trainings with hospitals that received state owned hearing screening equipment.

Submitted a successful application to CDC for data management and tracking and implemented the program in Newborn Hearing Screening.

Participated in the Maternal and Child Health Newborn Hearing Screening grant to implement universal newborn hearing screening of infants prior to hospital discharge.

Distributed educational materials regarding causes of infant hearing loss and language and hearing developmental milestones to the appropriate facilities statewide.

Collaborated with the Office of Vital Records in the statewide implementation of the EVRSS successfully linking birth records with infant metabolic and hearing screening for all infants born in the state. This system allows for tracking of these infants for follow-up, confirmatory testing and treatment. It is linked with the hospitals, physician clinics and audiologists who provide

follow-up and diagnostic services to the infants.

Welcomed an additional diagnostic audiologist to a vastly needed area of the state.

Developed and implemented training manual on the EVRSS program.

b. Current Activities

Continuing to collaborate with facilities to ensure that all babies born in South Dakota are screened for hearing impairment before the age of 1 month, evaluation from a diagnostic audiologist by three months of age, and early intervention by six months of age.

Planning periodic meetings of the Advisory Committee on Newborn Hearing Screening in person and via DDN.

Continue to organize training with facilities that have received state owned hearing screening equipment.

Implement and train facilities on data entry into the EVRSS program with rescreening, medical evaluation, and diagnostic audiological results.

Include Newborn Hearing Screening Program brochure into the Bright Start box which is distributed to each baby that is born in South Dakota.

Update the Newborn Hearing Screening web page with current information.

Ordering video tapes explaining the Newborn Hearing Screening program that is developed in English and Spanish closed caption, along with American Sign Language to be distributed to facilities that do screenings and diagnostics.

Ordering video tapes explaining to parents about early intervention for infants and young children with a hearing loss. This has been developed in English and Spanish closed caption, along with American Sign Language. These will be distributed to facilities that interact with families who have an infant or young child with some degree of hearing loss.

c. Plan for the Coming Year

Continue to collaborate with facilities to ensure that all babies born in South Dakota are screened for hearing impairment before the age of 1 month, evaluation from a diagnostic audiologist by three months of age, and early intervention by six months of age.

Monitor the data entry into the EVRSS for the Newborn Hearing Screening Program.

Continue to train and monitor the facilities in the process of the Newborn Hearing Screening program developed by the State of South Dakota.

Facilitate periodic meetings of the Advisory Committee on Newborn Hearing Screening, either in person or via DDN.

Implement and monitor the tracking of infants with possible hearing loss to the Birth to Three programs for early intervention services and funding.

Implement and monitor the tracking of infants with possible hearing loss with their screener, physician and diagnostic audiologist.

Distribute developed Newborn Hearing Screening materials to the appropriate sites.

Expand public and patient education efforts to reach those who do not have computer access. Make available appropriate materials that are consistent with what appears on the web page.

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

Collaborated with DSS to assure information regarding CHIP and the expanded non-Medicaid CHIP program was distributed to DOH staff and communities. Communication occurs at numerous levels including upper management-level with the HMS Division Director meeting throughout the year with the Director of the Medicaid Program, meetings with program staff from both agencies, and field staff working together on a daily basis to identify and enroll potential eligibles.

Provided CHIP applications in OCHS/PHA offices and assisted in completion of forms as needed.

Participated on the Robert Wood Johnson Covering Kids Initiative. The goal of the project is to improve the health status of low-income, uninsured children by assuring that children who are eligible for health care coverage be linked to health insurance programs.

Included questions regarding children without health insurance on the 2003 BRFSS. Results indicate that there was a slight increase in the percent of children without health insurance from 3.8 in 2003 to 4.1 in 2003.

Provided links to the DSS Medicaid website from the DOH website.

b. Current Activities

Collaborating with DSS to assure information regarding CHIP and the expanded non-Medicaid CHIP program is distributed to DOH staff and communities.

Providing CHIP applications in OCHS/PHA offices and assisting in completion of forms as needed.

Participating on the Robert Wood Johnson Covering Kids Initiative to improve the health status of low-income, uninsured children by assuring that children who are eligible for health care coverage be linked to health insurance programs.

Providing links to the DSS Medicaid website from the DOH website.

c. Plan for the Coming Year

Continue collaborative efforts with DSS to assure information regarding CHIP and the expanded non-Medicaid CHIP program was distributed to DOH staff and communities.

Continue to provide CHIP applications in OCHS/PHA offices and assist in completion of forms as needed.

Continue participation on the Robert Wood Johnson Covering Kids Initiative to improve the health status of low-income, uninsured children by assuring that children who are eligible for health care coverage be linked to health insurance programs.

Provide links to the DSS Medicaid website from the DOH website.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

Maintained ongoing collaboration with DSS to provide EPSDT services. DSS has administrative responsibility for Medicaid and EPSDT in the state and determination limits of eligibility, coverage of services and methods for reimbursing providers as well as set standards for screening protocols and periodicity with recommendations and comments from the DOH. Staff from DSS and DOH coordinated referral mechanisms at the local level to assure potentially eligible clients were appropriately referred.

Maintained interagency agreement with DSS to assure that Title XIX and Title V services are consistent with the needs of recipients and that objectives and requirements of the program are met.

Provided ongoing education to families regarding primary/preventive care for their children and to assure that children seen in public health agencies have a medical home.

b. Current Activities

Collaborating with DSS to provide EPSDT services. Staff from DSS and DOH are coordinating referral mechanisms at the local level to assure potentially eligible clients are appropriately referred.

Maintaining interagency agreement with DSS to assure that Title XIX and Title V services are consistent with the needs of recipients and that objectives and requirements of the program are met.

Providing ongoing education to families regarding primary/preventive care for their children and to assure that children seen in public health agencies have a medical home.

c. Plan for the Coming Year

Continue collaboration with DSS to provide EPSDT services. Staff from DSS and DOH will coordinate referral mechanisms at the local level to assure potentially eligible clients are appropriately referred.

Renew interagency agreement with DSS to assure that Title XIX and Title V services are consistent with the needs of recipients and that objectives and requirements of the program are met.

Provide ongoing education to families regarding primary/preventive care for their children and to assure that children seen in public health agencies have a medical home.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

Participated on March of Dimes Coalition to address issues related to prematurity.

Supported two perinatal health conferences - the Avera Health Systems Perinatal Conference and SD Perinatal Association Annual Conference.

Included education on warning signs of preterm labor to all Baby Care and Bright Start clients.

b. Current Activities

Collaborating with physician and hospital groups to identify issues surrounding delivery of very low birth weight infants.

Participating on March of Dimes Coalition to address issues related to prematurity.

Assessing all pregnant women seen at CHS/PHA sites for risks affecting pregnancy outcomes and provide ongoing education to clients on signs of preterm labor.

Collaborating with the Bright Start and Baby Care programs to educate pregnant women enrolled in the program on signs of preterm labor.

Reviewing documentation to assure that Baby Care and Bright Start charts reflect standards of care and evidence of education related to warning signs of preterm labor.

Developing new brochure "Helping Your Baby by Learning About the Warning Signs of Preterm Labor" for use with pregnant clients.

c. Plan for the Coming Year

Collaborate with physician and hospital groups to identify issues surrounding delivery of very low birth weight infants.

Participate on March of Dimes Coalition to address issues related to prematurity.

Assess all pregnant women seen at CHS/PHA sites for risks affecting pregnancy outcomes and provide ongoing education to clients on signs of preterm labor.

Collaborate with the Bright Start and Baby Care programs to educate pregnant women enrolled in the program on signs of preterm labor.

Review documentation practice in Bright Start and Baby Care programs.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

Continued to update suicide prevention resources on the DOH website.

Partnered with the HELP! Line Center to be a suicide prevention resource in South Dakota. Trained 1,041 gatekeepers through 40 QPR (Question, Persuade & Refer) presentations. Presentations were provided to a variety of groups including: Senior Companions, Southeast Technical Institute staff and students, Washington and Roosevelt High Schools' students, Northeast and Southeast Prevention Resource Centers' staff, Juvenile Detention students, Domestic Abuse Center staff, South Dakota NAMI, South Dakota Peer Helpers, Volunteers of America, and IHS staff. Received 672 calls on the 1-800-Suicide Crisis Line. Distributed 204

"Surviving After Suicide" packets for family and friends that have experienced the loss of a loved one to suicide.

Partnered with the Front Porch Coalition to support QPR Suicide Prevention Training. QPR training was provided for 12 training sessions with a total of 521 individuals being trained from a wide variety of organizations across the state. QPR was also delivered to several Indian reservations including Pine Ridge (30 people), Rosebud (150 people) and Cheyenne River (370 people).

Participated on the DHS Division of Mental Health's Child Subcommittee.

Collaborated with other state agencies and community representatives on the development of a South Dakota Suicide Prevention Plan.

Collaborated with the Children's Safety Network to provide analysis of 21 years of state suicide mortality data and shared the information with the statewide suicide prevention workgroup.

Updated the YRBS display for CHS office to provide local awareness of the behaviors of South Dakota adolescents.

b. Current Activities

Collaborating with other state agencies and community representatives to develop a state suicide prevention plan.

Partnering with the HELP! Line Center and the Front Porch Coalition to serve as a resource for suicide prevention in South Dakota.

Developing a speakers bureau (including standard protocols and information packets for distribution) to give suicide prevention presentations to target audiences associated with at-risk populations.

Assembling and disseminating a resource guide of evidence-based suicide risk screening and assessment tools, prevention programs, related materials, referral tools, and protocols for use by South Dakota caregivers and providing training on its use.

Establishing and widely promoting the 1-800-SUICIDE Hopeline and web-based database to provide up-to-date information for caregivers about the prevention, intervention and postvention services available in South Dakota.

Assessing university-level course content related to suicide and CEU offerings in clinical suicide training.

Working with primary care providers and related associations to build a Physician Champion network.

Forming a workgroup of stakeholders representing schools and youth to develop guidelines for suicide prevention, intervention and postvention policies and practices.

Working with the Suicide Prevention Resource Center and other partners to identify content, outcomes, funding, and distribution mechanisms that have been used elsewhere in public information campaigns for suicide prevention, intervention and postvention.

Working with the South Dakota media industry to recommend guidelines for news coverage of mental illness, suicidal behavior and the effects of suicide.

Collaborating with stakeholders to improve collection, analysis and dissemination of useful data on suicide attempts.

c. Plan for the Coming Year

Continued collaboration with other state agencies and stakeholders to update and share suicide prevention activities and strategies.

Collaborate with other state agencies and community representatives to implement the state suicide prevention plan.

Continue to partner with the HELP! Line Center and the Front Porch Coalition to serve as a resource for suicide prevention in South Dakota.

Maintain a speakers' bureau to give suicide prevention presentations to target audiences associated with at-risk populations.

Maintain a resource guide of evidence-based suicide risk screening and assessment tools, prevention programs, related materials, referral tools, and protocols for use by South Dakota caregivers and provide training on its use.

Promote the 1-800-SUICIDE Hopeline and web-based database to provide up-to-date information for caregivers about the prevention, intervention and postvention services available in South Dakota.

Implement recommended changes to university-level course content related to suicide and CEU offerings in clinical suicide training.

Maintain a Physician Champion network.

Work with the Suicide Prevention Resource Center and other partners to identify content, outcomes, funding, and distribution mechanisms that have been used elsewhere in public information campaigns for suicide prevention, intervention and postvention.

Collaborate with stakeholders to improve collection, analysis and dissemination of useful data on suicide attempts.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

Collaborated with DOH Office of Data, Statistics and Vital Records to reassess the number of very low birth weight infants born at locations other than facilities with Level III nurseries. Analysis of the data continue to reveal that there is no discernable pattern of facility utilization indicating that many of these births may have been the result of onset precipitous labor with little or no advance warning.

See activities under NPM #15.

b. Current Activities

Collaborating with physician and hospital groups, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of very low birth weight infants,

including preterm labor.

c. Plan for the Coming Year

Collaborate with physician and hospital groups, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of very low birth weight infants, including preterm labor.

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

a. Last Year's Accomplishments

Continued to evaluate data available through the Perinatal Health Risk Assessment survey to identify why women do not receive early prenatal care. Changes were implemented with the most recent survey to better identify intervention strategies.

Reprinted the "Health Diary" to provide pregnant women with prenatal education and encourage early and regular prenatal care.

b. Current Activities

Collaborating with physician groups to educate professionals who reportedly tell patients who believe they may be pregnant to delay accessing prenatal care until their fourth month (second trimester).

Encouraging all pregnant clients seen at OCHS/PHA and delegate family planning sites to access early and regular prenatal care.

Collaborating with the Bright Start, Baby Care and WIC programs to facilitate access to early and regular prenatal care for pregnant women enrolled in the program.

Analyze results of 2003 Perinatal Health Risk Assessment survey of new mothers which included questions regarding month prenatal care began.

Reviewing Baby Care and Bright Start documentation to assure adherence to standards of care and provision of education.

c. Plan for the Coming Year

Collaborate with physician groups to educate professionals who reportedly tell patients who believe they may be pregnant to delay accessing prenatal care until their fourth month (second trimester).

Encourage all pregnant clients seen at OCHS/PHA and delegate family planning sites to access early and regular prenatal care.

Collaborate with the Bright Start, Baby Care and WIC programs to facilitate access to early and regular prenatal care for pregnant women enrolled in the program.

Distribute report of the 2003 Perinatal Health Risk Assessment survey of new mothers which included questions regarding month prenatal care began.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Maintain/improve newborn metabolic screening data collection system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Screen/provide necessary follow-up for congenital hypothyroidism, galactosemia, and PKU.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Verify notification of indeterminate and abnormal test results through "Lab Alert" report.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide optional screening for hemoglobinopathy disorders and supplemental (optional) screening via arrangement with the state designated laboratory and Baylor University Medical Center.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Distribute newborn metabolic screening program brochure to health care providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Maintain and update newborn metabolic screening program website.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Link birth/death certificates with newborn metabolic screening program through EVRSS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Update program manual as necessary and distribute to hospitals and clinics in the state.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Refer infants diagnosed with a metabolic disorder to CSHCN program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Conduct site visits as needed with birthing facilities and laboratories to provide technical assistance with screening process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Collaborate with SD Parent Connection on activities to support parents in decision making.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Network with parent groups, private sector and others to promote family involvement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Seek input from parents of CSHCN through a variety of avenues.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide financial support for parent training and support activities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Conduct diagnostic and consultative specialty clinics at the CSHS regional office sites.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide care coordination services to children with chronic medical conditions/disabling illness.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Partner with state Medicaid program to provide high-level care coordination of CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Maintain ongoing relationships with physicians to facilitate coordination of care for CSHCN.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Provide financial assistance on a cost share basis for services for CSHCN.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assist in identification and referral of CSHCN to Medicaid, CHIP and SSI.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Formalize identification/referral process and improve coordination of care for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide pediatric specialty outreach and telemedicine clinics at 3 regional sites.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Assist adolescent CSHCN identify/address needs related to transition to adult life.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Purchase varicella vaccine.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Utilize local field staff to serve on local community immunization workgroups.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

3. Continue as a "selectively" universal vaccine provider and distribute federally-funded vaccine.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Distribute immunization materials to health care providers and other interested organizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Collaborate with DSS to assess immunization status of children receiving public assistance.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Assure access to immunizations for infants/children receiving Bright Start home visits.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Add a "Parent Guide to Childhood Immunization" to the Bright Start Welcome Boxes.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Refine local agency plan to improve assessment, administration and referral for immunizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Review immunization PSAs to educate on the importance of childhood immunizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Promote childhood immunizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Negotiate new/monitor existing contracts for provision of abstinence education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate with Family Planning program on services to adolescents.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide community/school education programs related to reproductive health as requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Establish new partnerships with Boys & Girls Club of South Dakota to conduct Male Involvement & Research Development Project.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Partner with WIC and DSS to distribute infant toothbrushes/gum massagers and education materials on the importance of early oral health care.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide "train the trainer" oral health education to Head Start/Early Head Start staff and DOH regional managers and CHNs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Support Outreach Dental Clinic in Watertown which utilizes University of Minnesota dental students to provide services to individual without a dental home.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

4. Update the DOH oral health webpage as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Partner with the DOH Office of Rural Health to conduct community dental needs assessments for the Dental Tuition Reimbursement Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Serve on the advisory board for the South Dakota Ronald McDonald Delta Dental Care Mobile.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Collaborate with the Tobacco Control Program to reduce spit tobacco use.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Participate in health fairs for 5th grade students to provide oral health supplies and educational materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Utilize the oral health informational booth at various events, conferences, health fairs, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Participate on the Roadway Safety Committee in the development/implementation of the "Office of Highway Safety Plan for South Dakota".	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate with the Office of Highway Safety on child passenger check points.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Distribute special needs child safety seats to children with certain medical conditions.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide materials to CHS staff to discuss child passenger safety with parents during visits/classes.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Collaborate with partners on activities related to injury prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Collect breastfeeding initiation rates for the state and by individual hospitals.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide electric breast pumps to MCH/WIC clientele to encourage continued breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Serve as active member of the Breastfeeding Coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Revise Breastfeeding Self-Study Packet used to provide initial/ongoing training for DOH staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Educate mothers in various DOH programs on the benefits of				

breastfeeding and provide support/encouragement to initiate and continue breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Ensure infants receive timely hearing screening, evaluation and intervention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Hold meetings of the Advisory Committee on Newborn Hearing Screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Organize training for facilities with state-owned hearing screening equipment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Implement and train facilities on data entry into EVRSS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Include Newborn Hearing Screening Program brochure and rattle in Bright Start welcome box.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Update the Newborn Hearing Screening web page with current information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Purchase Newborn Hearing Screening Program videos in English, Spanish and American Sign Language.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Purchase videos explaining early intervention for infants/young children with hearing loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Assure information regarding CHIP is distributed to DOH staff and communities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide CHIP applications in DOH field office and assist in completion of forms as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Participate on Covering Kids Initiative.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide links to the DSS Medicaid website from the DOH website.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Provide EPSDT services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assure Title XIX and V services are consistent with needs of recipients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide education to families regarding primary/preventive care for their children.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Identify issues surrounding delivery of very low birth weight infants.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Participate on March of Dimes Coalition to address issues related to prematurity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Assess/educate pregnant women seen at CHS/PHA sites for risks affecting pregnancy outcomes.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Educate pregnant women enrolled in Bright Start/Baby Care on signs of preterm labor.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Review documentation to assure that Bright Start/Baby Care charts reflect standards of care and evidence of education related to warning signs of preterm labor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Collaborate on development of a state suicide prevention plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Partner with HELP! Line Center and Front Porch Coalition to serve as	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

suicide prevention resource.				
3. Develop a speakers bureau to give suicide prevention presentations to target audiences associated with at-risk populations.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Assemble/disseminate resource guide of evidence-based suicide risk screening/assessment tools, presentations, materials, referral tools, and protocols.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Establish/promote 1-800-SUICIDE Hopeline and web-based database.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Assess university-level course content related to suicide and CEU offerings in clinical suicide training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Develop guidelines for suicide prevention, intervention and postvention policies and practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Identify content, outcomes, funding, and distribution mechanisms for suicide prevention, intervention and postvention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Work with South Dakota media to recommend guidelines for news coverage of mental illness, suicidal behavior and effects of suicide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Improve collection, analysis and dissemination of useful data on suicide attempts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Identify issues surrounding delivery of very low birth weight infants, including preterm labor.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Educate professionals on importance of early prenatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Encourage pregnant clients seen at OCHS/PHS/family planning sites to access early prenatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Facilitate access to early/regular prenatal care for pregnant women in DOH programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Conduct Perinatal Health Risk Assessment survey of new mothers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Review Bright Start/Baby Care documentation to assure adherence to				

standards of care and provision of education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of women who smoked prior to pregnancy and report they stopped during pregnancy.*

a. Last Year's Accomplishments

Placed all editions of the "New Beginnings" newsletter in local CHN offices for distribution to clients. The newsletters are given to each pregnant woman who is risk assessed and receives services through the DOH.

Risk assessed 3,517 clients in FFY 2003 and provided 5,308 visits to those clients eligible for case management services. Approximately 224 clients deemed not eligible for case management services received one or two sessions of prenatal education.

Worked with the Tobacco Control Coordinator to review smoking cessation programs.

Provided smoking cessation materials to Bright Start and Baby Care clients.

Provided information to local CHNs regarding the South Dakota Quit Line.

Continued using computerized data collections and medical record documentation form to gather data on smoking behavior and exposure to second-hand smoke. Fifty one percent of clients risk assessed admitted smoking prior to knowledge of pregnancy while 31% continued to smoke during pregnancy and 23% reported smoking at the time of delivery.

b. Current Activities

Collaborating with March of Dimes, Perinatal Association, American Cancer Society, and CHAD to educate professionals/public about the risks associated with smoking during pregnancy.

Collaborating with Bright Start Home Visit program to educate clients on risk factors associated with smoking during pregnancy.

Risk assessing pregnant clients and provide case management services through Bright Start and Baby Care. Provide tobacco cessation education/referral services to clients identified as using tobacco.

Collaborating with Tobacco Control Coordinator to review and evaluate smoking cessation programs.

c. Plan for the Coming Year

Collaborate with Bright Start home visiting program to educate clients on risk factors associated with smoking during pregnancy.

Risk assess pregnant clients and provide case management services through Bright Start and Baby Care. Provide tobacco cessation education/referral services to clients identified as using tobacco.

Improve case management services provided through Bright Start and Baby Care by means of policy development/revisions and quality assurance activities.

Review and analyze results from the 2003 Perinatal Health Risk Assessment survey of new mothers which includes questions regarding smoking and exposure to second-hand smoke during pregnancy.

Analyze data regarding risks and pregnancy outcomes through updated computer system.

Collaborate with the Tobacco Control Program to review and evaluate smoking cessation programs.

State Performance Measure 2: *The rate (per 1,000 live births) of children under age one who die as a result of Sudden Infant Death Syndrome.*

a. Last Year's Accomplishments

Participated on the South Dakota Infant Loss Center Governing Board in an advisory capacity.

Collaborated with the Infant Loss Center to provide resources to CHS offices and referrals for post-SIDS support.

Accessed materials from the "Back to Sleep" campaign to provide to Baby Care and WIC clients.

Purchased "Back to Sleep" campaign materials to be used in the Bright Start Welcome Boxes.

b. Current Activities

Promoting the "Back to Sleep" Campaign to educate parents and other caregivers on how to reduce SIDS deaths and the importance of laying babies on their back to sleep.

Collaborating with the Bright Start Program to include SIDS and "Back to Sleep" materials in the welcome box for parents of newborns.

Collaborating with Bright Start home visit nurses, Healthy Start contacts, local health councils, DOH staff, Head Start, and registered/licensed day care providers to promote the "Back to Sleep" campaign with new parents.

Collaborating with Infant Loss Center to promote "Back to Sleep" campaign in South Dakota.

Analyzing results of 2003 Perinatal Health Risk Assessment survey of new mothers which included questions regarding "Back to Sleep" information.

c. Plan for the Coming Year

Promote the "Back to Sleep" Campaign to educate parents and other caregivers on how to reduce SIDS deaths and the importance of laying babies on their back to sleep.

Collaborate with the Bright Start Program to include SIDS and "Back to Sleep" materials in the welcome box for parents of newborns.

Collaborate with Bright Start home visit nurses, Healthy Start contacts, local health councils, DOH staff, Head Start, and registered/licensed day care providers to promote the "Back to Sleep" campaign with new parents.

Distribute report of the 2003 Perinatal Health Risk Assessment survey which included questions regarding "Back to Sleep" information.

Collaborate with Infant Loss Center to promote Back to Sleep campaign in South Dakota.

Collaborate with Aberdeen Area IHS and local service units on promoting the "Back to Sleep" campaign on the reservations.

Work with DSVR unit to map out location and race of SIDS deaths in the state.

State Performance Measure 3: *Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.*

a. Last Year's Accomplishments

Provided family planning services to 14,744 clients in CY 2003. Of these clients, 9,537 were women over the age of 19 and 5,021 were adolescents aged 19 and under. Of the total clients, 11,072 were at or below 150 percent of poverty and 18,625 accessed a method of birth control.

During CY 2003, prevented 11,134 pregnancies through family planning services.

Provided community education regarding reproductive health/family planning to 5,241 adults.

Received additional Title X directed supplemental funding to provide cost effective and efficacious contraceptives to increase community education and involvement.

b. Current Activities

Continuing to provide counseling, education, medical, and contraceptive services to women at risk of unintended pregnancy.

Providing community education to individuals and groups regarding reproductive health and family planning topics.

Seeking additional funding through Title X directed supplemental funds to provide cost effective and efficacious contraceptives and continue expanded community efforts and partnerships.

Collaborating with the Title X training grantee JSI Research and Training to plan Reproductive Health Update which will be held in October 2004 in Rapid City. South Dakota providers are being encouraged to attend.

Collaborating with the University of Texas Southwestern Medical Center in Dallas to bring reproductive health clinician training to South Dakota in June 2004.

Disseminating information contained in the 2003 Perinatal Health Risk Assessment Survey

Report through the "South Dakota Public Health Bulletin", health fairs, conferences, etc.

c. Plan for the Coming Year

Continue to collaborate with Title X to provide family planning services to populations at high risk for unintended pregnancy.

Provide community education to individuals and groups regarding reproductive health and family planning topics.

Plan and conduct the 2005 Perinatal Health Risk Assessment Survey of new mothers.

Collaborate on abstinence-only grant activities.

Provide technical assistance to professionals working with target populations regarding the issue of unintended pregnancy and programs that work to reduce unintended pregnancy.

Collaborate with Medicaid and managed care organizations to assure contraceptive coverage.

State Performance Measure 4: *Percent of high school youth who self-report tobacco use in the past 30 days.*

a. Last Year's Accomplishments

Provided statewide telephone-based cessation services to individuals, including youth.

Provided quit line referral materials to DOH field offices, medical providers, partners, and others.

Sponsored community coalitions to work on tobacco prevention at the local level as well as a statewide conference to provide technical assistance to the coalition members and partners.

Promoted implementation of proven prevention education lessons into classrooms along with other prevention efforts to counter the pro-tobacco influences with pro-health messaging.

Served on the DHS Alcohol and Drug Abuse Council.

Provided educational boards to CHS staff to facilitate efforts to inform parents and the community about the health effects of smoking, secondhand smoke and spit tobacco.

Conducted the Youth Tobacco Survey (YTS). Results of the survey are currently being analyzed.

Utilized Prevention Resource Centers to distribute educational materials regarding tobacco use.

b. Current Activities

Issuing RFPs for community coalitions working on tobacco prevention at the local level.

Preparing for and sponsoring a statewide tobacco prevention conference to be held in August 2004 for members of tobacco prevention coalitions and other agencies and partners.

Working with DOE and Prevention Resource Centers to implement a tobacco prevention

education model in South Dakota school systems.

Conducting counter marketing media campaigns at the state and local level focusing on second hand smoke issues, reducing commercial tobacco use by Native Americans, and reducing tobacco use by pregnant women and youth.

Continuing to provide statewide, telephone-based cessation services via the Quit Line.

Preparing a report on the results of the statewide Adult Tobacco Survey (ATS) and YTS. Once completed, the report will be made available on the department's Tobacco Control Program website. Reports will also be distributed to participating schools as well as made available on request.

Utilizing data from the ATS and YTS to refine program activities to address needs of specific populations with higher tobacco use such as Native Americans, youth, young adults ages 18-24, pregnant women, and persons with low incomes.

c. Plan for the Coming Year

Sponsor and provide technical assistance to community coalitions working on tobacco prevention at the local level.

Continue to work with DOE, local communities, and partners across the state to sponsor implement effective tobacco prevention education efforts in schools.

Conduct counter marketing media campaigns at the state and local level.

Continue to provide statewide, telephone-based cessation services via the South Dakota Quit Line.

Continue to provide technical assistance and resources to DOH staff, community groups, medical providers, and others working on tobacco prevention and control.

State Performance Measure 5: *Percent of school-aged children and adolescents who are overweight or obese.*

a. Last Year's Accomplishments

Continued to collect and analyze school height and weight data. One-hundred forty-five schools submitted data on over 20,000 students for the 2002-2003 school year. Data collected for the 2002-2003 school year showed 16% of South Dakota students were overweight or obese and a total of about 1/3 are at risk of becoming overweight or already overweight. Data for the 2003-2004 school year is currently being solicited.

Presented data from the School Height and Weight Report as well as ways to prevent child obesity to a variety of organizations including school nurses, state recreation association, and state school food services personnel.

Provided print materials on child obesity to preschool and elementary schools. Materials were also available on the DOH web page.

Partnered with the Action for Healthy Kids Coalition to promote physical activity and healthy eating for school-aged children and youth.

Evaluated and utilized the CompCare findings to increase the responsiveness of child and adolescent health systems to the high incidence of child obesity in the state.

Sponsored a downlink of the satellite conference "Assessment and Behavioral Management of Childhood Obesity". The downlink was attended by 108 health and nutrition professionals at 10 sites across the state.

Co-sponsored the SDSU Nutrition Seminar on Obesity in March. Over 350 people were in attendance.

Trained all local community health nurses and nutrition staff about pediatric obesity and appropriate counseling. Also provided training to school nurses, school food service personnel, and others who work with children and adolescents.

b. Current Activities

Collecting and analyzing available height-weight data for school-aged children and distribute information to appropriate health and education providers in an effort to reduce the percent of overweight children.

Providing balance beam scales and measuring boards to schools to improve school height and weight data quality and to assist schools who wish to participate in the project but can't due to lack of equipment.

Providing educational information and materials to DOH staff and others for use with parents and schools on how to increase physical activity for all ages of children including strategies to decrease TV viewing.

Promoting the use of CDC growth charts and prevention and treatment guidelines to health professionals.

Collaborating with IHS to address overweight issues of Native American children.

Facilitating appropriate referral of obese children to medical providers for treatment.

Continuing to update and utilize DOH website for consumer and provider resources on overweight children and adolescents.

Coordinating with DOE to support and/or assist schools with selection and implementation of comprehensive health education.

Co-sponsoring SDSU Nutrition Seminar on Type 2 diabetes and sponsor satellite conferences on metabolic syndrome, pediatric allergies, and obesity in Indian country.

Collaborating with the Department of Game, Fish and Parks (GFP) to provide unique physical activity opportunities for youth through disc golf courses and events.

Providing booth and learning event on healthy eating and increased physical activity for school-aged children for State Fair.

c. Plan for the Coming Year

Collect, analyze and interpret available height-weight data for school-aged children and distribute information to appropriate health and education providers in an effort to reduce the percent of overweight children.

Provide balance beam scales and measuring boards to schools to improve school height and weight data quality and to assist schools who wish to participate in the project but can't due to lack of equipment.

Provide educational information and materials to DOH staff and others for use with parents and schools on how to increase physical activity for all ages of children.

Promote the use of CDC growth charts and pediatric prevention and obesity treatment guidelines to health professionals.

Collaborate with IHS and tribal health boards to address overweight issues of Native American children.

Facilitate appropriate referral of obese children to medical providers for treatment.

Coordinate with DOE to support and/or assist schools with selection and implementation of comprehensive health education.

Coordinate with DOE to support and assist schools with physical education standards and assessment.

Continue to update and utilize DOH website for consumer and provider resources on overweight children and adolescents.

Promote limiting television viewing as a strategy to prevent child and adolescent overweight.

Promote the "South Dakota Schools Walk" Initiative for all students in public, private and BIA schools in the state.

Revise and expand physical activity breaks for classroom teachers that reinforce core content standards and provide physical activity for students during the school day.

Provide health care providers a small steps guide for children at risk for overweight and obesity to increase physical activity and healthy eating.

Collaborate with GFP to provide physical activity opportunities for youth such as "Fantastic Fourth Grade Field Trip."

Train DOH field staff in evidence-based strategies to increase healthy eating and physical activity to prevent children overweight.

Collaborate with Coordinated School Health to support local school councils to provide physical activity, nutrition and tobacco prevention programs for school age youth.

Collaborate with CDC Nutrition, Physical Activity, and Obesity program and contribute to state plan to address obesity.

State Performance Measure 6: *Percent of children age 2-5 who are overweight or obese.*

a. Last Year's Accomplishments

Provided print materials on child obesity to preschool and elementary schools. Materials were also available on the DOH web page.

Evaluated and utilized the CompCare findings to increase the responsiveness of child and adolescent health systems to the high incidence of child obesity in the state.

Sponsored a downlink of the satellite conference "Assessment and Behavioral Management of Childhood Obesity". The downlink was attended by 108 health and nutrition professionals at 10 sites across the state.

Co-sponsored the SDSU Nutrition Seminar on Obesity in March. Over 350 people were in attendance.

Developed new print materials on infant and child feeding and weight issues. Provided 250,000 consumer nutrition education pamphlets on a variety of nutrition topics.

Trained all local community health nurses and nutrition staff about pediatric obesity and appropriate counseling. Also provided training to school nurses, school food service personnel, and others who work with children and adolescents.

b. Current Activities

Providing educational information and materials to DOH staff and others for use with parents on how to increase physical activity for children including strategies to decrease TV viewing.

Promoting the use of CDC growth charts and prevention and treatment guidelines to health professionals.

Collaborating with IHS to address overweight issues of Native American children.

Facilitating appropriate referral of obese children to medical providers for treatment.

Working with Bright Start, WIC and others to educate parents on the importance of good nutrition and physical activity for their children.

Continuing to update and utilize DOH website for consumer and provider resources on overweight children.

Co-sponsoring SDSU Nutrition Seminar on Type 2 diabetes and sponsor satellite conferences on metabolic syndrome, pediatric allergies, and obesity in Indian country.

Providing training to Early Childhood Enrichment staff to increase age-appropriate nutrition and physical activity opportunities for preschool children.

c. Plan for the Coming Year

Collect, analyze and interpret available height-weight data for preschool children and distribute information to appropriate health and education providers in an effort to reduce the percent of overweight children.

Provide educational information and materials to DOH staff and others for use with parents and schools on how to increase physical activity for all ages of children.

Promote the use of CDC growth charts and pediatric prevention and obesity treatment guidelines to health professionals.

Collaborate with IHS and tribal health boards to address overweight issues of Native American

children.

Facilitate appropriate referral of obese children to medical providers for treatment.

Work with Bright Start, WIC and others to educate parents on the importance of good nutrition and physical activity for their children.

Continue to update and utilize DOH website for consumer and provider resources on overweight children and adolescents.

Train DOH field staff in evidence-based strategies to increase healthy eating and physical activity to prevent children overweight.

Promote limiting television viewing as a strategy to prevent child and adolescent overweight.

Provide health care providers a small steps guide for children at risk for overweight and obesity to increase physical activity and healthy eating.

Collaborate with CDC Nutrition, Physical Activity, and Obesity program and contribute to state plan to address obesity.

State Performance Measure 7: *Percent of infants who are breastfed at least 6 months.*

a. Last Year's Accomplishments

This is a new performance measure in 2005.

b. Current Activities

This is a new performance measure in 2005.

c. Plan for the Coming Year

Continue representation on the South Dakota Breastfeeding Coalition to provide a networking system for breastfeeding education and promotion.

Educate mothers in the Bright Start home visiting, WIC and perinatal programs on the benefits of breastfeeding and provide support and encouragement to initiate and continue breastfeeding.

Provide information to health professionals, hospitals, worksites, and the public promoting breastfeeding.

Continue to provide and update breastfeeding information on the DOH website.

Collaborate with WIC to develop, purchase and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.

Collaborate with the Nutrition and Physical Activity program to promote continuation of breastfeeding to reduce overweight during childhood.

Partner with the Nutrition and Physical Activity program and OCHS to develop local coalitions to address breastfeeding environment and support in communities as well as provide resources to educators of prenatal and breastfeeding classes.

Set up Breastfeeding Coalition's display at the SDSU Nutrition Seminar.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percent of women who smoked prior to pregnancy and report they stopped during pregnancy.				
1. Educate professionals/public about risks associated with smoking during pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Educate Bright Start/Baby Care clients on risks factors associated with smoking during pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide tobacco cessation education/referral to pregnant clients identified as using tobacco.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Review and evaluate smoking cessation programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The rate (per 1,000 live births) of children under age one who die as a result of Sudden Infant Death Syndrome.				
1. Promote Back to Sleep Campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Include Back to Sleep materials in Bright Start Welcome boxes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Promote Back to Sleep campaign with new parents through Bright Start, Healthy Starts, day cares, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaborate with Infant Loss Center to promote Back to Sleep campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Analyze 2003 Perinatal Risk Assessment survey which included questions regarding Back to Sleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

3) Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.				
1. Provide family planning services to women at risk of unintended pregnancy.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide community education to individual/groups regarding reproductive health/family planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Seek additional Title X supplemental funding to provide cost effective/efficacious contraceptives and community efforts/partnerships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Plan Reproductive Health Update for South Dakota family planning providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Collaborate with University of Texas Southwest Medical Center to bring reproductive health clinician training to South Dakota.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of high school youth who self-report tobacco use in the past 30 days.				
1. Sponsor community coalitions working on tobacco prevention at the local level.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Sponsor statewide tobacco prevention conference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Implement tobacco prevention education model in schools.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Conduct counter marketing medical campaigns at state and local level.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide statewide, telephone-based tobacco cessation services.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Prepare/distribute report of the statewide Adult Tobacco Survey (ATS) and Youth Tobacco Survey (YTS).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Utilize data from ATS/YTS to refine program activities to address specific populations with higher tobacco use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of school-aged children and adolescents who are overweight or obese.				
1. Collect/analyze available school height-weight data and distribute to health/education providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide balance beam scales and measuring boards to schools to improve school height-weight data.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide information on how to increase physical activity for children and				

adolescents.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Promote use of new CDC growth charts and prevention/treatment guidelines to health professionals.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Collaborate with IHS to address overweight issues of Native American children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Facilitate appropriate referral of obese children to medical providers for treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Update DOH website with consumer/provider resources on overweight children and adolescents.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Support/assist schools with selection and implementation of comprehensive health education.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Collaborate with GFP to provide unique physical activity opportunities for youth through disc golf courses and events.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Provide booth at State Fair on healthy eating and increased physical activity for school-aged children.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of children age 2-5 who are overweight or obese.				
1. Provide educational information/materials for parents on how to increase physical activity including strategies to decrease TV viewing.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Promote the use of CDC growth charts and prevention/treatment guidelines to health professionals.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Collaborate with IHS to address overweight issues of Native American children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Facilitate appropriate referral of obese children to medical providers for treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Update DOH website with consumer/provider resources on overweight children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide training to Early Childhood Enrichment staff to increase age-appropriate nutrition and physical activity opportunities for preschool children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of infants who are breastfed at least 6 months.				
1. Participate on the South Dakota Breastfeeding Coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Educate mothers in various DOH programs on the benefits of breastfeeding and provide support/encouragement to initiate and continue breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide information to health professionals, hospitals, worksites, and public promoting breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Update breastfeeding information on DOH website.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop, purchase and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Collaborate with Physical Activity program to promote continuation of breastfeeding to reduce overweight during childhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Address breastfeeding environment and support in communities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

PREVENTIVE/PRIMARY CARE SERVICES FOR PREGNANT WOMEN, MOTHERS AND INFANTS

The state MCH Perinatal program, at the state, regional and community level, provides services, offers technical assistance, and partners with other agencies to improve the health of pregnant women, mothers, and infants and impact pregnancy outcomes. Staff in the community provide direct case management and education services, link clients with appropriate resources and collaborate with public and private partners to assure access to services. Quality of services is assured through formalized activities at the state and local level. Client education materials are made available for both agency staff and private partners to utilize in the provision of services to this population. Training for professionals is provided directly or through collaboration with other agencies.

PREVENTIVE/PRIMARY CARE SERVICES FOR CHILDREN AND ADOLESCENTS

DOH staff at the state, regional and community level provide services, offer technical assistance and partner with other agencies to improve the health of children and adolescents. Staff in the community provide developmental screening, immunizations, school screenings, health fairs, health education for school age children, parent education, and participate locally on various advisory groups such as child protection teams, coordinated school health councils, interagency teams, etc. They share information and resources to facilitate referral to programs such as CHIP, food stamps, and heating assistance for example. Program staff works with state agencies, organizations, communities and partners to provide technical assistance to promote MCH programs. Program staff also participates on several workgroups facilitated by state agencies, such as Division of Drug and Alcohol, Division of Mental Health and Coordinated School Health Programs.

SERVICES FOR CSHCN

The state CSHCN program, at the state, regional, and community level participates in numerous activities to enhance the capacity of the health and related service systems to identify and refer CSHCN in a timely and efficient manner. Networking and public education activities are ongoing by program staff. These activities also provide opportunities to discuss service delivery and other issues impacting CSHCN. MCH funds assist in the provision of respite care services for CSHCN, with staff also assisting in the application process as appropriate. The CSHCN Program Director also represents the program on the State Interagency Coordinating Council for Birth to Three, as well as various work groups and committees at the state level.

F. TECHNICAL ASSISTANCE

The MCH program is committed to assuring that all MCH populations in the state receive the highest quality care and have optimal health. The MCH program is requesting technical assistance in survey design and analysis of survey data for use in locating and addressing health disparities in the state.

V. BUDGET NARRATIVE

A. EXPENDITURES

Activities performed by MCH program and field staff that provide services funded by MCH Block grant are accounted for by a daily time study. This includes funding codes that reflects the population that is being served i.e. child/adolescent, pregnant women, infant and CSHS. Function codes determine if the service was direct, enabling, population based or infrastructure. Examples of this are: developmental screening, immunization administration, travel to provide services, training, networking, quality assurance and case management to name only a few.

The budget amounts reflect our anticipated activities of program and field staff, but actual expenditures can vary based on state economy, PH events such as outbreaks and natural disasters. Due to South Dakota law we are not allowed to have deficit spending so this results in Governor and legislation control of spending of general funds that in turn affect our dollars we have available for MCH block grant match

B. BUDGET

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

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 (i.e., Don't Thump Your Melon project private partners). No foundation or other private funding is currently available or utilized. The level of funds utilized from each match source varies from one year to the next based on availability of funds and the state's allocation process. Increasing inflationary costs have depleted revenue reserves within the DOH and the state as a whole and required shifts in match fund sources.

Budget development is subject to rules and requirements set by BFM that dictate both the process and content of the budget, including availability of funds and limitations on authorization levels. State MCH Programs were first required to use the current format of reporting budgets and expenditures, including levels of the pyramid, in FFY 1999. Since that time, South Dakota has been refining the budget development and expenditure process to meet both state and federal rules and requirements. The DOH continues to work to move to accounting programs that more easily reflects population group and pyramid level reporting requirements.

Direct Health Services: A portion of the MCH block grant has traditionally been allocated to health service delivery (state-employed CHNs and nutritionist/ dietitians) based on DOH time study data. For Alliance sites, services are contracted out to private agencies with the DOH staff providing technical assistance to communities and maintaining its role of assessment, assurance and evaluation. DOH time study data tracks the actual time spent delivering MCH services and activities. CHNs, dietitians, nutritionists, CSHS nurses, dietitians, and social workers provide MCH services statewide to assure a local delivery system of quality public health services. The budget reflects the projected allocations to assure provision of postpartum/MCH home visits, family planning services and direct medical services

for CSHCN. This allocation of funds enables a system of service delivery to assure essential health care services are available in rural areas of the state. DOH continues to move to reduction of direct health care services when appropriate.

Enabling Services: Includes activities to enhance access to care and assist consumers in receiving needed services (i.e., Bright Start toll-free number, care coordination for CSHCN and their families, translation, respite care, and parent support activities).

Population-Based Services: Includes newborn metabolic screening, coordinated school health, injury prevention, bicycle safety, oral health, school screenings, community immunization coalitions, immunizations, outreach and public education, risk assessment of pregnant women, child health conferences/ developmental screenings, and breastfeeding activities.

Infrastructure Building Services: Allocations in this area provide funding to support program staff, benefits, travel, operating, training, supplies, materials, capital outlay, and contractual services. Activities funded include needs assessment, community coordination/collaboration, community assistance, quality assurance, policy development, program planning and evaluation, interagency collaboration, training, technical assistance to field staff and public and private partners, and data collection and analysis.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.