



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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1.4 Overview of the State

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, promoting networking among health care providers in the delivery of care, and improving the health of the people of the state.

Systems development for women, infants, children, adolescents, and children with special health care needs (CSHCN) is an integral part of the DOH planning process. The systems development process includes analyzing service needs and 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.

The DOH focuses on a number of areas related to maternal and child health (MCH) including:

- Reducing unintended pregnancies;
- Reducing infant mortality;
- Improving pregnancy outcomes;
- Reducing morbidity and mortality among children and adolescents;
- Improving the health of, and services for, CSHCN through comprehensive services and support;
- Improving adolescent health and reducing risk-taking behaviors (i.e., intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization);
- Improving state and local surveillance, data collection and evaluation capacity; and
- Improving and assuring appropriate access to health services that are focused on families, women, infants, children, adolescents, and CSHCN.

To help address these issues, the DOH utilizes Title V funds to coordinate, develop and enhance systems of care for women, infants, children, adolescents, and CSHCN. MCH activities and services include, but are not limited to, preconception counseling and patient education, nutrition education, family planning, Bright Start infant/toddler home visits, distribution of prenatal newsletters, parenting education, newborn and well-child assessments, child/adolescent injury prevention, developmental screening, immunizations, metabolic screening and follow-up, newborn

hearing screening, coordinated school health education, care coordination, pediatric specialty outreach clinics, and staff competency/capacity building.

South Dakota is one of the least densely populated states in the nation with 696,004 people living within its 75,955 square miles for an average population density of 9.2 people per square mile (1990 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 over six 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) (see Section V.5.3.). Of the state's total population, 91.8 percent are White, 7.3 percent are Native American and the remaining 0.9 percent are classified as Other.

Many of the Indian reservation counties in South Dakota are considered to be the poorest in the nation, with Shannon County being the poorest. 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. Section V.5.3. shows the percent of people living below the FPL by county. When looking at poverty levels for counties on Indian reservations in the state, these numbers are significantly higher. Table 1 provides data on the percent of the population that lives below the FPL for the four largest reservations in the state. These counties also represent the five poorest counties in South Dakota.

Table 1. Percent of Population Living Below FPL for Four Largest South Dakota Reservations		
County	100% of FPL	200% of FPL
Shannon (Pine Ridge Indian Reservation)	63.1%	87.3%
Todd (Rosebud Indian Reservation)	50.2%	75.3%
Ziebach (Cheyenne River Indian Reservation)	51.1%	73.2%
Dewey (Cheyenne River Indian Reservation)	44.4%	69.6%
Corson (Standing Rock Indian Reservation)	42.5%	67.2%

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 10,695 in 1998 (26 of those were to women not in the 15-44 year age range). 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 1,153 active physicians licensed in South Dakota in 1997. Of those, 55.5 percent practiced in an urban location, 32.5 percent practiced in a large, rural area and 12.0 percent practiced in a small rural area (see Section V.5.3.). For the purpose of the survey, urban was defined as the two most populated counties (Minnehaha and Pennington), large rural as the next 11 most populous counties and small rural as all other counties. Of the 1,153 licensed physicians, 525 are considered primary care physicians (i.e., family practice – 259, internal medicine – 126, pediatrics – 55, OB/GYN – 53, or general practice – 32) for a population to primary care physician ratio of 1,326 to 1 compared to the U.S. ratio of 1,027 to 1. There are also approximately 300 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 (see Section V.5.3.). 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.

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 and lack of access to telephones.

Welfare Reform – The South Dakota Temporary Assistance for Needy Families (TANF) program is a temporary public assistance program administered by the Department of Social Services (DSS) and the Department of 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 because of: (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 South Dakota 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 medical care received. Medicaid managed care 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 is participating in the program.

Children's Health Insurance Program (CHIP) – Effective July 1, 2000, the South Dakota CHIP program was expanded to cover uninsured children through age 18 whose families income are at or below 200% of poverty (\$34,100 for a family of four) (see Health-Related Legislation, below). DSS estimates that an additional 2,4000 uninsured children in families with incomes at or below 200% of poverty will be eligible for the program.

2000 Health-Related Legislation – Of the 565 bills and resolutions introduced during the 2000 South Dakota legislative session, there were several bills which could potentially impact the MCH population.

- **SB 42** – Adds varicella (chicken pox) vaccine to the list of immunizations required for school entry in South Dakota. In addition, the DOH FY01 budget includes \$357,000 to purchase the chicken pox vaccine for two age groups – 12-18 month olds (the recommended age to receive the immunization) and five-year olds. Five-year olds will be included as a “catch-up” measure for about three years. After that, the current infants will be kindergarten age so they will already be immunized.
- **SB 124** – Provides statutory authority to DSS to promulgate rules that would permit the expansion of CHIP as a non-Medicaid (CHIP-NM) insurance program to uninsured children through age 18 in families with incomes up to 200% of FPL. Rules for the program specify that a child is not eligible if they are currently covered by health insurance or have had insurance under a group health plan in the three-month period immediately prior to the date of application for CHIP-NM. A child may still establish eligibility if they had health insurance coverage under a group health plan and that coverage was dropped for good cause. Federal regulations require the state to establish procedures to ensure that coverage provided under the CHIP-NM program is not used as a substitute for coverage under a group health plan.
- **SB 196** – Provides \$1 million in state general funds from the 1999 General Appropriation Act for FY 2000 to the Department of Human Services (DHS) for a tobacco prevention and reduction program (see HB 1243 below).
- **HB 1243** – Establishes a tobacco prevention and reduction program within DHS. Funding for the program comes from the \$1 million in general funds from the

1999 General Appropriation Act for FY 2000 (see SB 196 above) as well as \$700,000 from the FY 2001 general appropriation bill. The bill also establishes an 11-member Tobacco Prevention and Reduction Advisory Board that will meet at least twice a year to develop and approve a statewide strategic plan to prevent and reduce tobacco use including short- and long-term goals, benchmarks and standards for evaluation. The board will also establish program priorities, criteria for awarding grants and assessing overall program performance. Finally, the advisory committee must submit an annual report to the Governor and Legislature detailing progress toward meeting program goals and objectives, including reporting on changes in tobacco consumption, tobacco use rates and attitudes toward tobacco, especially among children and other high-risk populations.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The South Dakota Department of Health is an executive-level department with the Secretary of Health appointed by, and reporting to, the Governor. The DOH is charged with the protection of the public health by appropriate measures set forth and authorized by South Dakota law. The DOH is designated as the sole state agency to receive, administer and disburse federal Title V monies. SDCL 34-1-21 authorizes the DOH to adopt rules to administer the Title V program relating to MCH and CSHCN services. 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.

The DOH is organized into three divisions – Health and Medical Services, Administration, and Health Systems Development and Regulation.

Health and Medical Services (HMS) – HMS is the health care service delivery arm of the DOH. HMS administers the MCH block grant and consists of four offices.

1. **Office of Family Health (OFH)** – OFH provides oversight of MCH and nutrition activities for the DOH. OFH staff provide training and

ongoing technical assistance to Office of Community Health Services and Public Health Alliance field staff as well as private health care providers who deliver MCH services. OFH staff are responsible for the development and update of policies and procedures relevant to delivery of MCH services for pregnant women and infants 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 consultive outreach pediatric specialty clinics and provides financial assistance for specified conditions and procedures on a cost share basis.

Staff administering the perinatal component provide program direction and technical assistance for primary and preventive care for women and infants including risk assessment and care coordination of pregnant women, genetic counseling, perinatal education, prenatal and infant/toddler home visits, metabolic screening, and newborn hearing screening.

OFH also administers the Women, Infants and Children (WIC) program which 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 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's population and recommends appropriate nutrition intervention programming and policies.

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

2. **Office of Health Promotion (OHP)** – OHP coordinates a variety of programs designed to promote health and prevent disease. The Child and Adolescent programs (funded with Title V funds) recommend

appropriate intervention, programming and policies to reduce morbidity and mortality among children and adolescents. OHP also provides technical assistance to communities on such issues as oral health, sudden infant death syndrome (SIDS), school health, injury prevention, and reduction of youth risk-taking behaviors (i.e., intentional/unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug use). OHP is also responsible for coordination of the Abstinence Education program.

The Coordinated School Health Program (CSHP) works closely with the Department of Education and Cultural Affairs (DECA) to provide technical guidance and services to schools.

The *All Women Count!* Breast and Cervical Cancer Control Program covers the costs of mammograms and Pap tests for eligible women, coordinates statewide activities to promote early detection of breast and cervical cancer, and promotes awareness of early detection and treatment. The Diabetes Control Program ensures that people with diabetes are diagnosed and entered into the health care system, provides education materials, promotes screening for gestational diabetes, and provides blood glucose monitors to pregnant women with diabetes.

3. **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; communicable disease testing, counseling and education; 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 these services through contracts with local county governments and private health care providers. The office also administers the Bright Start Home Visitation Program (see Section I.1.5.2 for further details).
4. **Office of Disease Prevention (ODP)** – ODP provides vaccines for South Dakota's children to prevent such childhood diseases as measles, mumps, rubella, varicella, and bacterial meningitis. It also

provides recommendations and education on adult immunizations such as influenza and pneumonia. 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. Other HIV/AIDS services include educational materials, training for the public, schools and health care providers as well as 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 tuberculosis cases.

Administration – 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 state epidemiologist is located in the division and provides epidemiological support, technical assistance and guidance to DOH programs. The Data, Statistics and Vital Records (DSVR) unit is also located in the Division of Administration. DSVR 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, fetal deaths, and abortions and issues certified copies of such records.

The State Public Health Laboratory is also located in the Division of Administration and provides testing, consultation and expert testimony in support of local, state and federal government agencies and the general public.

Health Systems Development and Regulation (HSDR) – 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) is also located in HSDR. The mission of ORH is to improve the delivery of health services to rural and medically

underserved communities with an emphasis on access. Specific program examples include recruitment of health professionals, assistance to facilities such as hospitals and rural health clinics, helping interested organizations develop and use telemedicine applications, and general information and referral.

1.5.1.2 Program Capacity

The state's capacity to provide preventive and primary care services for pregnant women, mothers, infants, and children is outlined in Section I.1.5.1.1. above. The service delivery system in the field is structured to provide services through OCHS/PHA. OCHS/PHA provides direction to state-employed nurses, nutrition educators and dietitians throughout the state for the provision of community health services (see maps of OCHS/PHA sites in Section V.5.3.). Field staff providing primary preventive services for mothers, infants and children include 10.3 FTE for mothers and infants and 11.4 FTE for children and adolescents. Another 9.7 FTE provide family planning services in the state.

The service delivery system for CSHCN is a regional system with 12.2 FTE (including nursing, dietitians and social work) staff providing services at offices in Pierre, Sioux Falls, Aberdeen, and Rapid City. Services are provided in a community-based manner that enables families to receive appropriate consultation and care planning as close to the child's home as possible. Pediatric specialty clinics are held in each of the four regions. 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, the University of South Dakota (USD) School of Medicine and numerous hospitals and physicians across the state.

OFH and OHP central office program staff dedicated to providing program direction to specific MCH program areas include: 2.2 FTE for child and adolescent health, 1.5 FTE for perinatal health, 1.5 FTE for family planning services, and 1.0 FTE for CSHS.

OFH and OHP also receives technical assistance from DOH staff in ODP (immunizations and communicable disease) and Administration (financial management, epidemiological support and health data collection and interpretation).

1.5.1.3 Other Capacity

DOH staff that work on Title V programs have been outlined in Sections I.1.5.1.1. and I.1.5.1.2. Organization charts for the DOH along with curriculum vitas for key staff are provided in Section V.5.3.

1.5.2 State Agency Coordination

South Dakota's public health system includes the DOH, community health centers (CHCs), IHS, and tribal health representatives. These agencies do not directly provide all public health services. In many instances, public health agencies contract with other entities to assure needs are met. While many states use local health departments to deliver services, public health services in South Dakota are typically delivered by the DOH and are funded primarily with federal or state resources. There are two local health departments in the state – one in Sioux Falls and one in Lawrence County. However, their primary function is to inspect food and lodging establishments. Health issues outside the scope of the local departments are handled by the DOH.

The DOH maintains a memorandum of agreement (MOA) with the State Primary Care Association to enhance the delivery of comprehensive primary and preventive health care for the residents of the state. The purpose of the MOA is to demonstrate and increase interaction and collaboration to enhance the delivery of comprehensive primary and preventive health care to achieve 100 percent access and no health disparities in the state. A copy of the MOA for April 1, 2000 to March 31, 2001 is provided in Section V.5.3.

There are eight federally qualified CHCs with 19 sites statewide that provide primary health care services to underserved populations in the state regardless of their ability to pay. Representatives from the DOH and the Community HealthCare Association (CHCA) (formerly the Dakota Association of Community Health Centers) continually explore ways to increase collaboration and coordination of health services. Specific programs which have been targeted for increased collaboration include MCH, family planning, community health services, 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 and health centers in Fort Thompson, Lower Brule, Kyle, McLaughlin, Wagner, and Wanblee. On many of the reservations, tribally-appointed community health representatives also provide services. DOH staff

have ongoing communication with the Northern Plains Healthy Start Project that is under the direction of the Aberdeen Area Tribal Chairman's Health Board. 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. The DOH Data, Statistics and Vital Records office also provides birth and death data to IHS to assist with infant mortality review.

One of Governor Janklow's top priorities is to see that every baby born in South Dakota has the opportunity for a good start in life. His expectations for that good start include initiatives on infant brain development, health care and comprehensive early childhood development that includes physical, intellectual, emotional and social development, and parent training. The Governor's Bright Start Early Childhood Initiative is a comprehensive initiative with components including home visitation, newborn hearing screening; early intervention screening, immunizations, a web site, and a parent/infant welcome box.

The Bright Start Home Visitation program targets expectant mothers and is designed to help them improve their health in order to give birth to a healthy baby. Parents and prospective parents will receive visits from DOH nurses who have been specially trained to provide services under the David Olds home visitation model. Families receiving home visits will learn how to improve their ability to care for their personal health needs, care for their child, stimulate their child's development, and provide a safe and nurturing home environment. The DOH home visitation nurses have received their initial training and started to see families at the end of June 2000. The Home Visitation program is currently being piloted in Rapid City and Sioux Falls and is targeted to low resource, at-risk families.

The Bright Start website (<http://www.state.sd.us/bright/>) provides information that will assist parents or caregivers in nurturing a child's healthy development. Ages and stages information helps parents know what they can generally expect of their child at a specific age. Activities to stimulate domains of development (physical, intellectual, emotional, social) are included with the ages and stages information. Appropriate children's books and music are suggested. This web site also lists books, magazines, videos, links to related web sites, and telephone numbers that can assist parents in raising and nurturing their child.

A Welcome Box will be sent to every newborn infant in South Dakota. The items in the box are intended to assist parents as they help their babies get a

good healthy start in life. The Bright Start Box for South Dakota children includes the book *Good Night Moon*, a *Food for Thought* video, *Mozart Baby* CD, and Ages and Stages book, informational brochures (including information on *Back to Sleep* and SIDS), magnet with Bright Start Toll Free (800) number, library card, and informational inserts.

A Bright Start toll-free number (1-800-305-3064) has been established to provide referrals for service, answer questions and offer general information. The Bright Start toll-free number is a joint effort of many state agencies including DOH, DECA, DSS, DHS, and Labor. This number replaces the 1-800 number that has been used for several years by the DOH, DECA, DHS, and DSS to provide information on drug and alcohol treatment centers, health services, providers for infants and toddlers with disabilities, local DSS services and programs, and information on food pantries and nutrition. This information has been incorporated into the new Bright Start toll-free number.

In March 2000, the DOH was awarded a grant from the Maternal and Child Health Bureau (MCHB) to assist with the planning, development, implementation, and refinement of an early hearing detection and intervention program. Grant funds will be used to establish a newborn hearing screening program in the state that will facilitate screening of babies born in South Dakota by the age of three months and referral of infants identified as having a potential hearing impairment to appropriate follow-up testing, treatment and intervention. The first year of the grant will focus on development of the state infrastructure necessary to provide technical assistance and program support to providers, hospitals, parents and others in an effort to facilitate hearing screening. The second, third and fourth years will focus on refining the infrastructure with the ultimate goal of full implementation of a newborn hearing screening program by the end of the four-year project period.

The DOH collaborates with numerous agencies and organizations on injury prevention activities. The DOH participates on an Injury Prevention Workgroup consisting of representatives from DOH, DECA, Highway Patrol, EMS, Emergency Medical Services for Children (EMSC), and the Office of Highway Safety. The DOH also collaborates with EMSC, EMS, Office of Highway Safety, IHS, and other interested agencies to facilitate implementation of community-based injury programs. Other injury prevention activities include, but are not limited to, poison control, farm safety, bicycle and helmet safety, and seat belts.

The DOH also receives federal abstinence education grant money which it uses to support local abstinence education projects through schools and other community-based organizations.

Through a Title X Research and Development grant, the DOH has developed a partnership with Youth and Family Services in Rapid City to increase male involvement in family planning and reproductive health. Long term results of this project can yield increased responsibility of males to use contraceptives if sexually active, reduced unintended pregnancy rates and improved overall health of the community. The impact will be 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.

The DOH and DSS have an interagency agreement to establish and assure referral mechanisms between agencies. The intent of this agreement is to maximize utilization of services and assure that the 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.

DHS oversees the South Dakota Tobacco Education Project. This 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 regional 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 youth groups on awareness programs and other activities. The mission of the South Dakota Tobacco Education Project is to improve the quality of life for all South Dakotans by reducing the prevalence of tobacco use and addiction. The four specific goals of the Coalition are: (1) prevent minors' access to tobacco; (2) decrease the prevalence of spit tobacco; (3) promote youth-driven community activities; and (4) utilize counter-advertising to promote positive lifestyle choices to create a social environment in which tobacco products are not acceptable. Current Tobacco Education Project members include the DOH, DECA, DHS, Aberdeen Area Tribal Chairman's Health Board, Alcohol and Drug Prevention Resource Centers of South Dakota, American Cancer Society of South Dakota, American Heart Association, American Lung Association of South Dakota, March of Dimes, South Dakota Academy of Family Physicians, South Dakota Academy of Pediatrics, South Dakota Association of Healthcare Organizations, South Dakota Cooperative Extension Services/4-H Youth, South Dakota Dental Association, South Dakota Education Association, South Dakota Foundation for Medical Care, South Dakota High School Activities Association, South Dakota State Medical Association, South Dakota Nurses Association, South Dakota Parent-Teacher Association, South Dakota Pharmacists Association, South Dakota Society for Respiratory Care, IHS, USD Department of Dental Hygiene, Veterans Administration-Black Hills Health Care System, South Dakota Council for Mental Health Centers, South Dakota Soccer Association, South Dakota D.A.R.E. Program, and NYODA Girl Scout Council.

The DOH also collaborates with DHS Divisions of Mental Health and Alcohol and Drug Abuse to address issues affecting children and adolescents and their families such as HIV prevention, suicide, tobacco use (see above) and other associated risk factors. 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.

DHS administers the state's 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 CSHS. Parents are also represented on this group. The program is jointly funded, utilizing state general funds, MCH block grant funds and some DSS federal grant funds. The Respite Care Program offers services statewide. Though funding is limited, all eligible applications were funded during the grant period. 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.

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 Divisions of Mental Health and Developmental Disabilities 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 to support a collaborative relationship between DECA and the DOH in an effort to help local schools implement and coordinate comprehensive school health programs for students that address the six priority risk behaviors. The DOH and DECA have a MOA that outlines areas of responsibility and requirements to implement the program. A very effective relationship has been developed which allows for maximum use of financial and staffing resources.

The DOH also collaborates with DECA to update and revise suicide prevention resources and provides Suicide Prevention Packets as requested. The DOH has also attended meetings of the Aberdeen Area IHS Suicide Workgroup and provides technical assistance to this group as requested. The DOH is also working with CDC to provide analysis and interpretation of state-specific suicide data.

As a result of subjective information about an increasing problem with child obesity in South Dakota, the DOH in cooperation with DECA, school nurses, and physical education and health teachers, developed a method to collect height and weight data for school-aged children in the state. In March 1999, a joint letter from DOH and DECA was sent to all schools in the state requesting

height and weight data for students. Measurements for the 1998-1999 school year were received for over 16,000 students from 110 schools. DOH encoded the data which was then sent to CDC for analysis. 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. A workgroup of various state programs interested in combating child obesity was also started in the Fall of 1999. Members include MCH, WIC, Head Start, School Nutrition Programs, Coordinated School Health, and Child Care including after-school programs.

The DOH has a long-standing collaborative relationship with the South Dakota University Affiliated Program (UAP) 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 UAP 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 CSHCN director serve on the LEND advisory group. In addition to LEND, MCH and the UAP collaborate on a number of training and other interagency projects.

The DOH interacts with the South Dakota Dental Association (SDDA), IHS, DSS, and DECA to address the oral health needs of South Dakota children. DOH staff have met with Medicaid, Delta Dental, SDDA, DHS and Head Start to discuss access to dental services for low income children and review dental health professional shortage areas in the state. The Sioux River Valley Community Health Center (SRVCHC) in Sioux Falls will soon have a three-year federal assignee from the Bureau of Primary Health Care to provide dental services for SRVCHC clients. It is anticipated that the dental assignee will provide approximately 2,300 to 2,500 visits for about 1,500 clients each year. Ongoing assessment and evaluation over the next year by SRVCHC may indicate the need for a second full- or part-time dentist.

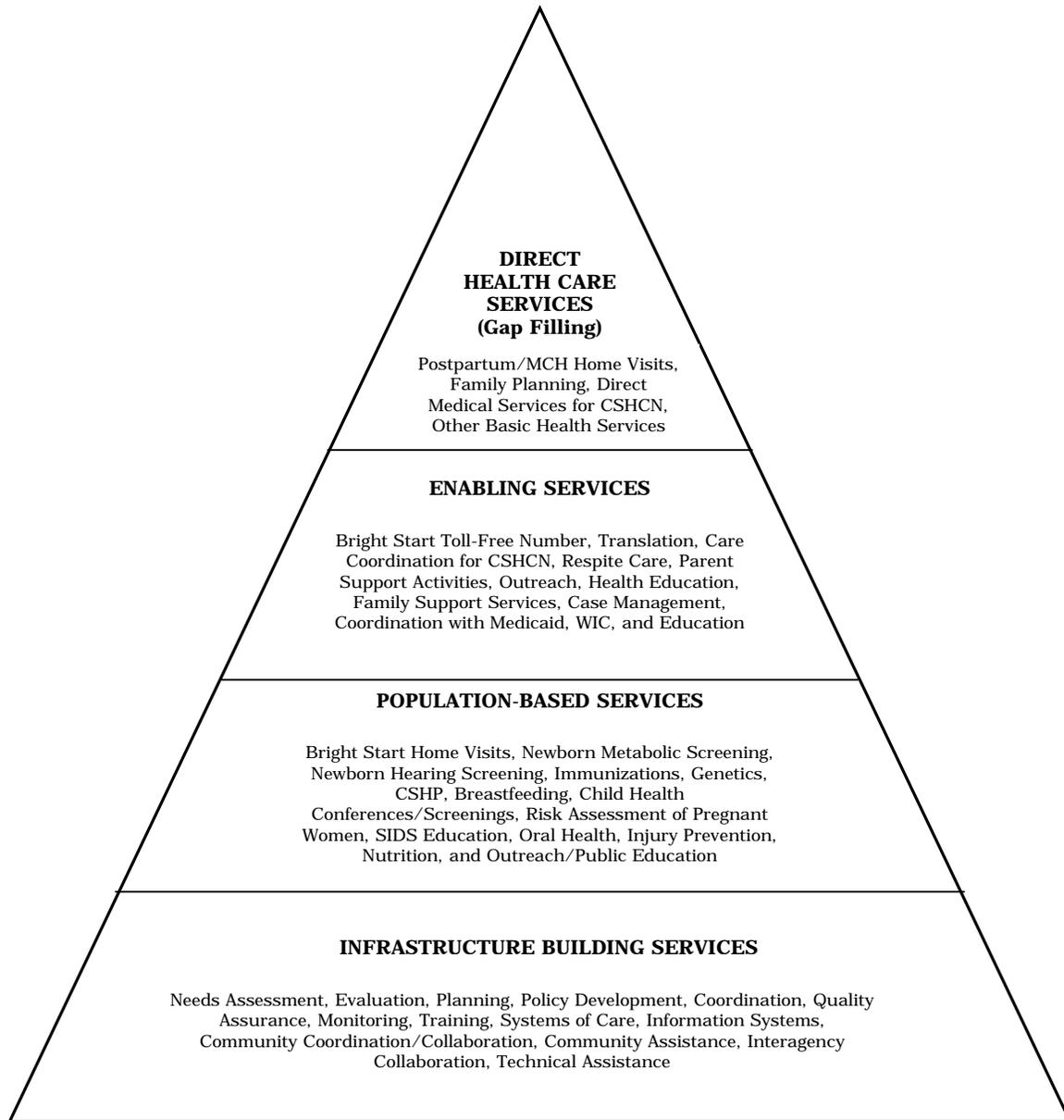
Other ongoing workgroups composed of a wide variety of representation from state agencies meet regularly to conduct program planning, networking and evaluation. The DOH participates on numerous workgroups, task forces and advisory groups including, but not limited to: Respite Care, South Dakota Interagency Coordinating Council for Birth to Three, Governor's Planning Council on Developmental Disabilities, South Dakota Breastfeeding Coalition, and UAP committees. In addition, the DOH has affiliations with other health care organizations and providers such as the South Dakota State Medical Association, Academy of Family Physicians, American Lung Association of South Dakota, Diabetes Association, Infant Loss Center, South Dakota Perinatal Association, March of Dimes, and family support organizations (i.e., Parent Connection, Parent to Parent, Inc., etc.).

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

See Forms 2, 3, 4, and 5 in Section V.5.4.

Figure 1.
CORE PUBLIC HEALTH SERVICES
DELIVERED BY STATE MCH AGENCY



2.2 Annual Number of Individuals Served

See Forms 6, 7, 8, and 9 in Section V.5.4.

2.3 State Summary Profile

See Form 10 in Section V.5.4.

2.4 Progress on Annual Performance Measures

DIRECT HEALTH CARE

CPM #01: 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. (Capacity)

Services for CSHCN

- Collaborated with DHS and SSA 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 that was signed by the DOH, DHS and SSA in December, 1993 assures that SSI child beneficiaries and potential beneficiaries under the age of 18 years are provided appropriate outreach, referral, disability determination, and rehabilitation services.
- Provided care coordination services, information and referral, and outreach specialty clinics to SSI beneficiaries. A total of 357 transmittals were received from SSA during SFY 99 (July 1998-June 1999).

CPM #02: The degree to which the state CSHCN program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. (Capacity)

Services for CSHCN

- Conducted diagnostic and consultative specialty outreach clinics at the four regional CSHS sites in the state. CSHCN not eligible for financial assistance were also seen in specialty clinics and either the child's family and/or appropriate third party payor were billed. CSHS utilized a multi-disciplinary team consisting of pediatric subspecialists, nurses, social workers, and dietitians to provide coordination of care and follow-up for CSHCN and their families. Financial assistance was provided for specified conditions and procedures on a cost share basis according to family size and income. Financial eligibility criteria were based on federal poverty guidelines.
- Provided care coordination services to children with chronic medical conditions and disabling illnesses in South Dakota. These services were provided by the nurses and social workers at the four CSHS regional offices.

- Provided services to 6,087 children with chronic medical conditions and disabling illnesses in South Dakota.
- Provided financial assistance for prescription medications, laboratory testing, radiology testing and procedures, as well as other diagnostic, consultative and treatment procedures

SPM #01: The percent of women on WIC or Baby Care who smoked prior to pregnancy and report they stopped during pregnancy. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Distributed the *New Beginnings* newsletter to 2,311 pregnant clients during FFY 1999.
- Risk assessed 2,299 pregnant clients in FFY 1999 and provided case management services to 1,825 clients. Clients identified as using tobacco were provided tobacco cessation education and referral.
- Redefined risk criteria used to identify those clients eligible for the *Baby Care* program, updated the policies and procedures for *Baby Care* and provided training for staff in August 1999. For those clients not meeting the requirements for *Baby Care*, one or two sessions of prenatal education were provided based on client need.
- Revised the Perinatal Health Risk Assessment survey and distributed to mothers in March 1999 with 1,263 surveys returned. Names of persons returning surveys were entered into a drawing for prizes donated by the South Dakota March of Dimes, South Dakota Perinatal Association, and the Office of Highway Safety.

Other Direct Health Care Services

Preventive/Primary Care Services for Children and Adolescents

- Contracted with 136 schools to deliver coordinated school-based services for the 1998-99 school year. These services included health education, screening and referral services for students and staff. Nursing staff provided the following services during the reporting period:

Hearing screening	2,671
Vision screening	11,759
Scoliosis screening	6,006
Lice screening	553
Assessment/treatment/general screening	7,819
Health counseling education for students	13,791
Developmental screening	23

- Developed school health resources for OCHS staff – specifically addressing head lice.

- Secured and distributed puberty teaching kits to all OCHS staff to assist in school health activities.

ENABLING SERVICES

CPM #03: The percent of CSHCN in the state who have a "medical/health home". (Capacity)

Services for CSHCN

- Required all children served through the CSHS program to identify a physician/health care provider who accepts responsibility for their primary care.
- Continued activities to enhance capacity of CSHS to identify CSHCN in the state. Through networking activities, CSHS provided education about the primary and preventive health care needs of CSHCN and the role this care plays in improving the overall health status of CSHCN.
- Utilized a multi-disciplinary team consisting of pediatric subspecialists, nurses, social workers, and dietitians to provide identification and referral, consultative services, coordination of care, case management, and follow-up for CSHCN and their families.

SPM #02: Identify issues and trends that may impact access to health care for CSHCN and their families. (Process)

Services for CSHCN

- Conducted periodic focus groups across the state with parents of CSHCN to discuss their needs and concerns.
- Participated in local interagency networks to discuss service delivery and other issues impacting CSHCN.
- Served on the Governor's Planning Council on Developmental Disabilities and the South Dakota Interagency Coordinating Council for Birth to Three. Both councils address issues that impact access to services for CSHCN.

Other Enabling Services:

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Coordinated the family planning training needs assessment with a general training needs assessment of all programs. Utilized data collected through the assessment in planning the Public Health Conference.

Preventive/Primary Care Services for Children and Adolescents

- Provided ongoing technical assistance as requested to school districts on *Guidelines for Administration of Medication and Assistance with Self-Administration of Medication.*

- Facilitated ongoing opportunities for Rural Development Telecommunication Network (RDTN) trainings through SDSU, central office staff, satellite downlinks, etc.

Services for CSHCN

- Provided financial support to the Respite Care Program to provide respite care to parents of CSHCN. CSHS staff assisted with referrals of children served through CSHS. The CSHS program director serves as a member of an advisory group for respite care services in the state. The advisory group is made up of parents, as well as staff from DECA, DSS, DHS, and DOH. In SFY 99, 997 children and adults in 773 families were authorized to receive respite care services. The number of children and adults in each diagnosis category were as follows:
 - Developmental disabilities – 443
 - Serious emotional disorder – 265
 - Chronic medical condition – 97
 - Developmental delay – 196
 - Adopted, no diagnosis – 5
 - Severe and persistent mental illness – 2
 - Family at risk – 4
- Continued to improve coordination of care for CSHCN through linkages with other agencies, programs and providers. Activities included staff inservices, maintaining appropriate interagency agreements and multidisciplinary training opportunities.

POPULATION-BASED SERVICES

CPM #04: Percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g., the sickle cell disease)(combined)]. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Continued centralized newborn screening at the Clinical Laboratories of the Midwest (CLM) with initial and repeat specimens completed at CLM.
- Distributed the South Dakota Newborn Screening Manual to providers as needed.
- Conducted ongoing site visits to hospitals and physician offices to provide technical assistance and education regarding newborn screening.
- Collaborated with CLM staff to provide follow-up on infants with indeterminate or abnormal specimens.
- Verified that infants were tested through ongoing matching of lab results to birth certificates. Conducted follow-up with the hospital of birth or physician on infants who did not have testing completed.
- Referred infants diagnosed with a metabolic disorder to CSHS clinics to be followed by the pediatric endocrinologist, dietitian, social worker, and nursing staff.

- Revised the newborn screening computer program to enhance data collection efforts.
- Provided mechanism for hemoglobinopathy screening upon individual request (test is not required by state law).
- Initiated mechanism for supplemental screening (MCAD, etc.) to provide testing upon request (see Section V.5.3.).

CPM #05: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Served on local community immunization workgroups to assess immunization needs and facilitate development of plans to immunize children. There are currently 16 local immunization coalitions across the state.
- Served as a universal vaccine provider. South Dakota is one of a limited number of states that is a universal vaccine provider. ODP distributed federally-funded vaccine free of charge. The OCHS/PHA nurses administered federally-funded vaccine to children and coordinated numerous activities to raise public awareness about the importance of immunizations. OCHS/PHA offices have access to the South Dakota Immunization Information System (SDIIS) which is a computerized network of private and public health care providers that allows the DOH to document and monitor individual immunization events for children in the state. SDIIS also monitors adverse events and generates follow-up reminders for children who are due or behind in their immunizations.
- Distributed immunization materials to maternal/birth facilities, OCHS/PHA offices, WIC offices, schools, day cares, Head Starts, and other interested organizations.
- Collaborated with DSS to assess the immunization status of children receiving public assistance through the TANF program. DOH and DSS state/local staff and primary care providers coordinated efforts to gather immunization records, update the statewide registry system and provide immunizations to those who were due or overdue for vaccinations.
- Continued ongoing collaboration with DSS to assess the immunization rates of children under age two in the general Medicaid population.

Preventive/Primary Care Services for Children and Adolescents

- See activities for CPM #05 under *Preventive/Primary Care Services for Pregnant Women, Mothers and Infants*.

CPM #06: The rate of births (per 1,000) for teenagers aged 15 through 17 years.

(Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Provided family planning services to 5,145 adolescents age 19 and under and provided community/school education services related to reproductive health to 6,199 adolescents.
- Provided technical assistance and education on teen pregnancy and related risk factors upon request.
- Received grant from Title X Family Planning to implement a male involvement project in Rapid City. The project is in partnership with Youth and Family Services in Rapid City and targets young males aged 8-16 years at high risk of early sexual activity.
- Collaborated with DECA on the development of the 1999 YRBS questions.

Preventive/Primary Care Services for Children and Adolescents

- Funded nine abstinence-only projects across the state. Of those nine projects, five were school-based and four were community-based. Two projects specifically targeted Native American adolescents.
- Purchased 20 relationship and marriage curriculums titled *Connections* for Family and Consumer Science teachers across the state. This was part of a collaborative project with DECA, SDSU and other partners.
- Provided Search Institute Resource Packets to all abstinence grantees that discuss the importance of increasing the protective factors among youth and their relationship to decreasing risk factors among youth.
- Provided inservice to OCHS field staff on the adolescent performance measures and activities.
- Developed and disseminated resources to OCHS staff discussing maturation and sexuality for youth with disabilities.
- Provided Catholic Diocese abstinence project video and curriculum guide to one of the youth correctional sites in the state.
- Purchased abstinence resources for local South Dakota school districts that did not compete successfully for abstinence only grant funds.
- Participated on an advisory panel for a cooperative agreement between AMCHP and DASH, with the main focus on decreasing risk taking behaviors of adolescents.
- Provided an overview of the abstinence-only program activities for the DSS TANF field staff.

CPM #07: Percent of third grade children who have received protective sealants on at least one permanent molar tooth. (Risk Factor)

Preventive/Primary Care Services for Children and Adolescents

- Collaborated with CDC and SDDA to finalize analysis of data for the South Dakota Oral Health Survey of School Children.
- Completed report and distributed to partners including the SDDA, DSS/Medicaid and Delta Dental.
- Communicated with SDDA regarding concerns related to access to dental care in South Dakota.
- Provided health education on dental/oral health in school classrooms.

CPM #08: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children. (Risk Factor)

Preventive/Primary Care Services for Children and Adolescents

- Continued partnership with the Office of Highway Safety to promote child passenger safety. The Office of Highway Safety purchased special needs car seats and the child health coordinator oversaw distribution of the seats in the state to children whose medical conditions require special support. Collaborated with CSHS staff in Sioux Falls, Aberdeen, Rapid City and Pierre to work with families with a CSHCN to provide proper fitting of the seat to the child and installation to the vehicle.
- Coordinated with the Office of Highway Safety to provide technical assistance on child passenger safety and information on where to obtain child passenger seats in specific areas of the state. In 1999, the Office of Highway Safety purchased 4,918 child passenger safety seats (1,200 infant seats, 2,382 convertible seats, and 1,336 booster seat) for the Governor's Child Seat Program.
- Assisted the Office of Highway Safety educate the public regarding the state's child passenger restraint law and proper usage of child passenger safety seats. State law requires the driver of any passenger vehicle in South Dakota transporting a child under five years of age to secure the child in an approved child safety seat. Children weighing at least 40 pounds may be secured in a seat belt instead of a safety seat. Children may not be removed from the safety seat for any reason while the vehicle is moving. A driver violating the law will be fined \$20. In 1999, there were five child passenger checkpoints in the state to help parents properly secure and fit the child safety seat correctly in their vehicles.
- Collaborated with Office of Highway Safety in an attempt to strengthen the seat belt law for children under age 18 in South Dakota. Even though these attempts failed, there is a heightened awareness of the issue in the Legislature.

- Discussed child passenger safety information with parents during well child assessments, home visits, prenatal classes, and health education classes provided by OCHS/PHA staff.
- Collaborated with an in-house work group, Office of Highway Safety, EMS, IHS, and EMSC to work together on injury prevention activities and available data in the state.
- See activities for SPM #08 under *Preventive and Primary Care Services for Children and Adolescents*.

CPM #09: Percentage of mothers who breastfeed their infants at hospital discharge. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Started collecting breastfeeding initiation data via the newborn screening form.
- Served as active member of the Breastfeeding Coalition which is made up of lactation consultants, USD School of Medicine, South Dakota State University (SDSU) Extension Services, tribal WIC programs, and other interested parties. The Coalition met with the Governor requesting assistance in promoting breastfeeding. The Governor established a policy for state employees who wish to breastfeed including offering a breastpump as part of the insurance incentive program and established lactation rooms in state buildings for employees and guests to breastfeed. A coordinated effort between Coalition partners also promoted World Breastfeeding Week.
- Developed a breastfeeding display used at the state Perinatal Conference, the state Academy of Pediatrics meetings and the state Public Health Conference.
- Sponsored speaker at the Public Health Conference on breastfeeding.
- Developed policies to alert pregnant women and breastfeeding WIC participants to know their HIV status and to discourage breastfeeding if a mother is HIV positive.
- Purchased 10 more electric breastpumps, bringing the total to 75 electric breastpumps that are available in field offices for high risk WIC participants.

CPM #10: Percentage of newborns who have been screened for hearing impairment before hospital discharge. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Surveyed the 54 hospitals in the state regarding newborn hearing screening. In 1999, 62 percent of infants born in South Dakota were screened for hearing loss.
- Conducted research on newborn hearing screening activities in other states, screening equipment and other issues/trends in newborn hearing screening.
- Provided technical assistance to individuals and facilities as requested.

- Reviewed patient education materials for use by DOH field staff and other health care providers upon request.

SPM #03: Percent of women who report not drinking alcohol upon knowledge of pregnancy. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Risk assessed 2,299 pregnant clients in FFY 1999 and provided case management services to 1,825 clients. Clients identified as drinking alcohol were provided education and referral services to assist in discontinuing alcohol use.
- See activities for SPM #01 under *Preventive/Primary Care Services for Pregnant Women, Mothers and Infants*.

SPM #04: Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Provided family planning services to a total of 14,966 clients in CY 1999. Of these clients, 9,821 were over the age of 19 (100 males) and 5,145 were adolescents aged 19 and under (187 males). Of the total clients, 11,294 were at or below 150 percent of poverty and 14,184 accessed a method of birth control.
- Provided community education regarding reproductive health and family planning topics to 2,436 adults.
- Revised the Perinatal Health Risk Assessment survey and distributed to mothers in March of 1999 with 1,263 surveys returned. Names of persons returning surveys were entered into a drawing for prizes donated by the South Dakota March of Dimes, South Dakota Perinatal Association and the Office of Highway Safety. Questions regarding intendedness of pregnancy and utilization of birth control remained the same as the 1997 survey.
- Piloted computerized client education software at the Downtown Women's Health Care Center in Sioux Falls. The software educates the client regarding birth control methods as well as assessing which method would be best considering client circumstances. This activity was funded through a technical assistance grant from the Title X Regional Office.
- See activities for CPM #06 under *Preventive/Primary Care Services for Pregnant Women, Mothers and Infants* related to teen pregnancy.

SPM #05: Percent of high school youth who self-report taking a drink in the past 30 days. (Risk Factor)

Preventive/Primary Care Services for Children and Adolescents

- Provided technical assistance to Public Health Alliance Community Health Councils, as well as many other communities to help address health issues related to children and adolescents such as suicide, teen pregnancy, eating disorders, and substance abuse.
- Provided materials and technical assistance to several nurses in the SDSU School of Nursing masters program for the development of community projects on such areas as substance abuse, abstinence, nutrition, and youth mentoring projects.
- Provided inservice to OCHS field staff on the adolescent performance measures and activities.
- Assisted DHS review Safe and Drug Free School applications.
- Provided funding to support implementation and maintenance of the Growing Healthy curriculum and Teen Health Teaching Modules (THTM) through a MOA with DECA. These curricula provide children with basic health concepts to help them make appropriate healthy lifestyle choices. During the 1998-99 school year, funding was provided to 34 schools to purchase materials and for teacher training. In addition, collaborated with DECA to provide technical assistance to numerous schools on implementation of the curriculum.
- Collaborated with DECA on the development of the 1999 YRBS questions.

SPM #06: Percent of high school youth who self-report tobacco use in the past 30 days. (Risk Factor)

Preventive/Primary Care Services for Children and Adolescents

- Provided technical assistance to Public Health Alliance Community Health Councils as well as many other communities to help address health issues related to children and adolescents such as suicide, teen pregnancy, eating disorders, and substance abuse.
- Provided materials and technical assistance to several nurses in the SDSU School of Nursing masters program for the development of community projects on such areas as substance abuse, abstinence, nutrition, and youth mentoring projects.
- Disseminated Tobacco Free *Kids Kick Butts Day* kits to all OCHS staff and Alliance Community Council chairpersons.
- Provided inservice to OCHS field staff on the adolescent performance measures and activities.
- Assisted DHS review Safe and Drug Free School applications.
- Provided funding to support implementation and maintenance of the Growing Healthy curriculum and Teen Health Teaching Modules (THTM) through a MOA with DECA. These curricula provide children with basic health concepts to help them make appropriate healthy lifestyle choices. During the 1998-99 school year,

funding was provided to 34 schools to purchase materials and for teacher training. In addition, collaborated with DECA to provide technical assistance to numerous schools on implementation of the curriculum.

- Partnered with the South Dakota Academy of Family Physicians, South Dakota Nurses Association, the American Lung Association of South Dakota, the South Dakota Pharmacists Association, the Respiratory Care Society of South Dakota, and USD School of Nursing to support the Tar Wars program. Tar Wars provides an opportunity for health care professionals, school personnel and community members to form local coalitions to address tobacco use among youth. During the 1998-99 school year, a total of 161 health professionals presented Tar Wars to more than 4,700 fifth grade students in 127 schools/230 classrooms. There were 67 posters entered in the state contest. The winning poster from South Dakota won honorable mention at the national Tar Wars contest. Through a collaborative effort with the DHS Impact Coalition and the American Lung Association of South Dakota, the state's winning poster was made into billboards located across South Dakota. The poster was also made into book covers for fifth grade students.
- Collaborated with DECA on the development of the 1999 YRBS questions.

Other Population-Based Services:

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Collaborated with the South Dakota March of Dimes on folic acid issues. The State Nutritionist attended the kickoff meeting of the national folic acid campaign as did the director of the South Dakota March of Dimes and the past president of the South Dakota Chapter of the Association of Women's Health and Neonatal Nurses.
- Submitted a grant application in cooperation with the South Dakota March of Dimes for a folic acid campaign. While South Dakota did not receive the grant, cooperative efforts in this area continue.
- Presented information on the role of folic acid in the prevention of neural tube defect at the annual meetings of the South Dakota Dietetic Association and the South Dakota Hospital Auxiliary.
- Co-sponsored SDSU Nutrition Seminar in March with topics including calcium and iron during pregnancy and lactation. There were over 250 seminar attendees.
- Sponsored satellite videoconference that was downlinked to 10 sites across the state on the use of herbal remedies including during pregnancy. Nearly 200 attended or viewed the tape.
- Involved the state genetics coordinator in various DOH workgroups and technical assistance activities as needed.

- Participated in the Great Plains Genetics Services Network activities and meetings and the Great Plains Clinical Genetics Society.
- Provided lectures and preceptorships on birth defects/genetics to medical students, interns, residents, and other health care providers.
- Presented information on genetics services to a variety of audiences including child care workers and high school and college students.
- Provided information regarding teratogens to referring health professionals and counseled individuals at risk via the teratogens hotline.

Preventive/Primary Care Services for Children and Adolescents

- Developed two asset-based questions for inclusion in the 1999 YRBS.
- Collaborated with DECA to provide a display board and materials at a Safe Schools Conference sponsored by the Attorney General's Office.
- Participated in Coordinated School Health workgroup and advisory council.
- Participated in the South Dakota Nutrition Network funded by of a Food Stamp grant through the SDSU Extension Service. Focus groups were conducted with low-income families to determine needs and issues to increase quality of diet. A social marketing campaign *Healthy Eating - You and Your Family Are Worth It* was developed. Materials were also developed and distributed to DOH offices for use.
- Trained all field staff via two-hour RDTN on how to maximize early brain development.
- Sent packet of materials to field offices on nutrition and oral health.
- Co-presented information for the nutrition track at the Black Hills Health Education Conference.

Services for CSHCN

- Arranged for the University of Cincinnati videoconference on Nutrition for Special Needs to be downlinked into Pierre and Sioux Falls.
- Provided input to the DSS Medicaid program on specialized formula products including comments on administrative rules, recommendations for appropriate products for specific children and coordination with formula available from the WIC program.
- Provided training on the specialty feeding clinics that are held monthly in Sioux Falls to dietitians working in CSHS clinics. CSHS nutrition staff also attended staff training on cultural awareness and topics specific to nutrition.
- Provided training and coordination for three hyper-phe clients participating in the WIC Program.
- Initiated quality assurance visits for new staff providing CSHS nutrition services to help assure up-to-date and consistent counseling.

- Provided genetics services to individuals and families via CSHS outreach clinics, hospital consultations and other referral sources.
- Participated in numerous outreach and public education activities throughout the year including presentations at interagency meetings, inservices to staff from other agencies and the private sectors, health fairs, and networking and outreach activities with other health care and related providers.

INFRASTRUCTURE BUILDING

CPM #11: Percent of children with special health care needs in the state CSHCN program with a source of insurance for primary and specialty care. (Capacity)

Services for CSHCN

- Assisted in the identification and referral of numerous CSHCN and their families and facilitated their application to Medicaid and SSI.
- Facilitated identification and referral of children eligible for CHIP.

CPM #12: Percent of children without health insurance. (Capacity)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- See activities for CPM #12 under *Preventive/Primary Care Services for Children and Adolescents*.

Preventive/Primary Care Services for Children and Adolescents

- Collaborated with DSS to assure information regarding the expansion of CHIP was distributed to DOH staff and communities. Effective July 1, 1999, the CHIP program was expanded from 133 percent to 140 percent of poverty to cover children aged 6-18 years.
- Continued quarterly meetings with Medicaid/CHIP to facilitate and coordinate outreach efforts.
- Worked with DSS outreach workers to enhance identification of potential eligibles.
- Provided CHIP applications in OCHS/PHA field offices and assisted in completion of forms as appropriate.
- Reevaluated the South Dakota Caring Program in recognition that CHIP will be covering the current Caring Program target population. The Caring Program continued to refer children to CHIP and alternatives for the program continued to be evaluated.

CPM #13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. (Process)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- See activities for CPM #13 under *Preventive/Primary Care Services for Children and Adolescents*.

Preventive/Primary Care Services for Children and Adolescents

- Collaborated with DSS on provision of EPSDT services. DSS Office of Medical Services has administrative responsibility for Medicaid and EPSDT in South Dakota. In that capacity, they determine limits of eligibility, coverage of services and methods for reimbursing providers of health services. They also set standards for screening protocols and periodicity with recommendations and comments from the DOH. EPSDT services are unbundled to allow CHNs to be reimbursed for developmental screening, health education and immunizations. Staff from DSS and DOH coordinated referral mechanisms on the local level to assure potentially eligible clients are appropriately referred.
- Maintained an interagency agreement with DSS to assure that Title XIX and Title V services are consistent with the needs of recipients and that the objectives and requirements of the programs are met.
- Provided ongoing education to families regarding primary and preventive care for their children and to assure that children seen in public health agencies have a medical home.

CPM #14: The degree to which the state assures family participation in program and policy activities in the State CSHCN program. (Process)

Services for CSHCN

- Continued participation in the statewide system of local interagency coordinating networks. CSHS regional staff attended local network meetings and collected information from families and providers of services regarding needs of CSHCN. Single Points of Contact (SPoCs) function as service coordinators for families of children eligible for Birth to Three services.
- Received input regarding service delivery issues and concerns impacting families of CSHCN through the Interagency Coordinating Council for Birth to Three.
- Continued to seek input from consumers, health care providers and other related service providers regarding the needs of CSHCN and their families via discussions at outreach clinics, home visits, focus groups, and local interagency meetings.

CPM #15: Percent of very low birth weight live births. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Supported three perinatal health conferences – the Presentation Health System Perinatal Conference (115 attendees), the South Dakota Perinatal Association Annual Conference (220 attendees), and the 1999 Conference on Infant Mortality in South Dakota (52 attendees). In addition, OFH staff coordinated an annual public health conference with MCH tracks to provide staff and other interested

providers with program updates and continuing education opportunities. The 1999 Public Health Conference had 241 attendees.

- See activities for SPM #01 under *Preventive/Primary Services for Pregnant Women, Mothers and Infants*.

CPM #16: The rate (per 100,000) of suicide deaths among youths aged 15-19. (Risk Factor)

Preventive/Primary Care Services for Children and Adolescents

- Collaborated with DECA to facilitate travel for four individuals to attend the first National Suicide Prevention Conference. These individuals represented public school administration, school counselors and a Native American Advocacy Project as well as the DOH, DECA and DHS.
- Collaborated with DECA to provide a breakout session on Youth Suicide Prevention at the annual Joint Conference for educators statewide.
- Provided suicide prevention strategies to physician assistants at the South Dakota Academy of Physician Assistants annual convention.
- Printed suicide survivor support group booklets for a support group in central South Dakota.
- Provided inservices to OCHS field staff on the adolescent performance measures and activities.
- Developed a youth suicide prevention, intervention and postvention resource packet for schools and communities that included multiple fact sheets, a CD-ROM suicide prevention program and a nationally produced video filmed in South Dakota. This resource was disseminated to all public, nonpublic and Bureau of Indian Affairs (BIA) school districts across the state.
- Collaborated with DECA to provide suicide prevention training to all public school teachers in a central South Dakota county with a disproportionately high youth suicide rate. School staff in an adjacent county were also provided this training. An additional 70 community members were trained in an evening session.
- Held preliminary conversations with HRSA Region VIII, CDC and Children's Safety Network to assist with analysis of South Dakota suicide data, programs and activities.
- Collaborated with DECA on the development of the 1999 YRBS questions.

CPM #17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Collaborated with the DOH Data, Statistics and Vital Records unit to reassess the number of very low birth weight infants born at locations other than facilities with

Level III nurseries. Analysis of the data continues 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 for CPM #15 under *Preventive/Primary Care Services for Pregnant Women, Mothers and Infants*.

CPM #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Revised the Perinatal Health Risk Assessment survey and distributed to mothers in March of 1999 with 1,263 surveys returned. Names of persons returning surveys were entered into a drawing for prizes donated by the South Dakota March of Dimes, South Dakota Perinatal Association, and the Office of Highway Safety. The questions regarding accessing prenatal care were revised to assure specific reasons for not obtaining early prenatal care were identified. The results of the survey can be found on the DOH website at www.state.sd.us/doh.
- See activities for SPM #01 under *Preventive/Primary Care Services for Pregnant Women, Mothers and Infants*.

SPM #07: Communities that develop and implement activities to address youth suicide prevention, intervention and postvention. (Capacity)

Preventive/Primary Care Services for Children and Adolescents

- Provided technical assistance to Public Health Alliance Community Health Councils as well as many other communities to help address health issues related to children and adolescents such as suicide, teen pregnancy, eating disorders, and substance abuse.
- Facilitated a breakout session at the Public Health Conference where a panel of community members discussed the development of a community-based prevention initiative addressing suicide and depression.
- Assisted an eastern South Dakota community Suicide Prevention Committee put on a Suicide Prevention Conference. Support included printing and mailing of brochures. DOH staff also presented information regarding South Dakota suicide statistics and activities to conference attendees.
- Provided resources for display in all OCHS exam rooms that provide a checklist for clients to use to assess whether they might be depressed or at risk for becoming depressed.

- Provided funding to the Volunteer and Information Center to print the QPR resource books to be used in presentations, primarily on the eastern part of the state.
- Updated adolescent suicide fact sheets and made them available on the DOH website.
- Collaborated with DECA on the development of the 1999 YRBS questions.

SPM #08: Communities that establish community-based systems for prevention of childhood injury. (Capacity)

Preventive/Primary Care Services for Children and Adolescents

- Collaborated with EMSC, EMS, Office of Highway Safety, IHS, and other interested agencies to facilitate implementation of community-based injury programs such as the *Don't Thump Your Melon (DTYM)* bicycle/helmet safety program, promoting injury prevention activities and data with communities (Safe Communities), Sioux Valley Hospital Poison Control kits, Child C.A.R.E. kits, etc.
- Assisted EMS and Office of Highway Safety coordinate data, activities and materials for interested communities in preventing injuries.
- Continued coordination of the *DTYM* bicycle/helmet safety program and provided such materials as DTYM brochures, t-shirts, stickers, signs, and educational kit to communities in the state. Collaborated with supporting partners (Office of Highway Safety, EMSC, Sioux Valley Hospitals and Health System, Rapid City Regional Hospital) on the program.
- Collaborated with DSS Office of Child Care Services to promote the importance of bicycle helmets for children at an early age.
- Included injury prevention information in the *Color Me Healthy* calendar.
- Offered *DTYM - Wear a Helmet* signs to communities statewide.
- Served as the state contact to distribute Consumer Product Safety Commission (CPSC) information and alerts to OCHS/PHA offices, nutritionists, family planning offices, CSHS offices, and DSS Office of Child Care Services.
- Collaborated with DSS Office of Child Care Services to implement the Healthy Child Care Grant for South Dakota.
- Continued marketing and education on injury prevention data and information (such as displays, speaking events, DOH website information).
- Partnered with Easter Seal, County Extension offices and local health care providers to expand Save Our Farm Youth safety camps for children in rural communities.

- Collaborated with Sioux Valley Poison Control Education Center on developing and distributing the Poison Control Kit to public/private/BIA schools, public libraries, SDSU Extension Services and Head Start contacts in the state.
- Collaborated with the Office of Highway Safety and Safe Kids Coalition to train contacts in the state to provide education on child passenger safety.
- Conducted child passenger check points to educate others on the correct usage of child safety seats.

SPM #09: Percent of children who are overweight. (Process)

Preventive/Primary Care Services for Children and Adolescents

- Held various planning meetings culminating in a joint letter from the DOH and DECA requesting schools to voluntarily submit height and weight data on school-aged children. Letters were sent to school superintendents, building principals, school nurses, and health/physical activity teachers in March of 1999. By mid-June, 110 schools had sent in measurements on over 16,000 students. Analysis of the data and plans for the report also started during this time period.
- Analyzed data collected from the Pediatric Nutrition Surveillance System and distributed a report of the analysis to DOH field offices and other interested parties.
- Distributed packet of information to field offices regarding sports nutrition for children which included practical information for parents, coaches and health personnel regarding appropriate pre-game meals such as what to pack for long bus trips, supplement use, etc.
- Cooperated with DECA in the development, printing and distribution of educational materials for third and fourth grade students on healthy eating and physical activity.
- Sponsored speaker at the Public Health Conference on child obesity prevention.
- Sponsored satellite conference downlinked to 10 sites (125 participants) across the state on the new growth charts. Topics included how to evaluate and intervene with children who are obese or who have special needs.

SPM #10: Percent of adolescents with disordered eating. (Process)

Preventive/Primary Care Services for Children and Adolescents

- Developed an eating disorder board using a life-size Marilyn Monroe model and Youth Risk Behavior Survey data.
- Held one of 10 national focus groups in November of 1998 regarding prevention of eating disorders in middle school children at the request of Educational Services, Inc. The focus group provided input on eating disorders among Native American

youth and boys. The final result of these focus groups was the HHS initiative *BodyWise*.

- Started an interagency workgroup on Eating Disorders with DECA.
- Collaborated with the SDSU Eating Disorder Group to co-sponsor a statewide training in October of 1999 via RDTN. About 250 dietitians, school nurses, teachers, and counselors attended.
- Sponsored speaker at Public Health Conference on eating disorders.
- Developed brochure on eating disorders that also lists places in South Dakota that provide services.

Other Infrastructure Building Services:

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Assisted with the collection and reporting of data for South Dakota KIDS COUNT. South Dakota KIDS COUNT is a coordinated effort of state agencies, the Annie E. Casey Foundation and the USD State Data Center and is part of a national program designed to promote accountability of children through a nationwide profile of their condition. The goal is to improve the collection of national, state and local data on the well-being of children to increase awareness of their situation and provide the means to address their needs.
- Conducted family planning staff training needs assessment, planned for utilization of training needs assessment completed by all staff and facilitated the Public Health Issues Conference process.
- Facilitated ongoing opportunities for RDTN trainings through SDSU, central office staff and satellite downlinks.
- Continued to collaborate with the Infant Loss Center. The center is responsible for the development of bereavement support services offered to families experiencing the death of an infant.
- Purchased educational materials for the Infant Loss Center Resource Library and other educational materials for dissemination to families, health care providers and other interested parties.

Preventive/Primary Care Services for Children and Adolescents

- Continued review and development of child/adolescent materials through the Child Health Materials Review Committee and the Nutrition Education Materials Review Committee.
- Collaborated with DECA to produce and distribute the *Color Me Healthy* comprehensive school health education calendar to all elementary schools and other interested child care providers.

- Developed display and educational materials for presentations, school health fairs and community health fairs.

Services for CSHCN

- Continued to enhance CSHS capacity for data collection and analysis.
- Continued to formalize identification and referral processes and improve coordination of care for CSHCN through linkages with other agencies, programs and providers. Activities included staff inservices, updating appropriate interagency agreements, and multidisciplinary training opportunities.

2.5 Progress on Outcome Measures

During 1998, there were 10,281 live births in South Dakota. Of these, 8,383 were to White mothers, 1,716 were to Native American mothers, and 182 were to women of any other race or unknown. This included 93 births to Black mothers. In 1998, there were 92 South Dakota resident infant deaths reported for an infant mortality rate of 8.9 per 1,000 live births. In comparison, there were 78 infant deaths in 1997 for an infant mortality rate of 7.7 per 1,000 live births. Although this appears to be a sharp increase, caution should be used when comparing these annual rates. Because the number of South Dakota resident births provides a relatively small denominator to determine infant mortality rates, a small change in the number of infant deaths can result in a relatively large rate change. For instance, there were 60 infant deaths in 1996 for a rate of 5.7 per 1,000 live births while there were 99 infant deaths in 1995 for an infant mortality rate of 9.5 per 1,000. This measurement must be monitored over a period of time. In 1998, the White infant mortality rate was 7.3 per 1,000 live births (61 deaths) and the Native American infant mortality rate was 16.9 per 1,000 live births (29 deaths). South Dakota resident deaths for White infants increased by 35.6 percent and Native American infant deaths increase by 3.3 percent from 1997 to 1998. Since 1980, the total number of infant deaths of races other than White or Native American has never risen above 3 and is more typically 0 or 1.

The number of neonatal deaths in 1998 totaled 46 for a rate of 4.5 deaths per 1,000 live births. The number of postneonatal deaths was 46 for a rate of 4.5 deaths per 1,000 live births. In comparison, the 1997 neonatal and postneonatal rates were 3.9 and 3.7, respectively, per 1,000 live births.

The overall leading cause of infant death for South Dakota residents was certain conditions originating in the perinatal period – accounting for 37.0 percent of all deaths. Considering race, certain conditions originating in the perinatal period were the leading cause of death for both White and Native American infants. They comprised 24 White infant deaths and 9 Native American infant deaths.

Known low birth weight infants accounted for 43.5 percent of the 1998 South Dakota resident infant deaths. For neonatal deaths, known low birth weight infants accounted for 69.6 percent of the resident infants deaths in 1998. In comparison, low birth weight infants accounted for 19.6 percent of all 1998 resident postneonatal deaths.

There are several South Dakota programs which impact neonatal and postneonatal mortality including care coordination of high-risk pregnant women, Back to Sleep, infant car seat, specialty care through the CSHS program, and newborn metabolic screening. Also, the MCH program collaborates with numerous agencies and programs to promote the health of pregnant women and infants including WIC, Medicaid, USD, DHS, DSS, and Birth to Three.

As has been the case for a few years, there were no reported maternal deaths in 1998. Fortunately, maternal deaths are fairly infrequent in a state with just over 10,000 births per year.

The child death rate per 100,000 children aged 1-14 fluctuates considerably due to a small population. It is expected that the seat belt law enacted in 1998 will have an impact on the motor vehicle fatality rate – a major contributor to the child death rate. Other important interventions involve bicycle helmet programs, farm safety programs and other safety education for children. Other sources of data such as ambulance trip reports are evaluated to determine special problem areas.

Programs such as CHIP, Medicaid, CSHCN, and childhood immunization also play a role in reducing the child death rate. Although there is not currently a team review at the state level for every child death in the state, the two most populated counties (Minnehaha and Pennington) do have active local child death review teams.

III. REQUIREMENTS FOR THE APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

In December of 1999, the DOH established a MCH Needs Assessment Workgroup to meet on an ongoing basis for the purpose of: (1) developing a comprehensive data collection system for the State Title V program; (2) assessing the health status of women, children, adolescents, CSHCN, and families in South Dakota; (3) identifying assets, best practices and gaps within the system of care; (4) developing and implementing a five-year plan to be used as an integral part of ongoing program planning; and (5) developing and implementing a surveillance system to monitor the health status of women, children, adolescents, CSHCN, and families. The workgroup, made up of staff from OFH, OHP and DSVR, has also established subgroups specific to the

population groups (i.e., pregnant women and infants, children and adolescents and CSHCN). The DOH has also collaborated extensively with other partners to gather data for the needs assessment (i.e., DSS, DECA, DHS, SDDA, Delta Dental, Office of Highway Safety, March of Dimes, IHS, and others).

To date, the workgroup has focused its efforts on development of the needs assessment for the MCH grant application. With Region VIII technical assistance, the DOH will initiate “next steps” in addressing the issues identified in the needs assessment utilizing the expertise of Dr. Roger Rochat who is a MCH epidemiologist. Once the needs assessment is completed, the workgroup will work with interested stakeholders to assist in prioritization and rating of the needs of the MCH population. Based on input received from stakeholders, the DOH will finalize MCH plans and priorities to determine assets, best practices and needs within the current system of care. Once completed, this will serve as the basis for the MCH Five-Year Plan.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population’s Health Status

Assessing the health status of women, infants, children, adolescents, and CSHCN is an integral part of the DOH planning process. The process includes data collection and analysis, analyzing service needs and 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.

The DOH focuses on a number of areas related to MCH including:

- Reducing unintended pregnancies;
- Reducing infant mortality;
- Improving pregnancy outcomes;
- Reducing morbidity and mortality among children and adolescents;
- Improving the health of, and services for, CSHCN through comprehensive services and support;
- Improving adolescent health and reducing risk-taking behaviors (i.e., intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization);
- Improving state and local surveillance, data collection and evaluation capacity; and

- Improving and assuring appropriate access to health services that are focused on families, women, infants, children, adolescents, and CSHCN.

As was mentioned earlier, South Dakota is one of the least densely populated states in the nation with 696,004 people living within its 75,955 square miles for an average population density of 9.2 people per square mile. 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 over six 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, 91.8 percent are White, 7.3 percent are Native American and the remaining 0.9 percent are classified as Other.

Many of the Indian reservation counties in South Dakota are considered to be the poorest in the nation, with Shannon County being the poorest. According to the 1990 Census, 15.9 percent of South Dakotans live below 100 percent of the 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 with the four largest reservations in the state representing the five poorest counties in South Dakota.

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 10,695 in 1998 (26 of those were to women not in the 15-44 year age range). Pregnancies were estimated by totaling resident births, 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 1,153 active physicians licensed in South Dakota in 1997. Of those, 55.5 percent practiced in an urban location, 32.5 percent practiced in a large, rural area and 12.0 percent practiced in a small rural area. Of the 1,153 licensed physicians, 525 are considered primary care physicians (i.e., family practice - 259, internal medicine - 126, pediatrics - 55, OB/GYN - 53, or general practice - 32) for a population to primary care physician

ratio of 1,326 to 1 compared to the U.S. ratio of 1,027 to 1. There are also approximately 300 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. 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.

3.1.2.2 Direct Health Care Services

See Section III.3.1.2.3 – Enabling Services.

3.1.2.3 Enabling Services

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

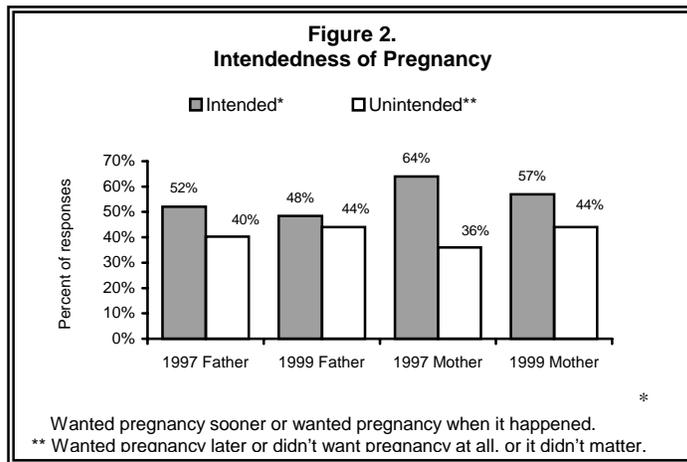
Decisions about sexual behavior and childbearing are personal and family decisions. Although a woman's ability to become pregnant spans almost half of her lifetime, most women today typically want only two children. The timing of these pregnancies is inherent to the overall health and well being of both mother and child. Pregnancies that are unintended – that is, either mistimed or unwanted – can result in serious burdens on children and families.

The consequences of an unintended pregnancy are great. Mothers are more likely to seek prenatal care after the first trimester or not obtain care altogether. She is more likely to expose the fetus to harmful substances such as tobacco or alcohol. The baby is at greater risk of being low birthweight (less than 2,500 grams), of dying in the first year of life, of being abused, and of not receiving sufficient resources for healthy development. The mother may be at greater risk of physical abuse herself, and her relationship with her partner is at greater risk of dissolution. Both mother and father may suffer economic hardship and fail to achieve their educational and career goals.

In the United States, where contraceptive use is the norm, nine in 10 women who are sexually active, are fertile and do not wish to become pregnant, report that they use a contraceptive method. When used consistently and correctly, most birth control methods are very effective in preventing pregnancy. Yet, almost 60 percent of all pregnancies in the United States are unintended. In almost half of these pregnancies, the contraceptive method the couple used did not work as it should have or

they used it inconsistently or incorrectly. In the rest, however, the couple used no contraceptive method.

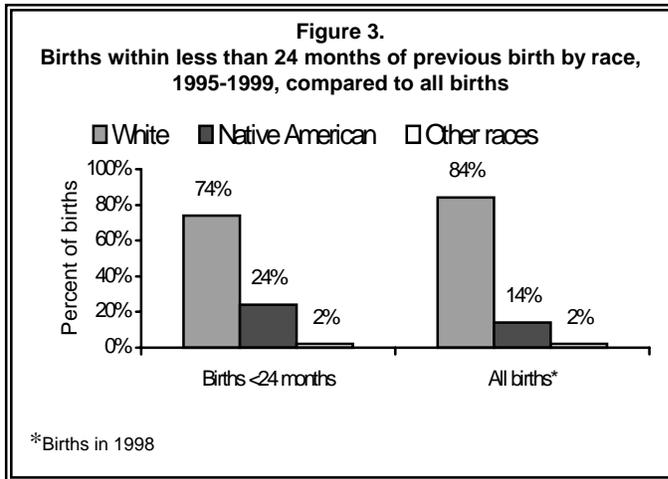
For those couples that choose not to use contraception, most reasons relate one way or another to lack of access. Some people may not be able to afford birth control methods on an ongoing basis; some live a great distance from any family planning service or medical provider. Others may be embarrassed to buy contraceptives or seek services, be reluctant to admit that they are having sex or be afraid of parental or community disapproval.



In South Dakota, results from the Perinatal Health Risk Assessment indicated that 36 percent of the pregnancies in 1997 were unintended while 44 percent were unintended in 1999 (see Figure 2). During both survey years, the intendedness of the mothers surpassed the intendedness of the fathers.

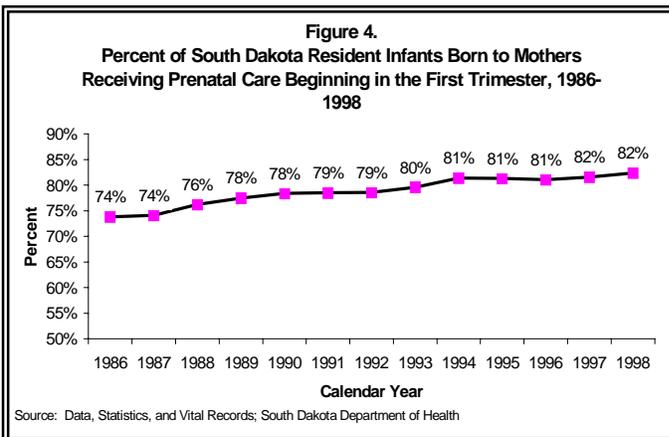
According to 1995 statistics published by the Alan Guttmacher Institute, a leading authority in reproductive health issues, of 162,240 women aged 13-44, 78,010 are at risk for unintended pregnancy in South Dakota. Low-income women and adolescents are at highest risk for not using birth control. In 1995, according to the same source, 17,950 women aged 20-44 and 13,460 adolescents females aged 13-19 were at or below 150% of poverty. Providing reproductive education and counseling services and improving access to clinics where low cost birth control methods are available can reduce the number of unintended pregnancies among South Dakota women in these groups.

Overall, 16.8 percent of births in the state were within less than 24 months of the previous birth (see Figure 3). The rate of close birth intervals was especially apparent among Native Americans with 24



place the woman and fetus at risk.

Many women in the U.S. receive little or no prenatal care even though there has been social support for the importance of prenatal care since the early 1900s. Women beginning care in the third trimester and women receiving no prenatal care are at increased risk for poor pregnancy outcomes.

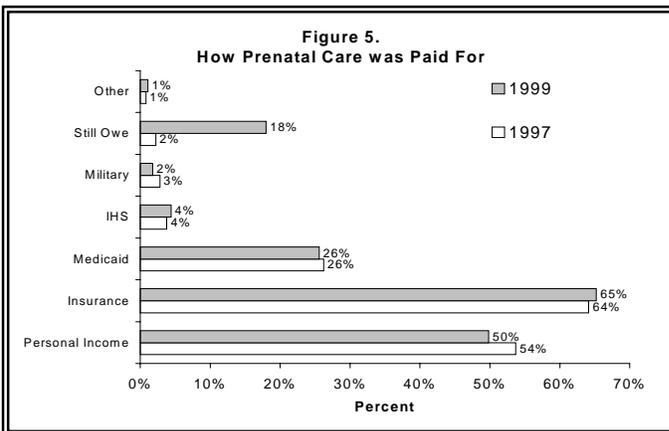


percent of births having less than a 24-month interval compared to their 14 percent share of the births.

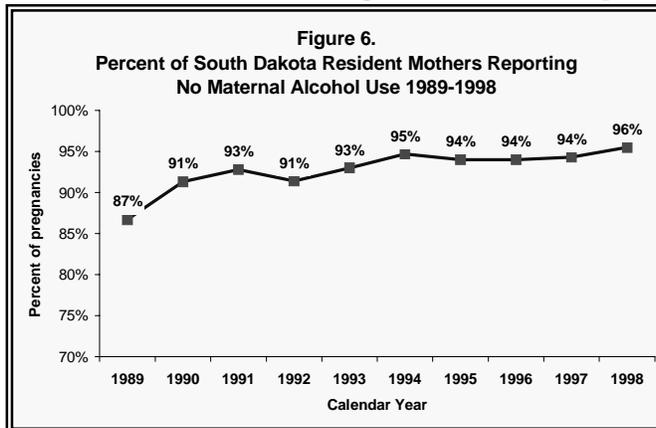
Early and adequate prenatal care has long been associated with improved pregnancy outcomes. Continued contact with the pregnant woman, via comprehensive prenatal care, provides an ideal opportunity for the health care provider to identify potential problems that may

Relatively little is known about factors that influence a pregnant women's decision about initiating and continuing prenatal care. Key demographic factors associated with insufficient prenatal care include poverty, being unmarried, age under 20, higher parity, and having less than a high school education.

Variables that influence use of prenatal care and are associated with the previous demographic factors include an unintended pregnancy, little perceived value attached to prenatal care, a tenuous connection to the health care system, negative experiences with health care providers, financial difficulties, and ambivalence or fear regarding the pregnancy.

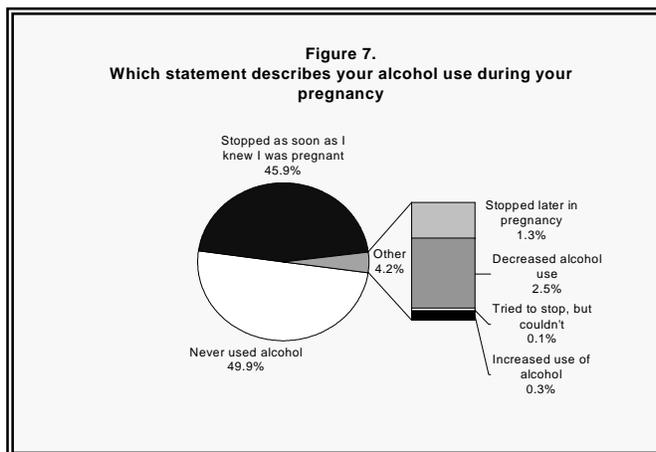


According to South Dakota birth certificate data, 82 percent of women indicated that they received prenatal care in the first trimester (see Figure 4). Figure 5 shows how prenatal care was paid for.

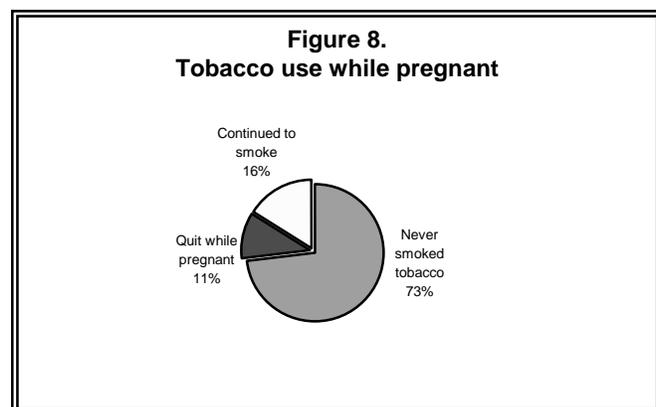


Between 1986 and 1998 there was a steadily increasing trend of mothers receiving prenatal care beginning in the first trimester of pregnancy. This increase is due to improved education of mothers seeking prenatal care and the willingness of providers to see clients during the first trimester.

Four percent of South Dakota mothers reported drinking alcohol while pregnant. The percent of mothers not drinking alcohol while pregnant has been increasing steadily since 1989 (see Figure 6). Of those drinking alcohol, less than one percent said they drank more or they tried to stop, but couldn't (see Figure 7).



Substance use or chemical dependency affects all body systems and can cause cardiac, pulmonary, gastrointestinal, and psychiatric complications. When substance abuse occurs during pregnancy, maternal risk of abruptio placenta, preterm labor, sudden cardiac death, and stroke is increased. Obtaining accurate data related to the use of substances that could be damaging to the well being of the fetus remains an elusive venture.



According to the Perinatal Health Risk Assessment, 73 percent of South Dakota's mothers in 1997 and 1999 reported never

using tobacco (see Figure 8). Of those who smoked, 11 percent reported quitting completely during the pregnancy while 16 percent kept on smoking.

Preventive/Primary Care Services for Children and Adolescents

See information for *Preventive/Primary Care Services for Children and Adolescents* under Population-Based Services and Infrastructure Building Services.

Services for CSHCN

A number of factors challenge the delivery of a continuum of health care for CSHCN, particularly in a rural state like South Dakota. Problems with transportation, funding of care and availability of health care professionals and services top the list (see Section I.1.4).

The National Health Interview Survey (NHIS) was used to operationalize the MCHB definition. The NHIS is a continuing nationwide household survey that is conducted by the Bureau of the Census for the National Center for Health Statistics. Its purpose is to collect information on the health status and use of health services by the U.S. civilian noninstitutionalized population. During 1994, two special supplemental questionnaires on disability, collectively referred to as the National Health Interview Survey on Disability (NHIS-D), were included as topical modules.

The NHIS-D survey found that a large majority of children with existing special health care needs had a usual source of care in 1994 but 5.6 percent were without a usual place to go when the child was sick or when the family needed advice about the child's health. Nearly one in five respondents to the survey reported not being satisfied with at least one dimension of care provided to their child with an existing special health care need. More than one in 10 CSHCN were reported to have an unmet need for medical, dental, vision, prescription medications, or mental health care in the past year.

Children with chronic medical conditions are in need of frequent physician services. The NHIS-D survey found that children with existing special health care needs had more than twice as many physician contacts and five times as many hospital days as other children in 1994. Newacheck and Halfon also found that the presence of a childhood disability is associated with elevated use of health care services. On average, children with chronic conditions were reported to have 8.8 physician contacts annually, about three times the rate for children without disabilities and chronic conditions (2.9 contacts). Children with neoplasms, paralysis or injuries as the main cause of their disability were reported to have the greatest numbers of physician contacts - in each case averaging over 20 contacts annually. The lowest rates of physician

use were found for children with absent extremities and impairments related to speech, special sense and intelligence.

Newacheck and Halfon found that children with chronic, disabling conditions were about four times as likely as children without disabilities to be hospitalized over the course of a year (11.4% vs. 2.8%) and spent eight times as many days in the hospital. As with physician services, use of hospital care varied greatly by diagnostic category.

Ples and Perrin found that despite the obvious and considerable differences among the many specific types of health conditions, important commonalities exist in the experience of children and families affected with various kinds of conditions. Among them are the need for a wide array of community and professional services, heightened challenges to self-concept and optimal emotional development, extra financial hardships, and disruption of family and social activities

CSHCN are frequently in need of allied health professional services such as those provided by physical, occupational, speech and respiratory therapists, medical social workers and psychologists. National data indicates that children with chronic health conditions use six times as many of these services as children who do not have chronic conditions. CSHCN are also high users of prescription medications, vision/hearing aids, orthopedic appliances, DME, expendable medical supplies, and medical transportation services. Care coordination assists families in accessing and managing the wide array of services and providers that children with chronic conditions often require as part of their everyday lives.

Over the last decade, the health services sector has steadily expanded its focus to encompass not only a child's physical status, but also their cognitive, emotional and social status. The CSHCN population is diverse and includes children with many different health problems. Moreover, children with the same medical diagnosis may vary widely in their health care and other related needs. It is clear that health services must be comprehensive to meet the needs of these children. The provision of multiple health services from multiple health providers, as well as other professionals from different disciplines, is often required. Accordingly, a team approach is needed in the provision of services.

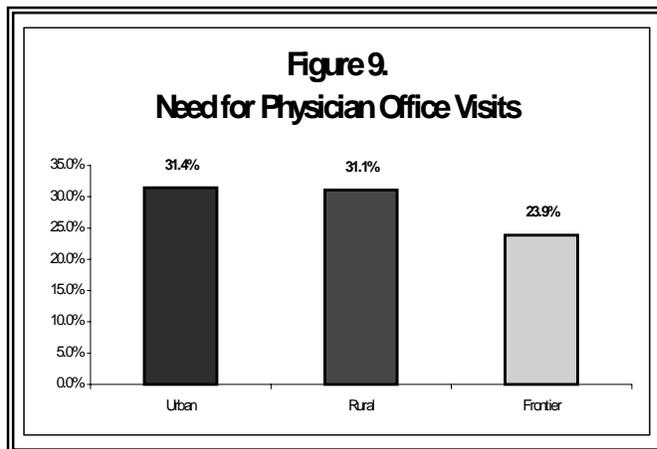
Parent responses in the CSHS 1998 survey revealed that help is needed for medical services by a substantial number of families (see Table 2).

Table 2. Need for Medical Services	
	% Still Need
Physician office visits	28.8%
Dental care	19.3%
Diagnostic Services	18.2%
Developmental Evaluation	15.3%
Medical Supplies	13.7%

Physician office visits was the most common need expressed by parents. Over 33 percent (33.3%) of parents responded that sometimes there are problems with availability of their primary physician. This problem may be compounded by difficulties in payment for medical bills and transportation. Perceptions and expectations differ individually on the issue of how difficult it is to travel to and access office visits. This was taken into consideration in the analysis of parent survey responses.

Regardless, the need for more physician office visits is an obstacle in the

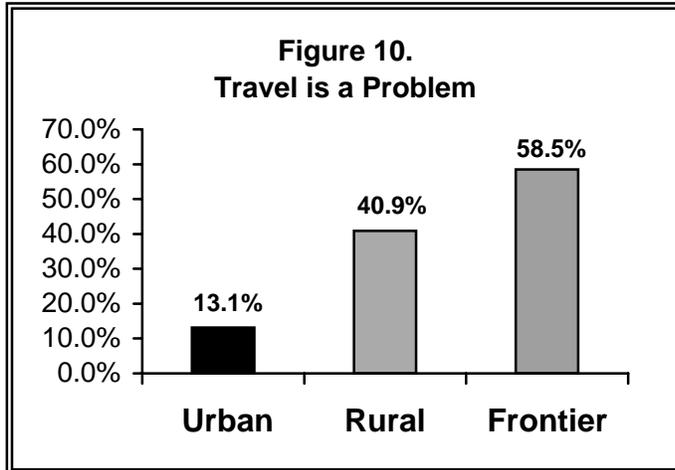
access and delivery of services to families and to complete care of the child. Responses for the need for physician office visits were broken down into urban, rural, and frontier counties (see Figure 9).



The number one problem stated by parents on both survey questions and on write-in responses dealt with funding issues and problems with paying for medical bills. Other

problems of lack of information and educational opportunities reveal the need for more outreach in communities and to families to better provide family-centered and comprehensive care (see Table 3).

Table 3. Need for Education and Supportive Services	
	% Still Need
Payment for medical bills	29.4%
Information on available services	23.1%
Educational opportunities	16.7%
Babysitting services	13.9%
Day care services	13.4%



Transportation is another issue expressed by parents to be an obstacle in receiving services. Thirty-three percent of parents stated that having to travel long distances for care is a problem for their family. Of those living in frontier counties, 58.5 percent indicated that travel was a problem while 40.9 percent of individuals living in rural counties also state that travel is a problem (see Figure 10).

Parents also expressed a need in finding transportation and in getting payment for travel (see Table 4). These problems show the need for more comprehensive care. Improved comprehensive care focuses on the family as a whole and on all issues involved in accessing and receiving care for the child.

Table 4. Need for Transportation and Services	
	% Still Need
Traveling long distances is a problem	33.0%
Need help getting payment for travel	13.7%
Need help finding transportation	4.9%
Babysitting services	13.9%
Day care services	13.4%

Transportation problems for parents were expected in this needs assessment because of the vastness of the state of South Dakota and the shortage and distribution of health professionals in the state. This is an important issue when discussing access to care for CSHCN and their family. For those families living on reservations, the lack of a reliable transportation system and a lack of access to telephones may complicate the problem of accessing health care for their children.

Parents were asked to respond to ways in which service coordinators can help in acquiring needed services (see Table 5). Funding and the need for help with paying bills were the primary issues and problems for families. Additional concerns involve the need for service coordinators to spend more time in the non-medical management of their clients. One-third of parents expressed interest in receiving information about

organizations related to their CSHCN. Information about support groups, programs about available services and connections with other families is needed in order to provide comprehensive care to these children and families. Parent focus group participants also expressed the need for more support groups for families of CSHCN. Those support groups that are available in their community are for all ages and the issues are too variable to be helpful for these parents.

Table 5. Services Most Needed by Parents	
	% Still Need
Help with paying bills	19.6%
Understanding Medicaid's Healthy Kids Program	18.4%
Linking with other families	18.1%
Getting information about support groups	15.2%

In the CSHS survey of physicians completed in 1998, physicians were asked to estimate the number of CSHCN that they see during an average week. Forty two percent of physician respondents reported seeing one to two CSHCN a week, 23 percent reported seeing three to five CSHCN a week, and 10.8 percent reported seeing six to ten CSHCN during an average week. Approximately 15 percent reported seeing over ten CSHCN in an average week.

Almost half of physician respondents did not characterize themselves as having a particular interest or expertise in the care of children with developmental disabilities, chronic illnesses or special health care needs which indicates a major obstacle in access to care for CSHCN and their families (see Table 6).

Table 6. Physician Interest and Expertise			
	Yes	Somewhat	No
Developmental disabilities	10.8%	37.8%	45.0%
Chronic illnesses	18.9%	36.9%	37.8%
Special health care needs	13.5%	33.3%	45.0%

Physicians were asked to rate their ability to obtain comprehensive services and coordinated care in their community for 23 chronic conditions (see Table 7).

Table 7. Conditions for Which It Was Difficult for Physicians to Obtain Services	
Condition	%
Cleft lip/palate/other craniofacial abnormalities	46.8%
End stage renal disease	33.3%
Congenital cardiac conditions	29.7%
Spina bifida	27.9%
Hemophilia	22.5%
Muscular Dystrophy	18.9%
Cystic Fibrosis	18.9%
Developmental disabilities	17.1%
Fetal alcohol syndrome	16.2%
Cancer	16.2%
Cerebral Palsy	14.4%
Behavior disorders	14.4%
Mental retardation	14.4%
AIDS	14.4%
Orthopedic conditions	13.5%
Seizure disorders	12.6%
Metabolic disorders	12.6%
Down's Syndrome	11.7%
Vision/eye disorders	11.7%
Juvenile onset diabetes	9.9%
Asthma	9.0%

In the needs assessment questionnaire, physicians indicated the activities needed but not easy to obtain (see Table 8). Again, these responses reflect the perception of need by physicians in the availability of service coordination activities. The lack of or difficulty in obtaining these services may reflect the need for better cooperation among agencies to improve the level of comprehensive and coordinated care for these children.

Table 8. Service Coordination Activities Perceived by Physicians as Needed	
	Needed and Not Easy to Obtain
Help with paying bills	33.3%
Finding transportation	29.7%
Staying out-of-town overnight	27.9%
Linking with other families	26.1%
Getting payment for travel	26.1%
Finding an interpreter	25.2%

Family Voices and Brandeis University conducted a national survey in 1998 of families with CSHCN. The survey was sent to 2,220 families in 20 states. The children had a wide variety of conditions with many being affected by more than one condition. One third of the children had a severe health condition. The average income for families was \$34,327, with about a third of the families with annual incomes below \$20,000. Families lived in urban, suburban and rural communities. Children in the study had health insurance coverage from a variety of payers with a third of the children having a secondary source of health coverage, most often a public program such as Medicaid.

Children in the Family Voices survey used many health care services. In the preceding 12 months, over three quarters had used specialty doctors and prescription medications, almost half received therapies, over a quarter received home health services, and almost a fifth received mental health services. Families reported that almost half needed durable medical equipment (DME) and over a third needed disposable medical supplies. Almost half of children in the survey were receiving home health care. Those receiving mental health services and those receiving therapies had encountered problems such as finding skilled and experienced providers and getting adequate coverage. A third of those needing DME and a quarter of those needing disposable medical supplies did not get them or had problems.

Many families reported not getting the care coordination they needed while many parents reported that they coordinated the numerous systems and payers of health care for their child themselves, relying on information from other parents to help them. Families who had case management that “worked” found it very helpful.

Most families gave high ratings to their child’s primary care provider and to the doctor they identified as most important to their child’s care. Almost half the parents said that a specialist rather than a primary care doctor was their child’s most important doctor.

The Family Voices survey found that for many parents, having a CSHCN had a significant family impact, affecting their finances, jobs and time spent providing direct health care. Nearly two-thirds of the parents reported that they had reduced their hours of employment and/or stopped working because of their child’s conditions. Half the families reported experiencing financial problems associated with meeting their child’s

needs. Families who had a child with Medicaid as a primary plan were less likely to report an impact on family finances.

A study done by Gortmaker et al, utilizing NHIS data confirms the presence of a chronic health condition as a significant risk factor for behavioral problems in children and adolescents in the U.S. This increased risk was independent of the socioeconomic, demographic and racial characteristics of the household. Gortmaker et al feel there is evidence that both targeted and comprehensive service interventions can improve the psychosocial functioning of children and adolescents with a chronic condition. The continuing evidence for risk, the demonstrated need for better coordinated and financed services and the success of some intervention studies to date signals the need for further interventions and their careful evaluation.

The Respite Care Program in South Dakota is an interagency project administered by DHS. There are several state and federal sources of funding for respite care services, including Title V/MCH and state general funds. Table 9 shows utilization of respite care services by primary diagnosis category.

Diagnostic Category	Time Frame		
	July 1996 - June 1997	July 1997 - June 1998	July 1998 - June 1999
Total			
Children & Adults Families	695	781	997
Developmental Disability	508	591	773
Serious Emotional Disturbances	318	361	433
Chronic Medical Condition	199	201	265
Developmental Delay	72	82	97
Adopted - No Diagnosis	101	125	196
Severe & Persistent Mental Illness	5	5	5
Family At Risk	0	2	2
	0	5	4

A study by Garwick et al regarding parental perception of helpful versus unhelpful types of support in managing the care of preadolescents with chronic conditions found that although parents reported receiving emotional, informational and practical help from all three clusters of support (i.e., family, service providers, and community), they placed different emphasis on the helpfulness of particular types of support they

received from these sources. Both mothers and fathers reported receiving more helpful emotional support and practical help than informational support from other family members. In contrast, participants in the study identified service providers as giving more helpful information and emotional support than practical help. According to both mothers and fathers, community leaders provided more helpful emotional support than practical help or information.

The five most common types of unsupportive behaviors from health care providers as found in the study, in descending rank order, were:

- Talked to parent or child in an insensitive, dismissive or rude way;
- Conveyed a disrespectful or negative attitude toward the child or family;
- Provided inadequate information about the child's condition or care;
- Provided inadequate services or referrals; or
- Provided poor care or treatment.

Approximately half of the incidents were related to communication problems between health care providers and families. Lack of information about the child's condition and care was another theme that families emphasized. A number of parents described problems with access and delivery of services from health care providers. Difficulty in accessing needed services, inadequate services and referrals, poor care and treatment, misdiagnosis, and fragmented care were perceived as unsupportive by parents.

This study also addressed the school system. The five most common types of unsupportive behaviors from school providers, in descending rank order, were:

- Provided inadequate services;
- Insensitive to the child's needs;
- Lacked understanding about the child's condition;
- Inadequate professional knowledge or training; or
- Did not recognize the child's problems or needs.

A number of parents in the study had difficulty accessing school-based services while other parents reported that existing services were inadequate. Parents were concerned not only about school personnel who treated their child unfairly, but also about those who were overly protective.

In the Garwick et al study, families of young children were adjusting to the diagnosis and searching for informational, emotional and practical support to meet the demands of the illness, while families of preadolescents were already linked to resources. These findings suggest that perceived social support differs in relationship to the time of diagnosis, which is an indicator of the length of time the family has had to adjust to the child's chronic condition.

3.1.2.4 Population-Based Services

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

While there is currently not a statewide newborn hearing screening mandate in place in South Dakota, several hospitals voluntarily provide hearing screening for newborns.

To encourage more hospitals to screen for hearing impairment, a joint letter from Governor Janklow and the Secretary of Health was sent to all hospitals in the state in December 1999. Hospitals were asked to respond back to the DOH on the status of a newborn hearing program in their facility and their willingness to participate in the program either by purchasing the necessary equipment or by working with an established program or audiologist to provide the screening. In addition, the letter suggested that facilities currently conducting newborn hearing screening might consider providing outreach for smaller facilities.

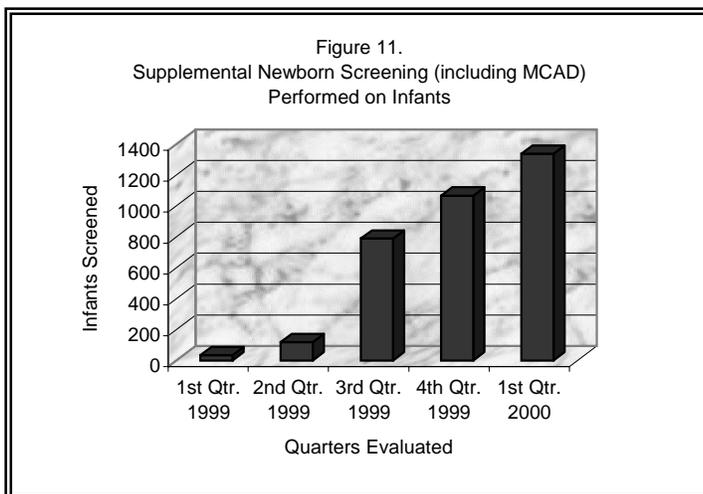
Response to the letter from hospitals was very positive. Of the 41 hospitals in the state performing deliveries, ten hospitals indicated that they were providing hearing screening for all infants born in their facility while an additional three hospital provided screening for high-risk infants or upon physician referral. One hospital referred infants born in their facility to a nearby screening program and two hospitals were in the process of purchasing equipment to establish their own program. Nine of the facilities surveyed indicated they were looking at possible options and/or working with a nearby facility to develop a system to assure that their newborns would be screening. Nineteen facilities either did not respond to the letter or indicated that the small number of births at their facility did not justify purchasing equipment. It should be noted that the total number of births at these 19 facilities were 735 out of the 10,673 births in South Dakota in 1999.

Based on the response to the letter, the DOH estimates that approximately 62 percent of babies born in South Dakota are receiving a hearing screening.

There are also five IHS hospitals in the state that provide services to the state's Native American population. Of the five hospitals, only three perform deliveries. None of the facilities currently have newborn hearing screening equipment. Information from the Aberdeen Area IHS indicate that the Aberdeen Area has purchased an otoacoustic emissions (OAE) screener to perform follow-up screens on infants identified through ENT and audiology clinics on the various reservations.

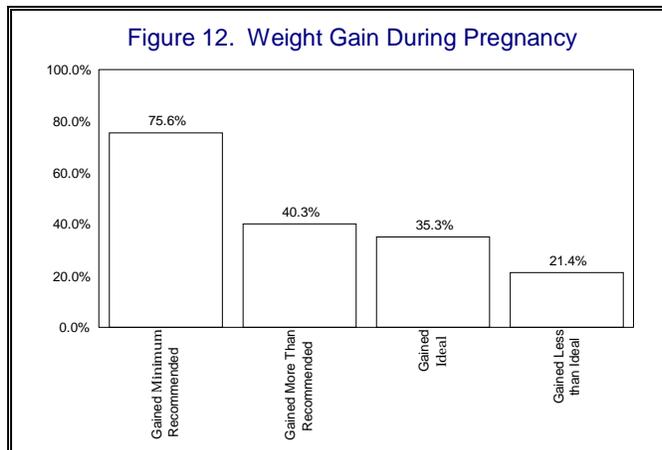
South Dakota law does mandate newborn screening for three metabolic disorders – congenital hypothyroidism, phenylketonuria and galactosemia. Table 10 shows the number of screens and confirmed cases per disorder in 1996 through 1998.

Table 10.				
Newborn Metabolic Screening Results, 1996-1998				
		1996	1997	1998
Phenylketonuria	# Screened	10,118	10,385	10,215
	# Confirmed	0	1	3
Congenital Hypothyroidism	# Screened	10,102	10,380	10,213
	# Confirmed	7	3	15
Galactosemia	# Screened	10,122	10,380	10,201
	# Confirmed	0	0	0



While there is not universal agreement on the need for newborn screening for disorders using tandem mass spectrometry, the DOH Newborn Metabolic Screening Program has worked with medical providers and the central lab that provides newborn screening services to make the optional screening available in the state. In June of 1999, the DOH informed medical providers across the state of the process for

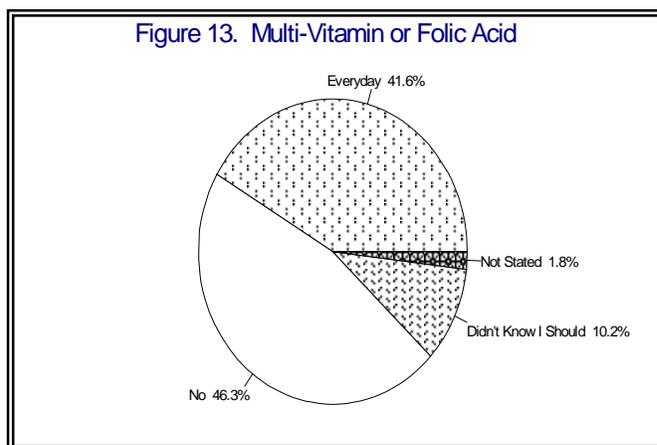
ordering optional supplemental screening. Figure 11 shows the significant increase in supplemental newborn screening performed since making it available.



Healthy People (HP) 2010 calls for an increase in the proportion of mothers who achieve a recommended weight gain during their pregnancies. According to the 1999 South Dakota Perinatal Health Risk Assessment, 35 percent of the mothers reported they gained the ideal amount of weight during their most recent pregnancy (see Figure 12). Of particular concern is the 21 percent who gained less than

the ideal amount of weight since inadequate weight gain during pregnancy is associated with an increased risk of IUGR, low birth weight and infant death.

Up to 80 percent of neural tube defects can be prevented if the mother has adequate folic acid levels one month before conception through the first three months of pregnancy. The HP 2010 goal is to increase to 80 percent the consumption of at least 400 micrograms of folic acid each day from fortified foods or dietary supplements by nonpregnant women aged 15 years to 44 years. As this is mainly prior to the woman knowing she is pregnant, all women of child-bearing age are encouraged to begin their

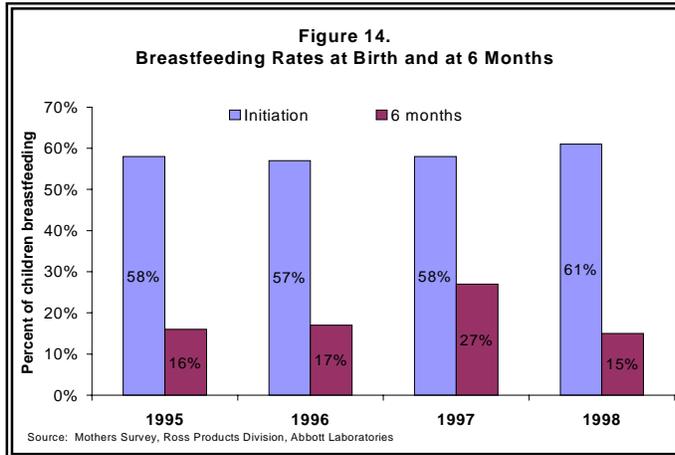


pregnancies with optimal levels of folic acid. While food folates play a role in the prevention of neural tube defects, the recommendation is to consume at least 400 mg from either fortified foods (enriched breads and cereals) or dietary supplements (mainly multi-vitamin preparations). According to the 1999 South Dakota Perinatal Health Risk Assessment, nearly half of the women

survey reported they had not taken a folic acid supplement or a multi-vitamin with folic acid prior to their most recent pregnancy (see Figure 13). Also half of the women surveyed reported they did not know which foods are high in folic acid. While BRFSS data indicates the proportion of women who know about folic acid and the proportion of women who

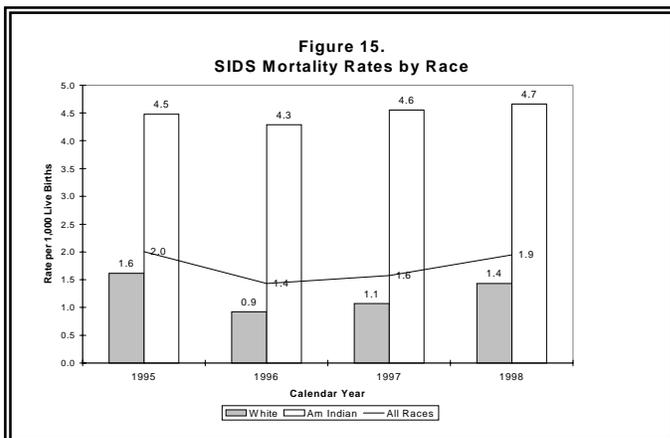
consume folic acid is increasing, there is much work to do if the HP 2010 objective is to be met.

Breastfeeding is not only beneficial to the infant but also to the mother who breastfeeds. The HP 2010 objective is to increase the percent of mothers who breastfeed in early postpartum period to 75 percent, at six months to 50 percent, and at one year to 25 percent.



In South Dakota, there has been a slight upward trend in the percent of infants starting to breastfeed (see Figure 14). The 1999 Perinatal Health Risk Assessment reported that 69.8 percent of the surveyed mothers were breastfeeding their baby at the time of hospital discharge. In addition, starting in 1999, initiation of breastfeeding is being reported as part of the newborn

metabolic screening information for all births in South Dakota. Data for the last half of CY 1999 shows initiation of breastfeeding at 62 percent. An average of 19 percent of women continued breastfeeding through the sixth month. Although this rate is far below the HP 2010 objective and a decrease in the last reporting, a slight upward trend suggests improvement in sustained breastfeeding. The 1999 Perinatal Health Risk Assessment reported the most common reasons that women did not breastfeed were because they didn't want to or planned to go back to work or school.



Each year in the U.S. nearly 5,000 babies die of SIDS – the sudden and unexplained death of an infant under one year of age. Between 1995 to 1998, 72 South Dakota children died of SIDS before their first birthday, accounting for 22 percent of all deaths in this age group. Twenty-nine of these deaths were Native American infants and 43 were White infants. Figure 15

shows the SIDS death rate by race. SIDS is occurring over three times as much in the Native American population than with the White population.

While it is difficult to say why one baby dies of SIDS and another does not, research has found at least two preventable risk factors that parents can control to reduce the risk of SIDS – placing infants on their back to sleep and creating a smoke-free environment around the infant.

Placing infants to sleep on their backs can reduce the risk of SIDS. Some parents worry that babies sleeping on their backs may choke on spit-up or vomit during sleep but there is no evidence that sleeping on the back causes choking. The Perinatal Health Risk Assessment collected information on how babies were positioned when sleeping. In 1997, 53.3 percent of babies were laid on their back and this number increased to 69.5 percent in 1999 (see Table 11). However, there are a number of mothers that laid their baby on their stomach when sleeping (1997-13.1% and 1999 -11.4%). Table 12 shows why the mother chose the infant's sleeping position.

Table 11.		
In what position do you most often lay your baby down for sleep?		
	1997	1999
Stomach	13.1	11.4
Back	53.3	69.5
Side	32.2	21.0
Not Stated	1.4	0.5

Table 12.		
Why did you choose this sleeping position for your child?		
	1997	1999
Doctor/nurse suggested it	47.3	64.7
WIC staff suggested it	2.8	12.3
Public Health Nurse/CHN suggested it	1.8	8.6
Family member/friend suggested it	4.5	20.9
Read about it in a magazine, newspaper or baby care book	18.8	50.1
Heard about it on TV or radio	3.9	22.6
Way my other children slept	12.3	23.1
I sleep in this position	1.5	4.6
Afraid of vomiting/spitting up/choking	13.7	25.4
Other	16.6	18.7
Not stated		1.9

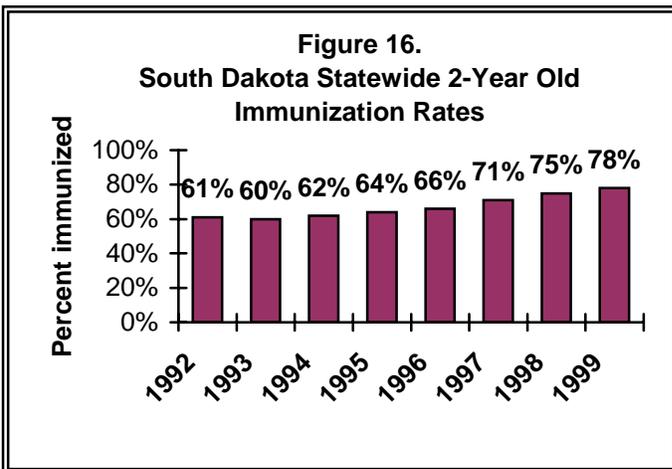
The number of babies that have been lost to SIDS is high and continued education is needed. The goal is to have healthy infants sleeping on their backs, even for naps.

Creating a smoke-free zone around the baby is very important to reducing the risk of SIDS. The Perinatal Health Risk Assessment collected information on the smoking behavior of individuals around a baby (see Table 13).

	1997	1999
No one smokes in house or car at all	74.5	75.2
No one smokes in house or car when baby is there	9.8	10.5
No one smokes in the room when baby is there	7.1	8.3
No one smokes in the car when baby is there	1.0	3.8
Smoking allowed anytime, anywhere in house or car	5.3	3.7
Other	2.1	5.9
Not stated	0.2	

Preventive/Primary Care Services for Children and Adolescents

The annual retrospective survey conducted in the spring of 2000 showed that 78.2 percent of children entering kindergarten in South Dakota during the 1999-2000 school year were adequately immunized with 4 DTP, 3 OPV, and 1 MMR by 24 months of age – up 3.7 percent from the previous year and up 7.3 percent from two years ago. Figure 16 depicts the statewide rates for South Dakota from 1992 to 1999.



SDIIS achieved near statewide implementation during 1999 with 225 providers (the majority) fully operational on SDIIS. The DOH is currently working with IHS to get their sites on the system, either through direct use or through an interface with their current system.

All providers were encouraged to use SDIIS to enter past immunization histories so that assessments could

be run. During 1999, an SDIIS assessment tool was created so that reliable provider level assessments could be run from the central office. Work is underway to utilize this tool to provide feedback to providers on the immunization rates for their particular clinics. This system will also

provide more up-to-date information than the retrospective survey on the immunization status of children.

While the majority of the private clinics are utilizing SDIIS, there are inconsistencies as to the information that is being entered. Some clinics are entering historical immunization data on their entire patient load while others are only entering immunization data when a child presents for an immunization. As will be seen, this makes it difficult to rely solely on SDIIS to assess immunization status of South Dakota children.

There have been several recent reviews of the immunization status of special populations in the state including WIC, TANF and IHS.

As part of its mission to ensure healthy infants and children, the DOH WIC program, in conjunction with the Immunization Program, conducted a study in 1998 of the infants ranging in age from newborn to 24-month-olds. The study focused on the difference WIC is making in increasing age-appropriate immunization levels in the state, identifying characteristics that lead to increased immunization levels of WIC participants and an exploration of other linkages between the program or increasing immunization levels.

The study included 33 of the 92 WIC sites in the state and covered 21 counties. Study results show that the WIC age-appropriate rates are usually higher than the county immunization rate if 70 percent or more of the immunization records were obtained for the study. Out of the 12 counties that obtained 70 percent or more of the immunization records, only one WIC site's immunization rates did not exceed the county rate. However the difference in the two rates was not significant.

It is important to note that the WIC age-appropriate rate that was determined for each site and used throughout the study does not include the clients that did not send in immunization records or had moved. Had all immunization records needed for the study been received, this rate would have been much higher. The study analysis revealed several findings:

- The WIC age-appropriate rate for those children for whom immunization records were received was 82.1 percent.
- The WIC age-appropriate rate that considered immunization records not received as age-appropriate was 88.8 percent. This rate is the highest possible rate.

- The WIC age-appropriate rate that considered immunization records not received as non-age appropriate was 55.1 percent. This rate is the lowest possible rate and has the potential to increase.

A reasonable conclusion can be made that WIC is making a difference in increasing age appropriate immunization levels in the state.

In South Dakota, proper immunization of children under age two is a priority. DSS, with the assistance of the DOH and primary care providers (PCPs), recently conducted an assessment of the immunization status of children receiving public assistance through the TANF program.

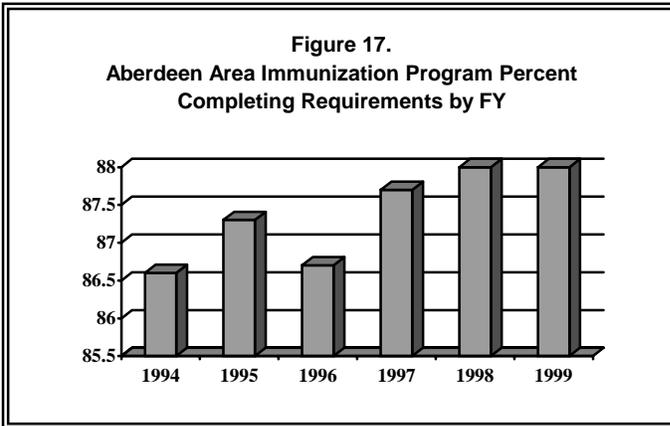
The study included children aged 0-2 years old as of April 1, 1999 who were receiving cash assistance under the TANF program. A computer match was done against SDIIS to get the initial list of age-appropriately immunized children. For those children who were unable to be determined as being age-appropriately immunized, letters were sent to the child's PCP requesting immunization records from their files. After analysis of the available records, letters were sent directly to the child's parents to request additional information. DSS field staff and DOH CHNs conducted outreach at the local level to obtain records for those recipients that DSS had been unable to get records for. These records were reviewed against the EPSDT periodicity schedule to determine if the child was age-appropriately immunized. If the child was delinquent in their immunizations, attempts were made by CHNs to provide necessary immunizations to get the child age-appropriately immunized.

The study included 727 children aged two and under as of April 1, 1999 who were receiving cash assistance under the TANF program. Of the original 727 children, 306 remained eligible for TANF cash assistance throughout the entire study period (32 were White, 272 were Native American and two were classified as Other). Of the 306 continuously eligible children, 249 of the children were age-appropriately immunized for a rate of 81 percent. Of the 249 age-appropriately-immunized children, 32 were White, 215 were Native American and 2 were classified as Other. This works out to an age-appropriate immunization rate by race of 100 percent for White and Other and 79 percent for Native Americans.

Immunization rates by provider type (i.e., IHS vs. non-IHS) were also assessed. Out of the 306 children, 160 had an IHS PCP and 146 had a non-IHS provider. Of the 249 fully immunized children, 136 had an IHS

PCP (for a rate of 85 percent) while 113 had a non-IHS PCP (for a rate of 77 percent).

The results show that South Dakota has a fairly high immunization rate for TANF children under the age of two. It is believed the immunization rate to be even higher than actually noted, but obtaining the immunization information was difficult since the more transient nature of the TANF population makes it difficult to track the



immunization rates of their children. The results also found that IHS facilities have a very impressive immunization rate for the children they serve.

The Aberdeen Area IHS Immunization Program submitted data regarding immunization rates for two-year olds from 1994-1999 (see Figure 17). IHS also provided

information on the immunization rates for two-year olds by IHS service units for the third quarter of FY99 (see Table 14). Staff at the Aberdeen Area IHS Office indicated that this is one of the better quarters that has been reported.

Service Area	% Immunized
Eagle Butte	90%
Ft. Thompson	91%
Lower Brule	92%
Pine Ridge	83%
Rosebud	83%
Sioux San	90%
Sisseton	91%
Wagner	92%

In comparing the data from the TANF study with the IHS data, it appears that the average age-appropriate immunization rates of those children served by IHS is approximately 85 to 88 percent.

A statewide assessment of the oral health status of children was initiated in 1995. Age groups for the assessment – third graders (8-9 year olds) and eighth graders (13-14 year olds) – were chosen to be comparable

with published standards and HP 2000 objectives and the sampling method allowed findings to be generalized to all children in the specified age groups.

Surveys were completed during the 1995-96 and the 1996-97 school years and had high participation rates compared to other states. The survey included 1,316 third graders (113 parents denied consent for a 91 percent participation rate) and 1,243 eighth graders (236 parent/student denied consent for an 81 percent participation rate).

The HP 2010 objective calls for a reduction in the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth to 42 percent and 51 percent, respectively. As can be seen in Table 15, the percentage of children in South Dakota with one or more caries are much higher than the HP 2010 targets. South Dakota does not currently have any baseline data for 2-4 year olds.

Age	# Experiencing Caries	% Within Age Group
7	26	61.9%
8	340	62.2%
9	439	65.0%
13	322	58.2%
14	355	59.0%
15	33	56.9%

The percentage of untreated decay among South Dakota children and adolescents is also higher than the HP 2010 which call for a reduction in the proportion of children and adolescents with untreated dental decay to 21 percent and 15 percent, respectively (see Table 16).

Age	# with Untreated Caries	% Within Age Group
7	13	31.0%
8	192	35.1%
9	226	33.5%
13	126	22.8%
14	124	20.6%
15	15	25.9%

To address both the number of children with dental caries as well as the number with untreated dental caries will require collaboration and coordination with providers, parents and communities.

Dental sealants are one of the preventive measures addressed by HP 2010. The objective is to increase to at least 50 percent the proportion of children who have received dental sealants on their molar teeth. For ages with significant numbers of participants, the goal of 50 percent was almost attained (see Table 17). The overall data concluded that 45 percent of the occlusal molar surfaces were sealed while 55 percent were not sealed. Some molars might not need to be sealed due to their structure or previous restoration. Thirty-one percent of those unsealed molars needed sealants.

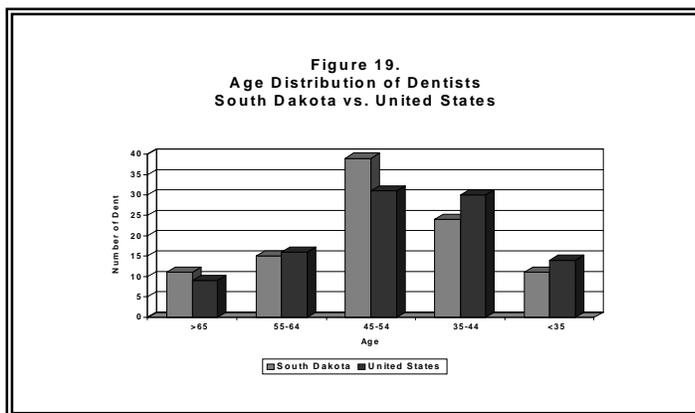
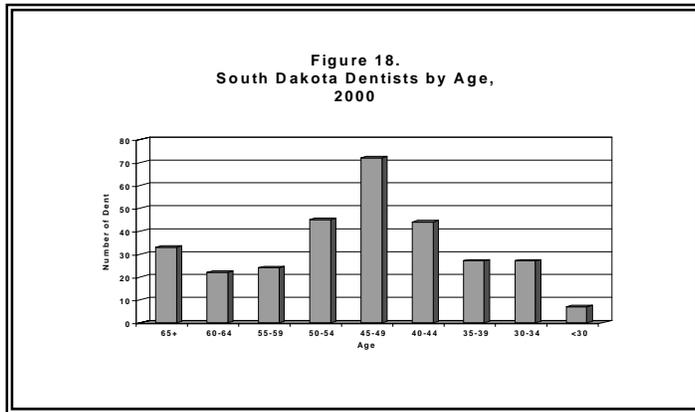
Age	Participants with One or More Molars Sealed	% Within Age Group
8	230	42.0%
9	307	45.5%
13	275	49.7%
14	279	46.3%

Since there is no sealant program in South Dakota, it could be assumed that the current percentage of 45 percent could be contributed primarily to the work that dentists are doing as they see patients in their practice.

Approximately three percent of the students surveyed indicated spit tobacco use. This information, coupled with 1999 YRBS data where 16 percent of high school students reported using smokeless tobacco during the past 30 days, indicates that spit tobacco is a serious oral health concern in South Dakota.

According to the 1997 South Dakota BRFSS, 67 percent of respondents had seen a dentist in the past year. The main reasons given for not visiting the dentist in the last year were had no reason to go (i.e., no problems, no teeth) at 56 percent and cost at 19 percent. The “had no reason to go” response would seem to indicate a significant need for public education on the importance of oral health care.

The 1997 BRFSS also asked about insurance coverage that paid for some or all of routine dental care (i.e., dental insurance, prepaid plans such as HMOs, or government plans). Forty-one percent of respondents had such coverage while 57 percent did not.



Access to care continues to be a concern in South Dakota with only 350 licensed dentists statewide. The Medicaid program estimates that 80 percent of the licensed dentists in the state are Medicaid providers. Figure 18 indicates the number of dentists by age while Figure 19 compares the age distribution in South Dakota with the U.S. The SDDA has been reviewing this data and has expressed concern about the number of dentists in the 35-44 and 45-54 year age categories since many of these providers have indicated that they are planning on early retirement. The large number of providers in these age categories, coupled with their intent on early

retirement, leads to concern about even greater access issues in the next 10 to 15 years.

Drinking fluoridated water has been shown to significantly reduce the risk of developing dental caries. The South Dakota Legislature passed a law in 1969 requiring all public water systems serving 500 or more people that have a natural fluoride content of less than 0.9 mg/L adjust the fluoride level to 1.2 mg/L which is considered to be the optimum level for the prevention of dental caries. Approximately 535,000 South Dakotas are provided with fluoridated drinking water though 102 water systems (excluding Indian reservations). Many of the smaller public water systems in South Dakota that serve communities of less than 500 people are either connected, or plan to be connected, to rural water systems which tends to increase the number of citizens being served fluoridated drinking water. Additionally, many of the farmsteads that have utilized private wells in the past are either now connected to a rural water system or plan to be in the future. If the current trend continues, essentially all public water systems in South Dakota will be serving fluoridated water to consumers.

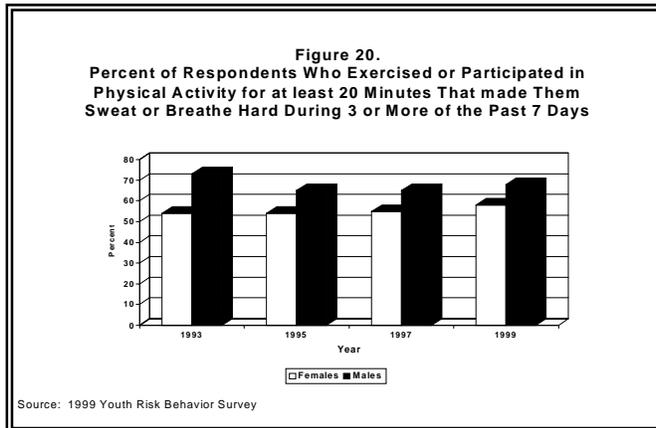
Elevated blood lead levels (above 10 µg/dL) can have a negative affect on the children. Children with higher lead levels are likely to have lower IQ scores, slower development and more attention problems than similar children with lower blood lead levels. In the spring of 1993, blood lead levels were completed on a total of 400 kindergarten children in Sioux Falls, Huron and Sturgis as part of a pilot screening conducted by the DOH. The three towns were chosen because of the large numbers of homes in the community built before 1960 – the year manufacturers began removing lead from paint. Thirty elementary students and preschoolers were identified with elevated blood lead levels (see Table 18).

Table 18.			
1993 Pilot Lead Screening in South Dakota			
Blood lead levels	Sioux Falls	Huron	Sturgis
Samples	242	135	51
Blank	25	2	1
10 - 14 µg/dL	13	7	1
15 - 19 µg/dL	2	1	3
20 µg/dL +	2	2	0
Total Elevated	17	10	3
% Elevated Blood Levels	7.8%	7.5%	6.0%

In April 1997, in effort to further determine the level of childhood lead poisoning in the state, the DOH conducted two additional childhood lead-screening projects. The screening sites for the project were again selected based on the percentage of homes built prior to 1960. The two cities selected were Mobridge (located in the north central part of South Dakota) and Lead/Deadwood (located in the northern part of the Black Hills on the western border of South Dakota). Children six months to six years of age were targeted for the screening projects in each community. A total of 71 children were screened during this project with only one elevated blood level over 10 µg/dL (see Table 19).

Table 19.		
1997 Pilot Lead Screening in South Dakota		
Blood lead levels	Mobridge	Lead/Deadwood
TOTAL SAMPLES COLLECTED	30	41
0 - 9 µg/dL	30	40
10 - 14 µg/dL	0	1
16 - 19 µg/dL	0	0
20 + µg/dL	0	0
Total Elevated Lead Levels	0	1
# living in pre-1960 homes > 1 year	26	27

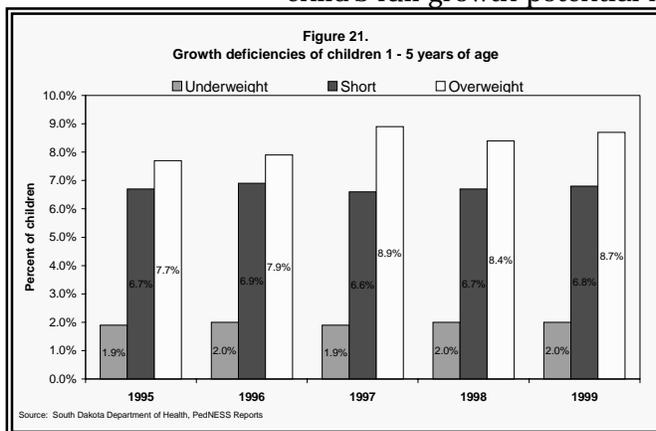
From the testing that has been completed in the state, the results do show there are some high levels in some of these areas in the state. Continued education is needed for professionals and families to remind of the importance of having children tested for lead poisoning.



According to the 1999 YRBS, 63 percent of South Dakota adolescents exercised or participated in physical activities for at least 20 minutes that made them sweat and breathe hard such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities during three or more of the past seven days (see Figure 20). This is below the

HP 2010 objective to increase to 85 percent the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion.

Growth retardation, or short stature, is defined as those having a height-for-age below the 5th percentile. Growth retardation may be evidence of compromised health, delayed development or poor diet. A child's full growth potential may be impaired by compromised nutrition,

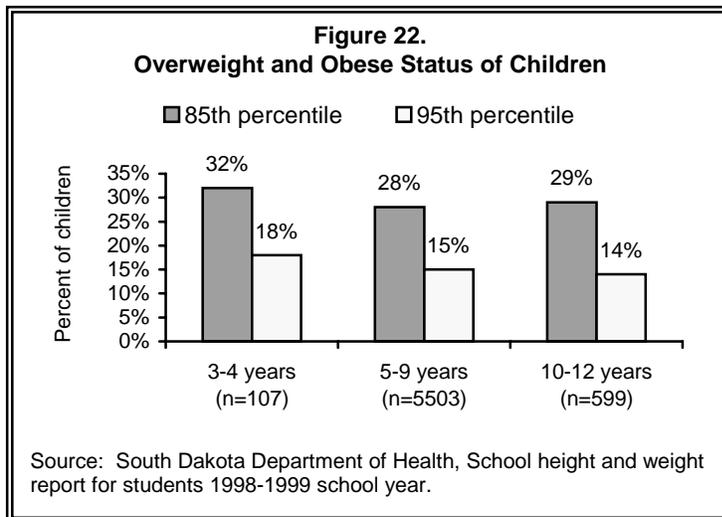


infectious and chronic diseases. Over the five-year reporting period the percentage of short stature children remained virtually unchanged – averaging 6.7 percent in low-income children (see Figure 21). This indicates that South Dakota can achieve the HP 2010 objective of reducing growth retardation among low-income children under age five to 5.0 percent.

Underweight children and infants are those who fall below the fifth percentile in weight-for-height reference population. Conditions contributing to underweight status include an inadequate dietary intake, failure to thrive or chronic and infectious diseases. Over the five-year reporting period, the percentage of underweight children on the WIC program has remained virtually unchanged averaging 2.0 percent. The

School Height and Weight Report for South Dakota Students during the 1998-1999 School Year reports underweight as 1.9 percent for 3-4 year olds, 1.6 percent for 5-9 year olds, and 1.2 percent for 10-12 year olds.

Overweight children are defined as those who are above the 95th percentile weight-for-height. Overweight status suggests obesity which is a risk factor for adult conditions such as cardiovascular disease, hypertension, diabetes, degenerative joint disease, and psychological problems. In South Dakota from 1995 to 1999, there has been an

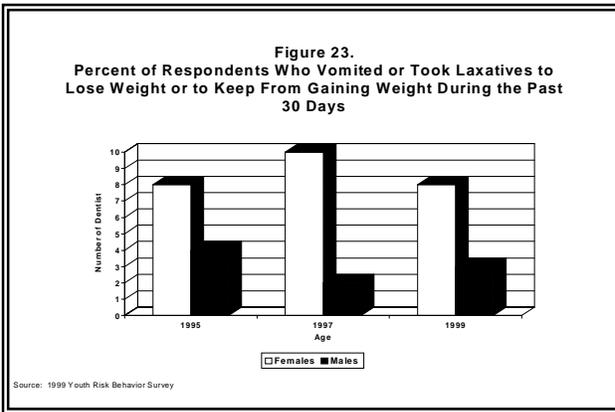


increasing trend toward a higher percentage of overweight low-income children 1-5 years old with an average of 8.3 percent overweight children during these five reporting years. Native American children were more likely to be overweight and obese than non-Indian children.

During the 1998-99 school year, South Dakota schools voluntarily submitted height and

weight data on 10,675 students aged 5-12 years and 5,526 students aged 13-18 years. In the 5-9 year old age group, 15.2% of the students were above the 95th percentile weight-for-height while 14.5% of the 10-12 year old age group were about the 95th percentile (see Figure 22). The percentage of children above the 95th percentile was higher among Native American children than White children of the same age. In the age group 14-18 years, 19.4 percent of the White students had a Body Mass Index (BMI) above the 95th percentile and 41.9 percent of the Native American students had a BMI above the 95th percentile. It is unlikely that South Dakota will meet the HP 2010 objective to reduce the proportion of children and adolescents who are overweight or obese to 5.0 percent.

According to the 1999 YRBS Report, 44 percent of adolescent respondents are trying to lose weight. Disordered eating is a pattern of eating that can lead to an eating disorder such as anorexia, bulimia, or binge eating. Eight percent of females and three percent of males reported having vomited or taken a laxative to lose weight or to keep from gaining weight during the past 30 days (see Figure 23). Teens also reported other



unhealthy eating habits such as fasting and taking diet pills to lose weight or keep from gaining weight. Care must be taken to promote healthy eating and exercise habits that address the increasing problem of child and adolescent weight while not encouraging weight preoccupation in appropriate eating habits and extreme amounts of exercise associated with eating disorders in youth.

South Dakota teens have very poor dietary habits which puts them at risk for developing chronic diseases both now and as they age. According to the 1999 South Dakota YRBS, only 44 percent of male adolescents and 27 percent of female adolescents meet the minimum average daily goal of at least five servings of fruits and vegetables during the past seven days. This is far below the HP 2010 objectives of increasing to 75 percent the proportion of persons aged two years and older who consume at least two daily servings of fruit and increasing to 50 percent the proportion of persons aged two years and older who consume at least three daily servings of vegetables, with at least one-third being dark green or deep-yellow vegetables. Higher intakes of fruits and vegetables tend to lead to lower fat intake and fruits and vegetables provide essential nutrients for growth and development and many have protective effects against chronic diseases.

Nearly all bone mass occurs during childhood and adolescence and is thought to be protective against fractures in later life. Women are at particular risk for developing osteoporosis. According to the 1999 YRBS, only 22 percent of South Dakota female adolescents and 36 percent of South Dakota male adolescents drank three or more glasses of milk per day during the past seven days. Since it is nearly impossible to meet the dietary recommendations for calcium without drinking milk, at the current rate it is unlikely that South Dakota will meet the HP 2010 objective to increase to at least 75 percent the proportion of persons aged two years and older who meet the dietary recommendations for calcium.

Lack of food security can lead to delayed development, illness and poor learning among children. According to the 1997 BRFSS, four percent of the households who responded indicated that at least once in the last six months they or someone in their household did not have enough food to eat and no money with which to buy food or they thought that soon they may not have enough food. The most common things they did were to skip one or more meals, borrow food from friends or relatives and serve smaller meals. This data appears to indicate that South Dakota will meet the HP 2010 goal of increasing to 94 percent food security among U.S. households and in doing so reducing hunger. However, it should be remembered that BRFSS is a telephone survey and may not be reaching

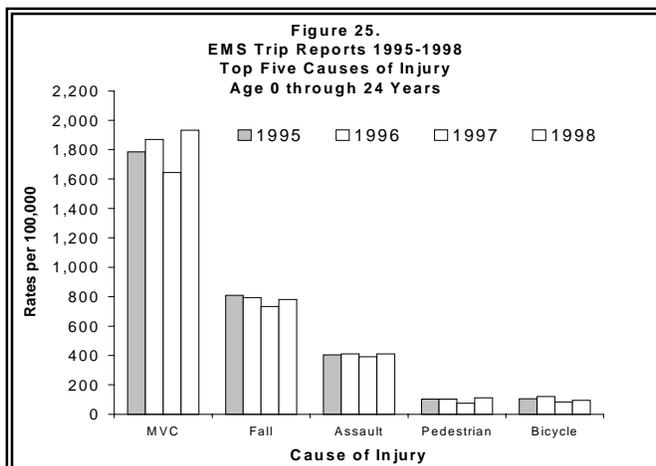
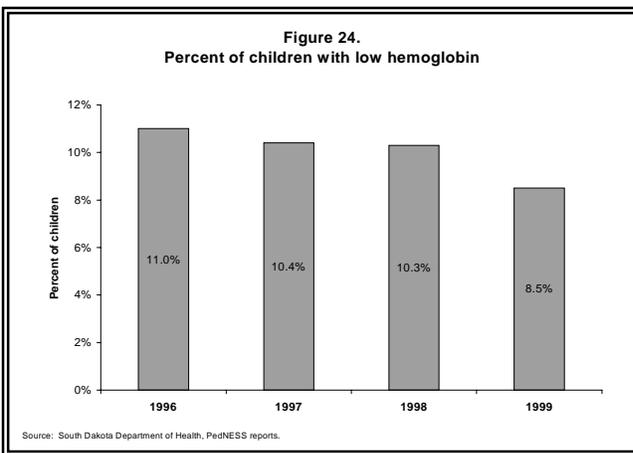
those most likely to be experiencing food insecurity.

Anemia is defined as having a hemoglobin or hematocrit below the fifth percentile of the age matched reference population. Anemia stems from a wide variety of conditions, including iron and other nutritional deficiencies, acute or chronic blood loss or hemolysis, or intrinsic hemoglobinopathies. In South

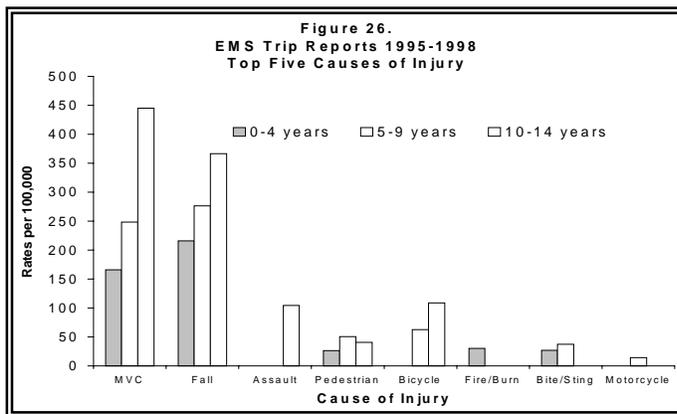
Dakota there has been a decreasing trend of children with anemia among children who are WIC participants (see Figure 24). This improvement is attributed, in part, to less use of low-iron formula for infants, recommendation of earlier introduction of meats in infants and increased emphasis on all dietary sources of iron including enriched cereals for all

WIC participants. It is not known if all young children in South Dakota have similar results but even with current improvement in anemia rates, it is unlikely low-income children will meet the 2010 objective of reducing iron deficiency among children aged 1-2 years to 5.0 percent and among children 3-4 years to 1.0 percent.

In South Dakota unintentional injuries are a leading cause of death among our



children (aged 0-24 years) and the rate is increasing for all unintentional injury deaths, including motor vehicle injury death (see Figure 25). Motor vehicle fatalities made up 52 percent of all fatal unintentional injuries of children during the four-year reporting period (1995-1998). In South Dakota, the rate is higher averaging 8.9 per 100,000 over the reporting period and the trend rate is increasing slightly. Between 1995 and 1998, there were 60 fatalities for children 14 and under due to motor vehicle crashes. In South Dakota, motor vehicle crashes are the leading cause of deaths for individuals between the ages 1-44.



According to South Dakota EMS Trip Reports, the leading top causes of injury in South Dakota for children under 14 year of age from 1995 and 1998 were motor vehicle crashes, falls, bike, pedestrian, and assault (see Figure 26). According to the South Dakota EMS Trip Reports, motor vehicle crashes are the leading cause of injuries for children 10-

14 years old and the second leading cause of injury for children under nine years of age.

Under South Dakota law, the driver of any passenger vehicle transporting a child under five years of age and less than 40 pounds, must secure that child in an approved child safety seat. If the child weighs 40 pounds or more, the child can be secured in a seat belt instead of a safety seat. Children covered by the law may not be removed from the safety seat for any reason while the vehicle is moving. South Dakota law currently requires the front seat occupants to wear a seat belt, however this law is only enforceable as a secondary law.

The major objective to lessen the incidence and severity of injuries resulting from motor vehicle crashes are to increase the use of safety devices. The 1998 seat belt survey in South Dakota shows that seat belt usage rate to be just over 43 percent for all ages (in 1994 the seatbelt rate was 40%). According to National Highway Traffic Safety Administration (NHTSA), the use of a seatbelt restraint has been shown to decrease mortality and serious disability by approximately 50

percent. Increasing seat belt restraint usage has the promise of dramatically improving the safety and longevity of South Dakotans.

Another issue is using safety restraints and properly installed child passenger seats. With so many types of child safety seats and seat belt systems, it's hard to be sure child safety seats are installed correctly. In South Dakota, random child passenger checkpoints done in Sioux Falls and Pierre showed the number of seats installed correctly to be low with only 19 of the 262 seat checked installed correctly. This is an issue not only in South Dakota but also on a national base. According to NHTSA, over half of child car seats in use today are installed incorrectly without parents realizing it.

The following would assist to achieve routine use of seat belts by motor vehicle occupants:

- Mobilizing statewide support for legislation requiring seat belt use by all vehicle occupants as a primary law.
- Encouraging law enforcement officers to enforce the seat belt law vigorously.
- Encourage employers to promote the use of occupant restraints and other traffic safety practices and require use of seat belts by all employees on business.

The second leading cause of injury according to the South Dakota EMS Trip Reports is falls. According to National Safe Kids Coalition, more than 80 percent of fall-related injuries among children age four and under occur in the home. Among older children, age 5-14, 45 percent of fall-related injuries occur in the home and 23 percent occur at school. The majority of falls occur between noon and early evening, the most common playtime for children. It is hard to determine the cause of these injuries. Infants are at greatest risk from falls associated with furniture, stairs and baby walkers. Toddlers are at risk from window-related falls and older children tend to suffer from playground equipment-related falls. Children aged 14 and under account for one-third of all fall-related visits to hospital emergency rooms. More than half of all nonfatal injuries to children are associated with falls. Falls are the leading cause of nursery product-related injuries among children ages five and under. According to National Program for Playground Safety, more than 200,000 children are treated in emergency rooms for playground-related injuries each year – that's one

child every 2½ minutes is taken to the emergency room for playground related injuries in the U.S. Almost three-fourths of these injuries occur on public playgrounds, such as those found in parks, school grounds, or child care centers. The National Program for Playground Safety conducted a survey that found that hard surfacing like asphalt, concrete, packed dirt, or rock is the leading cause of children's injuries on public and private playgrounds. Falls onto playground surfaces were a contributing factor in 70 percent of injuries requiring hospital visits. Climbing equipment, slides and swings were involved in most public playground injuries.

The distance of the fall to the landing surface determines the severity of the fall-related injury. Head injuries are associated with the majority of deaths and severe injuries resulting from falls. Because falls are associated with a child's curiosity and development of motor skills, children ages 10 and under are at the greatest risk of fall-related death and injury.

Falling is typically caused by an underlying physiologic problem requiring medical treatment or by adverse environmental conditions or both. Unfortunately, understanding of the specific causes of falls is limited and there is little direct evidence of the effectiveness of any specific preventive strategy. Assessment and modification of homes and community environments, including playgrounds, can help to eliminate environmental hazards. Many of these hazards persist because of the limited coverage and enforcement of existing regulations. Regulation of playground equipment for example, vary widely, and there is no uniform state code for playground surfaces or equipment. Medical and environmental strategies to avoid falls are available but rarely used. Too many people regard falls as unavoidable accidents or isolated episodes. Educating children, their parents and older people to recognize avoidable hazards in the home and elsewhere can heighten awareness of risks and lead to adoption of safer behaviors. Special educational efforts are needed for health professionals, schoolteachers, playground superintendents and others who deal with individuals at greatest risk.

The third leading cause of injury according to the South Dakota EMS Trip Report is bicycle-related. According to the South Dakota EMS Trip Reports, from 1995 to 1998 there were 388 children under the age of 14 transported by South Dakota ambulance services due to bicycle crashes

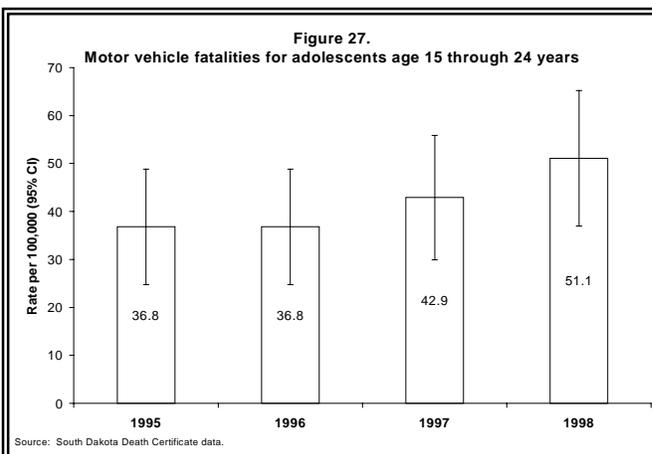
with two fatalities. Of these children injured, only two percent were wearing bicycle helmets. According to National Safe Kids Coalition, more than 70 percent of children age 5 to 14 ride bicycles. This age group rides about 50 percent more than the average bicyclist and accounts for approximately 24 percent of all bicycle-related deaths and more than 50 percent of all bicycle-related injuries. Despite the fact that bicycle helmets can reduce the risk of serious head injury by as much as 85 percent, helmet usage continues to be low.

Injury prevention and control has not traditionally been perceived as a public health issue and concern. Rather, injuries have been viewed as unavoidable accidents that are part of everyday life. The definition of injury and accident provide a distinction, suggesting injuries are indeed preventable. The scientific study of injuries has demonstrated that injuries do not occur at random. Like disease, they follow a distinct pattern. Studying these patterns has made it possible to predict and prevent many injuries from occurring. Educating children, adults, schools, health care setting, media and communities to avoid unnecessary injuries from occurring will assist to reduce death and injuries among people in South Dakota.

The top three causes of death for adolescents are accidents, primarily motor vehicle crashes, suicide and cancer. There are several factors that contribute to these top causes of death. Youth test their independence through risk-taking behavior and often believe they cannot be hurt while participating in recreational or vehicular activities. Seat belt use is estimated to reduce motor vehicle fatalities by 40 to 50 percent and serious injuries by 45 to 50 percent. Alcohol is a major contributing factor in approximately half of all homicides, suicides and motor vehicle

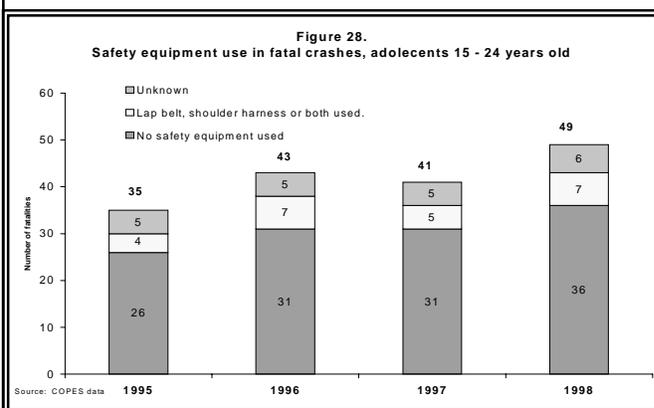
crashes. The goals of the DOH are to increase seat belt usage and to decrease the incidence of risk taking behavior among this population.

The average rate for motor vehicle deaths for adolescents are 42 deaths per 100,000 (see Figure 27.) which is well beyond the HP 2010 targeted objective of 25.4 per 100,000.



There is a dramatic increase in deaths occurring in late adolescence. Overall mortality rates for young people rise by 239 percent when they reach 15-19 (relative to rates 10-14 year olds). Violent causes of death such as accidents, homicides or suicides are responsible for this increase. This, coupled with increased risk taking behavior and the initiation of driving, highly contributes to these climbing rates.

Motor vehicle crash fatalities for adolescents averaged 42 deaths per year in South



Dakota from 1995-1998 and were the number one cause of mortality for this age group. The HP 2010 goal is to reduce deaths caused by motor vehicle crashes for 15-24 year olds to no more than 25.4 per 100,000. South Dakota's rate exceeds the HP 2010 objective and appears to be on an upward trend. Of the adolescents who died in motor vehicle crashes, 74 percent were not using safety restraints,

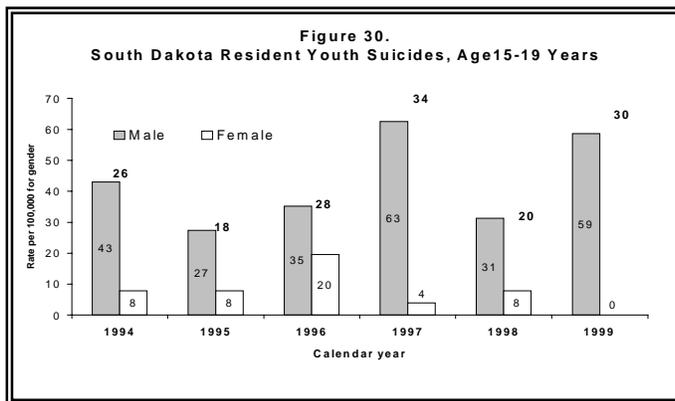
14 percent were using either lap belts, shoulder harnesses or both, and 14% were unknown (see Figure 28.).

During the same period, an average of 2,497 adolescents were injured in motor vehicle crashes. Of the adolescents injured, 52 percent were not using safety restraints while 48 percent were using some type of restraint (see Figure 29.). The results of the 1999 Youth Risk Behavior Survey (YRBS) showed that 25 percent of respondents who drove a car always wore a seat belt and 15 percent always wore a seat belt when riding in a car driven by someone else. Some common reasons and misconceptions regarding seat belt usage by South Dakota youth are that "as many get hurt wearing them as those that don't", "they are uncomfortable", "uncool" and that "most parents don't wear them."

There is also a strong link between substance use and adolescent injury. Adolescents who use tobacco, become drunk or use other drugs are less likely to use seat belts and are more likely to engage in other risky vehicle use (e.g., driving recklessly or driving under the influence of alcohol). The 1999 YRBS reported that 59 percent of respondents reported having at least one drink of alcohol on one or more of the past 30 days preceding the survey while 46 percent reported having five or more drinks of alcohol in a row, within a couple of hours on one or more of the past 30 days. Forty-four percent of respondents reported riding one or more times in a car or other vehicle driven by someone who had been drinking and 27 percent reported having drove a car or other vehicle one or more times when they had been drinking.

South Dakota does have a limited graduated driver licensing system but this falls short of the recommendations from the National Committee on Uniform Traffic Laws and Ordinances (NCUTLO) as referenced in HP 2010. South Dakota law currently requires the front seat occupants to wear a seat belt. However this law is only enforceable as a secondary law.

None of the risk behaviors noted above occur in isolation from one another. Strategies to address these rates for South Dakota youth should involve multiple approaches delivered through multiple settings, including schools, media, communities, families and health care settings.



The second leading cause of death for South Dakota youth is suicide. From 1994-1999, South Dakota youth suicide rates ranged from a low of 18 per 100,000 in 1995 to a high of 34 per 100,000 in 1997 (median 27 suicides per 100,000) (see Figure 30.). The HP 2010 objective is to reduced the suicide rate for all populations to no more then 6 per 100,000. As evidenced by the data, South

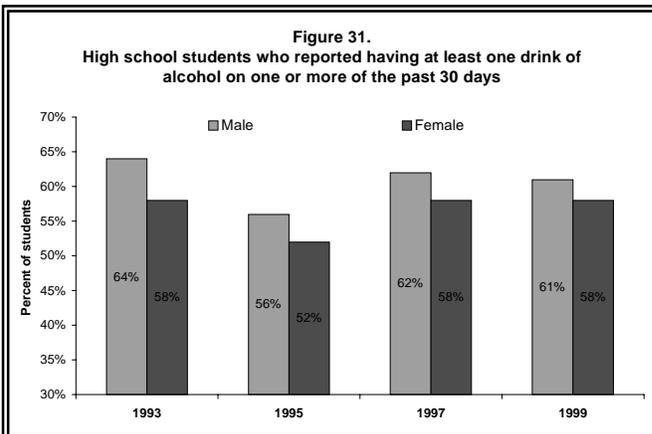
Dakota’s youth suicide rate continues to be more then double the HP 2010 objectives. At present this trend shows no signs of leveling off or reversing. During the six-year reporting period, 85 percent of the youth suicides were completed by boys. This mirrors national data that shows that males are more likely to complete suicide while females are more likely to attempt suicide. The actual rate of suicide attempts is unknown, although it is estimated to be anywhere from 50 to 200 times that of completed suicides.

South Dakota EMS trip reports for 1994-1997 reported 617 transports for self-inflicted injuries. The obvious factor that distinguishes suicide completions from attempts is the lethality of the method. Nationally, 60 percent of all completed suicides involve firearms, followed by hanging, poisoning by liquids and solids and poisoning by carbon monoxide. From 1995-1999, 62 percent of all completed suicides in South Dakota were done using firearms.

The 1999 YRBS reports the 23 percent of respondents reported feeling so sad or hopeless almost every day for two weeks or more in a row during the past 12 months that they stopped doing some usual activities. Twenty-two percent had seriously considered attempting suicide, 16

percent had made a plan about how they would attempt suicide and 7 percent have actually attempted suicide. Two percent reported attempting suicide resulting in an injury, poisoning or overdose that had to be treated by a doctor or nurse.

A supplemental question added to the survey assessed where youth would go if they wanted help for suicidal thoughts. The question asks, “If you had a friend who wanted help for suicidal thoughts, who would you recommend they talk to?” Forty-three percent of the respondents said they would refer their friend to family, friends or peer helpers while 20 percent said they would refer to a school counselor, school nurse, school psychologist, or school social worker. The remainder of the respondents would refer to a religious leader, other counselor, teacher, doctor, clinic, or nurse. Reducing adolescent morbidity and mortality therefore requires utilizing health promotion and disease prevention strategies that enlist the support of many individuals and institutions that affect the lives of adolescents.



The South Dakota 1999 YRBS indicated that 46 percent of respondents reported having five or more drinks of alcohol in a row, within a couple of hours, on one or more of the past 30 days (see Figure 31). This percentage far exceeds the HP 2010 target goal of 11 percent. For the period of 1995-1998, 17 adolescents 15-17 years of age were killed in a motor vehicle crash because a

driver had been drinking, and another 343 were injured because a driver had been drinking. Numbers for youth aged 20-24 exceed those for the 15-17 year olds. When asked on the 1999 YRBS, 44 percent reported that they rode with a driver who had been drinking and 27 percent reported that they drove after they had been drinking. When South Dakota youth were asked, “Why do teens get involved with alcohol?”, they responded “to be cool”; “in this town there is nothing else to do”; “it is easy to get”; “to relieve the pressure of life”; “bored, nothing else to do”; “to get attention from parents” and “to fit in, there is more pressure to drink than to have sex”. Youth were also asked if there was a relationship between alcohol use and having sex. Their responses are as follows: “Yes, there is”; “drugs

and alcohol make you do things you normally would not”; “alcohol is an excuse for not holding people responsible for their actions” and “when you go out and get drunk you’re never sure what you may end up doing”.

Alcohol use and alcohol-related problems are common among adolescents. Age of onset of drinking strongly predicts development of alcohol dependence over the course of the lifespan. About 40 percent of those who start drinking at age 14 years or younger develop alcohol dependence at some point in their lives. For those who start drinking at 21 years or older, about 10 percent develop alcohol dependence at some point in their lives. Substance abuse, including tobacco use and nicotine dependence, is associated with a variety of other serious health and social problems. The stigma attached to substance abuse increases the severity of the problem. The hiding of substance abuse, for example, can prevent persons from seeking and continuing treatment and from having a productive attitude toward treatment.

HP 2010 objectives to address adolescent alcohol use are: to reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking to no more than 30 percent; to increase the age of first use to 16.1 years of age; to increase the percent of high school seniors never drinking alcohol to 29 percent; to reduce the percentage of high school students engaging in binge drinking to 11 percent; and to increase the proportion of adolescents who disapprove of substance abuse to 83 percent.

For the period 1998 to 1999, a total of 16,287 adolescents received services through 53 accredited treatment facilities throughout the state – a 13.5 percent increase from 1997-1998. These clients received services ranging from crisis intervention to structured treatment programs. The greatest number of admission for services for alcohol and drug services were for youth less than 18 years of age (3,906 clients or 24% of total admissions). Youth aged 18 to 20 were the fourth largest group of admissions for a total of 2,797 or 17 percent of total admissions. Additional admission data shows that nine percent of clients reported their first use of alcohol and/or drugs prior to age 11. An additional 11 percent reported their first use of alcohol and/or drugs between the ages of 11-12. Of all clients served, 83 percent reported their first use of a chemical including alcohol occurred prior to age 21. Community-based drug and alcohol prevention education and activities are provided through

the Prevention Resource Centers located in three locations across the state.

All of these indicators support the use of a multi-component approach to youth substance abuse. This approach includes focusing on mobilizing and leveraging resources, raising public awareness and countering pro-use messages. Several strategies may be effective, such as increasing the involvement of parents and parent groups at the local level, increasing the number of adult volunteers involved in drug prevention at the local level, changing normative attitudes among youth from “everyone’s using drugs” to “everyone has better things to do than drugs,” and increasing the proportion of youth participating in positive skill building activities.

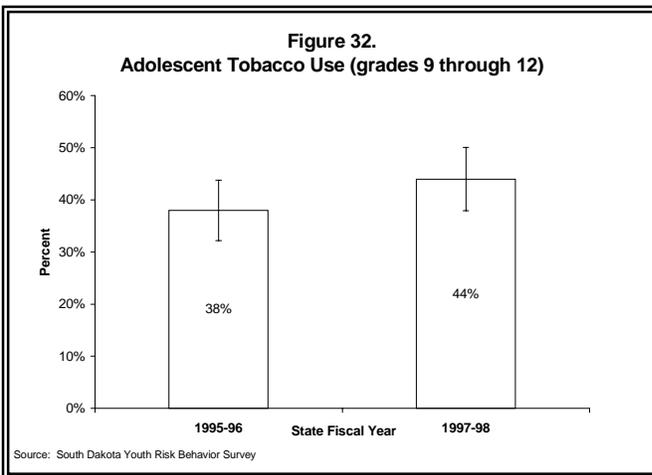
Other important issues for South Dakota youth are teen pregnancy and STDs. South Dakota data has shown a decreasing trend in the pregnancy rate for women aged 15-17 over the past four years. Since 1996, South Dakota’s teen pregnancy rate has decreased from a rate 34.6 per 1,000 to 27.5 per 1,000 in 1999 which is considerably lower than the HP 2010 objective to reduce pregnancies among females aged 15-17 to no more than 46 per 1,000. However, in 1999, there were 399 teen pregnancies (15-17 year olds). Of those 399 pregnancies, there were 347 live births recorded. Declines in teen pregnancy rates can be attributed to either fewer teens having sex or because more teens are using contraceptives.

Results of the 1999 YRBS indicated that 44 percent of respondents reported that they have had sexual intercourse which was unchanged from the 1997 YRBS. There was an increase from 28 percent in 1997 to 32 percent in 1999 in the number of respondents reporting that they had had sexual intercourse with one or more people during the past three months. There was also an increase in the number of respondents who report either using birth control pill or condoms during their last sexual intercourse. What remains unknown are the number of youth using both birth control pills or a long term contraceptive such as Depo-Provera to prevent a pregnancy and condoms to prevent STDs. STDs are the most common and destructive infectious diseases among adolescents. Forty-two percent of all chlamydia cases (1,547) and 26 percent of all gonorrhea cases (191) reported in 1999 can be attributed to youth aged 15-19. Serious negative outcomes associated with STDs include pelvic inflammatory disease and associated chronic pelvic pain, tubal infertility

and ectopic pregnancy in females, and genital cancers and HIV infection leading to AIDS in both males and females.

The South Dakota Family Planning program provides services to approximately 5,000 adolescents under the age of 19 in addition to community and school educational services related to reproductive health. The South Dakota Abstinence program data show that this program reaches approximately 6,000 youth across the state.

It is also worthwhile to note that adolescents who use substances are more likely to be sexually active. In a nationally representative sample, adolescents who were sexually active were more likely to use alcohol and marijuana during the following year than those who were not sexually active. The use of alcohol and illicit drugs is also associated with sexual behaviors that place adolescents at increased risk for unintended pregnancy and sexual behaviors that place adolescents at increased risk for unintended pregnancy and sexually transmitted diseases.



Since 1991 cigarette smoking among South Dakota high school students has significantly increased from 38 to 44 percent (see Figure 32). Results of the 1999 YRBS show that 32 percent of South Dakota ninth grade students reported smoking a whole cigarette for the first time before age 13.

Recognizing that middle school is a critical period for the initiation of tobacco use, South Dakota conducted the 1999 Middle School Youth Tobacco Survey. This survey reported that 12 percent of the sixth, seventh and eighth graders surveyed are considered current smokers and 68 percent of the current smokers report having tried to quit smoking.

Cigarette smoking is the single most preventable cause of death with an estimated one in five deaths caused by tobacco use. Cigarette smoking causes heart disease, several kinds of cancer (lung, larynx, esophagus, pharynx, mouth and bladder) and chronic disease. Youth are put at an increased risk of initiating tobacco use by several risk factors ranging from accessibility and availability of tobacco products to cigarette advertising and promotion, price of tobacco products, perceptions that

tobacco use is normal, peer and sibling use and approval, and lack of parental involvement. South Dakota's goal to increase the age of initiation and the integration of research-based health curriculums in schools will ultimately decrease the numbers of South Dakota youth who report using tobacco products.

HP 2010 objectives that address youth tobacco use are to reduce tobacco use by adolescents to no more than 21 percent of 9th-12th graders, to increase the average age of first use of tobacco products by adolescents and young adults to 14 years of age; and to increase tobacco use cessation attempts by adolescents smokers to 84 percent.

Currently South Dakota has a full-time tobacco control coordinator located in DHS and three regional coordinators across the state. The goal of this program is to establish local projects and coalitions in several communities to raise awareness and decrease youth tobacco use. A significant number of South Dakota schools have implemented a K-12 comprehensive health curriculum which do address tobacco prevention within the larger context of health issues. The scope of this component is largely dependent on teacher interest and resources available.

The state also does compliance inspections of tobacco retail outlets. Since the initiation of the program in 1994, illegal buy rates have dropped significantly from 84 to 11 percent. This drop is the result of both the enforcement and retailer education program. Possession or consumption of tobacco by a minor is a Class 2 misdemeanor. The State Legislature recently strengthened the youth penalty from a petty offense. The maximum authorized punishment for a Class 2 misdemeanor is a fine of \$200, 30 days in jail, or both, similar to the penalty for retail employees who sell tobacco to minors. Law enforcement personnel do not routinely cite youth for tobacco violations unless another violation is involved and sentencing policies vary widely among communities. Youth enforcement is largely done on or near the school grounds only. Diversion programs to address tobacco addiction, not just the violation, are not widely available. There have been limited statewide counter-marketing campaigns through the South Dakota Tobacco Education project using billboards, radio and television public service announcements. A portion of the tobacco settlement funds will be designated to create a tobacco prevention and reduction program. These funds may be used for the following programs and grants – community-based programs, school-based programs,

statewide programs, cessation programs, public education and counter marketing, enforcement of effective tobacco laws, and evaluation of tobacco programs.

Many programs, strategies and services are in place to reduce risk taking behaviors and consequences related to those behaviors among South Dakota youth. While early prevention efforts are essential, it is not realistic to assume that engaging in high risk behaviors among adolescents will cease entirely. Secondary prevention that involves realistic safety strategies is important to the health of adolescents. For example, future programming strategies should include efforts targeted at adolescents who use alcohol to discourage drinking and driving or encourage sexually active teenagers to use condoms as a way to prevent pregnancy, STDs and HIV infection.

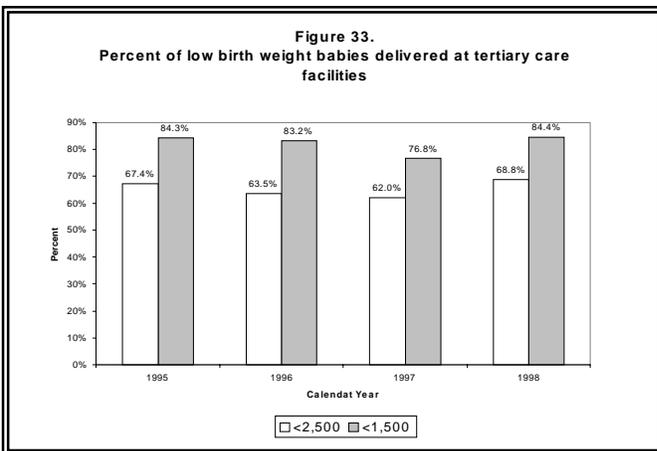
Services for CSHCN

See information for *Services for CSHCN* under Infrastructure Building Services

3.1.2.5 Infrastructure Building Services

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

The 20th century brought an unprecedented rate of change in approaches to improving pregnancy outcomes in the U.S. At the start of the 21st century, the DOH is challenged to continually improve upon those advances already made.



Improved outcomes of pregnancy have been associated with risk identification, care in a setting appropriate for the level of risk, and transport to specialized care when necessary. Specifically, premature (born at < 37 weeks gestation) and low birthweight (weighing < 2,500 grams at birth) infants born in hospitals with tertiary care facilities have better survival rates. The greatest impact

nationally has been in reducing the mortality of very low birthweight neonates (weighing < 1,500 grams).

From 1995 to 1998, 4.3 percent to 5.9 percent of South Dakota babies were born weighing less than 2,500 grams. Of those, 1-1.2 percent

weighed less than 1,500 grams at birth (see Section III.3.2 – HSI 4-6). Of those very low birthweight babies, 84.4 percent were born in tertiary care facilities (see Figure 33).

CDC has defined maternal deaths in two broad categories:

- Pregnancy-associated maternal death – the death of any woman from any cause, while she is pregnant or within one calendar year of termination of pregnancy, regardless of duration and site of pregnancy;
- Pregnancy related maternal death – the death of any woman resulting from complications of the pregnancy itself, the chain of events initiated by the pregnancy that led to the death or aggravation of an unrelated condition by the physiologic or pharmacological effects of the pregnancy that subsequently caused death.

Between 1992 and 1998, there were three deaths in South Dakota associated with childbirth. Of these maternal deaths, two were due to obstetric complications of the pregnancy and one was a death resulting from preexisting conditions not directly due to an obstetric cause.

Table 20 and 21 show medical risk factors and complications of labor and delivery that can impact birth outcomes.

Table 20.
Pregnancy Medical Risk Factors

	1995		1996		1997		1998		Total	
	n	%	n	%	n	%	n	%	n	%
Total single live births	10,333		10,307		10,046		10,122		40,808	
No risk factors	7,942	76.9	7,737	75.1	7,652	76.2	7,641	75.5	30,972	75.9
Hypertension, pregnancy associated	368	3.6	425	4.1	393	3.9	421	4.2	1,607	3.9
Previous infant >4000 grams	220	2.1	238	2.3	259	2.6	191	1.9	908	2.2
Diabetes, gestational	173	1.7	213	2.1	219	2.2	236	2.3	841	2.1
Hydramnios/ Oligohydramnios	158	1.5	208	2.0	222	2.2	238	2.4	826	2.0
Previous preterm or small-for-gestational-age infant	169	1.6	182	1.8	188	1.9	159	1.6	698	1.7
Anemia	135	1.3	147	1.4	111	1.1	141	1.4	534	1.3
Uterine bleeding	78	0.8	109	1.1	87	0.9	93	0.9	367	0.9
Hypertension, chronic	62	0.6	65	0.6	59	0.6	67	0.7	253	0.6
Diabetes, preexisting	49	0.5	33	0.3	45	0.4	62	0.6	189	0.5
Eclampsia	44	0.4	40	0.4	46	0.5	47	0.5	177	0.4
Genital herpes	49	0.5	32	0.3	50	0.5	38	0.4	169	0.4
Incompetent cervix	37	0.4%	35	0.3%	35	0.3%	31	0.3%	138	0.3%
Blood group sensitization	33	0.3%	31	0.3%	33	0.3%	25	0.2%	122	0.3%
Lung disease, acute or chronic	11	0.1%	21	0.2%	25	0.2%	48	0.5%	105	0.3%
Renal disease	15	0.1%	21	0.2%	15	0.1%	19	0.2%	70	0.2%
Cardiac disease	12	0.1%	14	0.1%	11	0.1%	15	0.1%	52	0.1%
Unknown	27	0.3%	10	0.1%	4	0.0%	7	0.1%	48	0.1%
Hemoglobinopathy	5	0.0%	1	0.0%	0	0.0%	2	0.0%	8	0.0%
Other	1,105	10.7%	1,172	11.4%	1,025	10.2%	1,092	10.8%	4,394	10.8%

	1995		1996		1997		1998		Total	
	n	%	n	%	n	%	n	%	n	%
Total births	10,470		10,469		10,168		10,281		41,388	
No risk factors	7,079	67.6	7,243	69.2	7,298	71.8	7,412	72.1	29,032	70.1
Fetal distress	546	5.2	532	5.1	429	4.2	464	4.5	1,971	4.8
Breech/Malpresentation	511	4.9	530	5.1	478	4.7	439	4.3	1,958	4.7
Dysfunctional labor	523	5.0	510	4.9	499	4.9	392	3.8	1,924	4.6
Meconium, moderate/heavy	415	4.0	392	3.7	331	3.3	354	3.4	1,492	3.6
Cephalopelvic disproportion	376	3.6	340	3.2	317	3.1	340	3.3	1,373	3.3
Premature rupture of membrane (>12 hrs)	342	3.3	296	2.8	252	2.5	240	2.3	1,130	2.7
Precipitous labor (<3 hrs)	225	2.1	176	1.7	181	1.8	208	2.0	790	1.9
Prolonged labor (>20 hrs)	161	1.5	164	1.6	153	1.5	134	1.3	612	1.5
Other excessive bleeding	84	0.8	88	0.8	71	0.7	83	0.8	326	0.8
Febrile (>38C)	91	0.9	90	0.9	62	0.6	75	0.7	318	0.8
Abruptio placenta	78	0.7	66	0.6	78	0.8	65	0.6	287	0.7
Placenta previa	12	0.1	14	0.1	35	0.3	33	0.3	94	0.2
Cord prolapse	22	0.2	15	0.1	14	0.1	17	0.2	68	0.2
Unknown	25	0.2	6	0.1	2	0.0	3	0.0	36	0.1
Anesthetic complications	7	0.1	3	0.0	6	0.1	4	0.0	20	0.0
Seizures during labor	5	0.0	4	0.0	4	0.0	6	0.1	19	0.0
Other risk factors	860	8.2	891	8.5	714	7.0	707	6.9	3,172	7.7

Preventive/Primary Care Services for Children and Adolescents

According to a document developed by the National Academy for State Health Policy, the Census Bureau Current Population Survey (CPS) data estimates the number of children below 200% of FPL who are uninsured in each state. The annual estimates are based on three years of survey data and updated each year. All of the survey periods are prior to the July 1, 1998 implementation of M-CHIP in South Dakota. However, they are the best available data to use as baseline. Baseline estimates were prepared using the Census Bureau Current Population Survey from 1995, 1996, 1997, and 1998. Estimates for 1999 and 2000 baseline figures are calculated by reducing the 1998 CPS estimate by the number of uninsured children enrolled in South Dakota Medicaid and South Dakota M-CHIP on the last day of each report year (see Table 22).

Table 22.	
South Dakota Estimated Number of Uninsured Children	
Census Survey	# of Uninsured Children
CPS 1993, 1994, 1995	17,000
CPS 1994, 1995, 1996	10,000
CPS 1995, 1996, 1997	12,000
CPS 1996, 1997, 1998	13,000
South Dakota 1999 Estimate	10,909
South Dakota 2000 Estimate	6,943

The reduction from 1995 to 1996 could possibly be explained by a Medicaid expansion that took place in July 1995. This expansion provided Medicaid coverage to children under 100% of FPL and born after July 1, 1983. The increases from 1996-1997 can be explained through a combination of change in the definition of insurance to exclude the IHS as an insurance and sample variability.

Table 23 reports the number of enrolled Medicaid and M-CHIP children for the ending date of each quarter from M-CHIP implementation to the end of FFY 1999. When the number of Medicaid eligible children is referred to, it includes all categories of Medicaid eligible children except SSI.

Table 23.		
Number Enrolled in Medicaid and M-CHIP		
Quarter Ending	Medicaid	M-CHIP
06/30/98	32,859	0
09/30/98	34,290	903
12/31/98	35,320	1,407
03/31/99	36,435	1,710
06/30/99	36,866	2,039
09/30/99	37,158	2,488

Extracted data from the MMIS over this time period revealed that 83 percent of the children enrolled in Medicaid were uninsured when considering all types of insurance including full coverage and limited coverage plans (hospital only, dental and cancer). All M-CHIP children were by definition uninsured.

Children enrolled in Medicaid prior to July 1, 1998 were children age 0-5 under 133% of FPL, children 6-18 under 100% of FPL and all other Medicaid categories. Children enrolled in Medicaid after July 1, 1998 include children age 6-18 under 133% of FPL and all previously eligible

categories. Effective April 1, 1999 children age 0-18 under 140% of FPL were also included. Children enrolled in M-CHIP prior to April 1, 1999 are considered uninsured children, not otherwise eligible for Medicaid ages 6-18, and under 133% FPL. Table 24 shows the increase in the number of uninsured Medicaid and M-CHIP individuals for FFY 1998 and 1999.

Table 24. Medicaid and M-CHIP Enrollment of Uninsured Children				
Baseline Year	Reporting Period	Uninsured Medicaid	M-CHIP	Total
1999	06/30/98-09/30/98	1,188	903	2,091
2000	10/01/98-09/30/99	2,381	1,585	3,966

Reducing the baseline estimate of 13,000 uninsured children from 1998 by the enrollment of uninsured children in Medicaid yields estimates of 10,909 children after the first FFY of M-CHIP operation and 6,943 after the second FFY of M-CHIP. Table 25 shows the percentage reduction in the number of uninsured children following each federal fiscal year of M-CHIP operation.

Table 25. Percentage Reduction in Number of Uninsured Children						
Period	Estimate of Uninsured Children	Medicaid Increase	M-CHIP Increase	Total	Remaining Uninsured Children	Percent Reduction in Uninsured Children
07/01/98-09/30/98	13,000	1,188	903	2,091	1999-10,909	16%
10/01/98-09/30/99	10,909	2,381	1,585	3,966	2000-6,943	36%
07/01/88-09/30/99		3,569	2,588	6,057	6,942	47%

Table 26 shows that Medicaid and M-CHIP have both contributed substantially to reducing the number of uninsured children in South Dakota. Recognizing that the baseline figures represent all uninsured children below 200% of the federal poverty level and that Medicaid and M-CHIP eligibility expansions were directed at incomes below 133% of FPL prior to April 1, 1999 and at incomes to 140% of FPL after April 1, 1999, the impact on very low incomes has been proportionally greater.

Table 26.				
Reduction in Uninsured Children				
Year Ending	Baseline	Baseline 133%	Enrollment	Reduction
09/30/98	13,000	8,662	2,091	24%
09/30/99	10,909	5,985-6,284**	3,966	63%-66%

*Assumed uniform distribution of uninsured children less than 200% by income
 **In April eligibility increased to 140% FPL, so baseline figure is represented as a range of the percent of uninsured children between 133%-140%.

DOH and DSS have been collaborating over the past year to further assess and validate data relative to health care coverage for children. The 1999 South Dakota BRFSS included an increased number of surveys to assure that there was an adequate sample of families with children to gather data specific to children and health care coverage. The families participating in the survey were questioned regarding the child in their home who had the most recent birthday.

Of the 1,506 families identified as having a child 18 or younger in their household, 6.7 percent indicated the child was uninsured (this can be compared to a smaller sample of responses in 1998 which indicated that 9.3 percent of the children were uninsured). Of those, 31.6 percent indicated that their child was without health coverage because of the loss of someone's employment, 12.2 percent went without needed medical care when sick or injured and 12.2 percent delayed medical care because of lack of coverage.

For those respondents who said their child had health care coverage, the type of health care coverage used to pay for most of the child's medical care was as follows: own employer - 42 percent; someone else's employer - 27 percent; a plan that the family or someone else buys on their own - 13.1 percent; Medicaid/CHIP/Medical Assistance - 10.3 percent; IHS - 3.7 percent; and military/ CHAMPUS/TriCare/VA - 2.2 percent.

Effective July 1, 2000, uninsured children aged 0-18 who are found ineligible for the current CHIP program because family income is above 140% but equal to or less than 200% of the federal poverty guidelines will be eligible for the new CHIP-NM program. With this additional coverage option, the percentage of children uninsured should continue to decrease.

Services for CSHCN

Special health care needs in children include chronic health conditions as well as limitations in mobility and physical movement,

sensory and communicative ability, activities of daily living, and/or cognitive and mental health functions. Many definitions are currently in use by policy makers and researchers, but there continues to be little agreement among them as to which components should be included or how they are best measured. Parental or individual perceptions of limitations, the severity and impact of the limitation and access to health care and services affect any estimate of chronic health conditions among children.

Historically, condition lists, functional impairments and disability have been used to identify target populations for public programs serving children with chronic conditions. As the mission of Title V programs for CSHCN has expanded, there has been a need to shift focus from a narrow conception of the target population to a broader concept. One example of this shift in focus is reflected in the change in terminology from crippled children to CSHCN.

While there is no universally accepted definition of chronic illness, most experts agree that a chronic illness is one that extends over a substantial period of time (typically longer than three months) and in some cases over an entire life span. CSHCN are a diverse group with more than 3,700 recognized conditions and disabling illnesses. MCHB defines CSHCN as those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions which require health and related services of a type beyond that required by children generally.

Results from the 1994 NHIS-D survey indicate that 12 percent of U.S. children under 18 years of age had a chronic physical, developmental, behavioral, or emotional condition and also used health or related services beyond those required by children generally. Included in this group were children reported as using the services of physicians, therapists and other health providers/facilities on a regular basis for the treatment of a chronic health problem; children with special diets or requiring prescription medications on a long-term basis, or needing personal assistance or using special equipment aids, or personal assistance for mobility, hearing, vision or other needs; and children receiving special education or early intervention services.

Analysis of the NHIS-D data indicates an additional six percent of children had a presumed need for health or related services beyond those

required by children generally. Children with elevated service needs may not actually receive services because of access barriers, lack of knowledge on the part of parents or providers and other factors. Children in this group experienced developmental delays, learning disabilities, vision and hearing impairments, and other types of functional limitations and disabilities.

For purposes of determining the number of children under 18 years of age in South Dakota who have a chronic physical, medical or neuro-developmental condition and also use health or related services beyond those generally required by children, this state's CSHCN program will utilize 12 percent to determine incidence. According to the U.S. Census Bureau, there were 198,037 children birth through 17 years of age in South Dakota in 1990. Based on an incidence rate of 12 percent, it can be estimated that 23,764 children in South Dakota birth through 17 years of age have some type of chronic physical, medical or developmental condition and require health and related services of a type or amount beyond that required by children generally.

The synthetic estimate developed five years ago as part of the comprehensive needs assessment was conservative in nature and was based on relevant factors at that time. The estimate stated above on the number of children with chronic medical conditions in the state is considerably higher. A number of factors justify a need for an adjustment including new information available from the NHIS-D, improved data collection, greater awareness of chronic conditions, greater sensitivity to impairments and chronic health conditions, and improvements in lifesaving medical technology.

CSHS utilizes a more narrow definition of CSHCN for program eligibility (i.e., financial assistance for specialty care). Limited resources will require the program to continue use of a narrow definition for such purposes. However, the MCHB definition more appropriately reflects the population to whom the CSHS staff provides care coordination, information and referral, and other linkage services.

The 1996 South Dakota BRFSS survey asked if the children in the households had any special medical conditions such as diabetes, asthma, cerebral palsy, heart defects, cleft lip or palate, cancer, epilepsy or seizures, kidney disease, Down's Syndrome, cystic fibrosis, spina bifida, hearing loss, hemophilia, scoliosis, or arthritis. Overall, 115 (5.5%) of the

survey respondents said that a child in their household had one or more special medical conditions. Over 66 percent (66.3%) of the respondents said that there were no children in their household. Of the 33.7 percent that did have children, the most common medical condition was asthma. Table 27 shows the percentages of children with special medical conditions.

Table 27.
Households with Children Having Special Medical Condition, 1996

Medical Condition	One or more Children With Condition	No Children With Condition	Unknown/Refused
Diabetes	0.9%	96.9%	2.2%
Asthma	9.3%	87.9%	2.8%
Cerebral Palsy	0.7%	96.2%	3.1%
Heart Defects	0.9%	96.3%	2.8%
Cleft Lip/Palate	0.6%	96.8%	2.7%
Cancer	0.3%	96.9%	2.8%
Epilepsy/Seizures	2.1%	94.8%	3.1%
Kidney Disease	0.4%	96.5%	3.1%
Down's Syndrome	0.4%	96.6%	3.0%
Cystic Fibrosis	0.3%	96.8%	3.0%
Spina Bifida	0.4%	96.8%	2.8%
Hearing Loss	2.3%	95.1%	2.7%
Hemophilia	0.4%	96.8%	2.8%
Scoliosis	0.8%	96.2%	2.9%
Arthritis	0.8%	96.6%	2.6%
# of households with children having medical condition = 115 (5.5% of respondents)			

Statistics from the SSA show that SSI child recipients are more likely to be boys than girls, by about three to two. Four out of five of the children lived with their parents. Almost two out of three (64%) of the SSI children were disabled based on a mental disorder and most of these (37%) were mentally retarded. The only other diagnostic category of any size was diseases of the nervous system and sense organs (12%) which included all of the approximately 6,600 blind children on SSI in December 1999 (see Table 28).

Table 28.					
Number of Children Receiving Federally Administered SSI Payments and Percentage Distribution, By Age and Diagnostic Group					
December 1999					
Diagnostic Group	Total	Age			
		Under 3	3-5	6-12	13-17
Total	843,370	63,400	103,350	388,720	288,000
Total with diagnosis	789,970	57,770	94,070	364,570	273,380
Infectious & parasitic diseases	3,010	200	530	1,680	600
Neoplasms	9,520	650	1,800	4,410	2,660
Endocrine, nutritional and metabolic	6,360	840	1,000	2,590	1,930
Mental disorders:					
- Schizophrenia	4,150		40	1,460	2,650
- Other psychiatric	213,060	5,000	24,530	108,990	74,540
- Mental retardation	291,770	2,220	16,460	136,780	136,310
Diseases of the -					
- Nervous system & sense organs	96,750	6,000	15,170	47,220	28,360
- Circulatory system	4,070	880	930	1,530	730
- Respiratory system	25,060	3,870	5,580	11,500	4,110
- Digestive system	2,990	890	690	990	420
- Genito-urinary system	2,320	220	330	960	810
- Musculoskeletal system	7,680	450	970	3,360	2,900
Congenital anomalies	41,900	9,340	10,080	15,920	6,560
Injury and poisoning	4,360	360	710	1,920	1,370
Other	76,790	26,850	15,250	25,260	9,430

Widely varying estimates concerning the prevalence of chronic childhood disorders exist depending upon the definitions used, the methods of study and the population under investigation. Among children with chronic medical conditions, there is a great deal of variation in severity, duration and age of onset. Mild chronic conditions, such as allergies, skin conditions, minor respiratory disease, and “innocent” heart murmurs, are often outgrown as children mature. Many children with chronic conditions experience minimal limitation in their usual daily activities. However, children with moderate to severe chronic medical conditions are often limited in the amount or kind of usual activity (school, play, or recreation) in which they can engage. Children with

severe chronic conditions and disabling illnesses frequently need health or medical services that will maintain their functional capacity.

The 1994 NHIS-D produced estimates of U.S. children with existing special health care needs. These estimates provide an epidemiologic profile of children with existing special health care needs. Table 29 utilizes the NHIS-D rates and 1999 population estimates to determine potential prevalence of selected chronic conditions in South Dakota.

Chronic Condition	Rate per 1,000	Age						Birth-17
		0-2	3-5	6-8	9-11	12-14	15-17	
Goiter or other disorders of thyroid	1.2	36	36	38	41	42	45	238
Diabetes	2.6	77	79	81	89	91	98	515
Anemia	7.2	213	218	225	245	253	270	1,426
Epilepsy	4.0	119	121	125	136	141	150	792
Migraine headaches	12.7	376	385	397	433	447	477	2,515
Kidney trouble	2.7	80	82	84	92	95	101	535
Bladder disorders	2.8	83	85	88	95	98	105	555
Disease of female genital organs	2.3	68	70	72	78	81	86	455
Rheumatic fever w/o heart disease	1.0	30	30	31	34	35	38	198
Heart disease	18.6	551	564	582	634	654	699	3,683
High blood pressure	0.6	18	18	19	20	21	23	119
Cerebrovascular disease	0.8	24	24	25	27	28	30	158
Hemorrhoids	0.9	27	27	28	31	32	34	178
Chronic bronchitis	53.6	1,588	1,625	1,677	1,827	1,885	2,013	10,615
Asthma	74.9	2,219	2,271	2,343	2,553	2,634	2,813	14,833
Chronic sinusitis	75.6	2,240	2,292	2,365	2,577	2,658	2,840	14,972
Arthritis	2.1	62	64	66	72	74	79	416
Visual impairment	7.0	207	212	219	239	246	263	1,386
Hearing impairment	14.9	441	452	466	508	524	560	2,951
Deformity/Orthopedic Impairment	29.8	883	903	932	1,016	1,048	1,119	5,902
Absence of Extremities	0.3	9	9	9	10	11	11	59
Paralysis of Extremities	2.5	74	76	78	85	88	94	495

Source: 1994 NHIS rates and 1999 population estimates for South Dakota

Utilizing NHIS-D rates, it is apparent that respiratory conditions (i.e., chronic sinusitis, asthma, and chronic bronchitis) affect a far greater number of children than any other condition. Other conditions listed with a rate of 10 per 1,000 or higher are deformity or orthopedic impairment, heart disease, hearing impairment, and migraine headaches.

Gortmaker et al have also developed prevalence rates of various chronic conditions. Again, the DOH has utilized these rates and 1999 population estimates to determine potential prevalence of these conditions in South Dakota (see Table 30).

Chronic Condition	Rate per 1,000	Age						Birth-17
		0-2	3-5	6-8	9-11	12-14	15-17	
Arthritis	2.2	65	67	69	75	77	83	436
Asthma (mod-severe)	10.0	296	303	313	341	352	376	1,980
CNS - TBI (severe)	0.05	1	2	2	2	2	2	10
CNS - Paralysis	2.1	62	64	66	72	74	79	416
Cerebral Palsy	2.5	74	76	78	85	88	94	495
Chronic renal failure	0.08	2	2	3	3	3	3	16
Cleft lip/palate	1.5	44	45	47	51	53	56	297
Congenital heart disease	7.0	207	212	219	239	246	263	1,386
Cystic Fibrosis	0.2	6	6	6	7	7	8	40
Diabetes Mellitus	1.8	53	55	56	61	63	68	356
Down's Syndrome	1.1	33	33	34	37	39	41	218
Hearing impairment	16.0	474	485	510	545	563	601	3,169
Hemophilia	0.15	4	5	5	5	5	6	30
Leukemia	0.1	3	3	3	4	4	4	22
Muscular Dystrophy	0.06	2	2	2	2	2	2	12
Neural Tube Defects	0.45	13	14	14	15	16	17	89
Spina Bifida	0.4	12	12	13	14	14	15	79
Encephalocele	0.05	1	2	2	2	2	2	10
Phenylketonuria	0.1	3	3	3	3	4	4	20
Sickle cell disease	0.46	14	14	14	16	16	17	91
Sickle cell anemia	0.28	8	8	9	10	10	11	55
Seizure disorder	3.5	104	106	109	119	123	131	693
Visual impairment	30.0	889	909	939	1,023	1,055	1,127	5,941
Impaired Visual Acuity	20.0	593	606	626	682	703	751	3,961
Blind	0.6	18	18	19	20	21	23	119

Source: Gortmaker & Sappenfield rates and 1999 population estimates for South Dakota.

In 1998, the DOH completed a survey to evaluate the delivery of, and access to, services and identify gaps and duplication of services to CSHCN in South Dakota. There were two components to the assessment process. In the first stage, surveys were sent to 2,770 parents of CSHCN, 318 physicians (i.e., pediatricians, family physicians, general practitioners and pediatric sub-specialists) and 1,300 other health-related professionals (i.e., physical, occupational and speech therapists). The overall response rate for the survey was 33.5 percent (38.4 % for parents, 34.9% for physicians, and 22.8% for other health professionals). The lower response rate for other health professionals could be due to the fact that a large percentage of them are affiliated with schools not in session during the summer months when the survey was conducted.

A second component of this needs assessment activity was focus groups. Focus groups provide a means for obtaining qualitative information from families and professionals regarding services delivered,

access to services and comprehensive care. The purpose of the focus groups was to gain more information regarding responses to the survey questionnaires. A copy of the final report can be found in Section V.5.3.

Heart conditions were the most common condition reported from parents (see Table 31).

Condition	Percent
Heart condition	24.1%
Asthma	21.1%
Developmental disabilities	17.8%
Vision impairment	9.8%
Seizure disorder	9.1%
Diabetes	8.7%
Other	38.4%

Since 1989, South Dakota birth certificates have contained check boxes to report some of the most severe congenital anomalies. Caution should be used when comparing yearly rates of specific anomalies since the infrequent occurrences of each specific anomaly can cause rates to change dramatically with a small change in occurrence. The total number of infants with at least one anomaly in the period from 1989-1998 was 2,130 with a total of 2,518 congenital anomalies being reported. Birth certificates for calendar years 1995-1998 were analyzed in regard to categories of congenital anomalies and selected reported congenital anomalies, i.e. spina bifida/meningocele, heart malformations, cleft lip/palate, and Down's Syndrome (see Tables 32 and 33).

Category	1995 (10,470 births)		1996 (10,469 births)		1997 (10,168 births)		1998 (10,281 births)	
	N	Rate	N	Rate	N	Rate	N	Rate
Central Nervous System	13	124.2	8	76.4	9	88.5	14	136.2
Chromosomal	10	95.5	11	105.1	9	88.5	15	145.9
Circulatory/Respiratory	32	305.6	29	277.0	41	403.2	27	262.6
Gastrointestinal	10	95.5	15	143.3	9	88.5	14	136.2
Musculoskeletal/ Integumental	59	563.5	84	802.4	88	865.5	74	719.8
Other	46	439.4	30	286.6	12	118.0	29	282.1
Urogenital	50	477.6	44	420.3	41	403.2	32	311.2
<i># of Anomalies</i>	220	2,101.2	221	2,111.0	209	2,055.5	205	1,994.0
<i># of Infants</i>	189		182		176		170	

Table 33.								
South Dakota Resident Births with Reported Congenital Anomalies								
Category	1995 (10,470 births)		1996 (10,469 births)		1997 (10,168 births)		1998 (10,281 births)	
	N	Rate	N	Rate	N	Rate	N	Rate
Cleft Lip/Palate	12	114.6	11	105.1	17	167.2	15	145.9
Down's Syndrome	3	28.7	7	66.9	7	68.8	10	97.3
Heart Malformations	20	191.0	16	152.8	16	157.4	17	165.4
Spina Bifida/ Meningocele	3	28.7	4	38.2	3	29.5	3	29.2
<i>Infants with Selected Anomalies</i>	15	143.3	18	172.0	24	236.0	25	243.2

As is evidenced above, widely varying estimates and vital statistics concerning population prevalence of chronic childhood disorders exist, depending upon the definitions used, the methods of study, and the population under investigation. State programs for CSHCN are challenged to tailor a system of care that best meets the needs of CSHCN and their families based on the unique factors present in their state.

There are many factors to consider when assessing the health status of children with special health care needs. Perrin et al, in their review of definitions of chronic conditions, stressed that one confusing element of standard definitions and systems of classification of chronic conditions is whether the focus is on the condition or on the child. Definitions based on a categorical approach derive from the presence of particular conditions. In contrast, definitions based on the noncategorical approach generally focus on the impact of conditions on the child. Regardless of which approach is taken, defining chronic conditions requires clarity about duration and conditions. Programs serving children with special health care needs must take these into consideration when designing health policies.

It is difficult to generalize about the health needs of children with chronic medical conditions. However, there are some factors that appear constant in several research studies. The type and level of disability varies greatly among children with chronic medical conditions. The results of the NHIS-D survey showed the prevalence of existing special health care needs varied by demographic and socioeconomic characteristics of the child population. Boys were about one third more likely than girls to have a special need. The NHIS-D survey also found that children in families with incomes at or below the federal poverty level were about one third

more likely that children in families with incomes above poverty to have an existing special health care need. Family structure was also related to prevalence; children in single-parent families were about 40 percent more likely to have existing special health care needs as children from two-parent households.

Differences were also apparent by race and ethnicity. Children from less educated households exhibited a higher likelihood of experiencing a special health need at the time of the survey. Family structure also related to prevalence; children in single-parent families were about 40% more likely to have special health care needs.

In the Newacheck and Halfon study, prevalence of disability was found to vary by demographic and socioeconomic characteristics of children. Older children, boys, children from poor families, and those from single-parent households all exhibited higher prevalences. The Newacheck and Halfon study found that prevalence rates varied only slightly by family size and region of the county.

Newacheck and Halfon, analyzing data from the 1992-1994 NHIS, found that conditions classified as chronic impairments were the main cause of about 39 percent of all childhood activity limitations, while those labeled as chronic diseases and injuries accounted for 61 percent. Overall, respiratory diseases (principally asthma) and impairments of speech, special sense, and intelligence (principally mental retardation) constituted the most common causes of disability. Each of these diagnostic categories accounted for a little more than one quarter of all cases of childhood disability. The third most prevalent diagnostic category, mental and nervous system disorders, accounted for about one sixth of disabilities.

The NHIS-D results indicate that prevalence increases with age, such that school-aged children were twice as likely as toddlers to be classified as having an existing special need. Newacheck and Halfon, found that prevalence increases with age, rising particularly after age five. However, the social role activity used to assess limitation in the questionnaire changes from play to school for children reaching school age. Newacheck and Halfon feel the observed increase in prevalence may reflect the added social role demands placed on children as they enter school, rather than a change in underlying disease pathology.

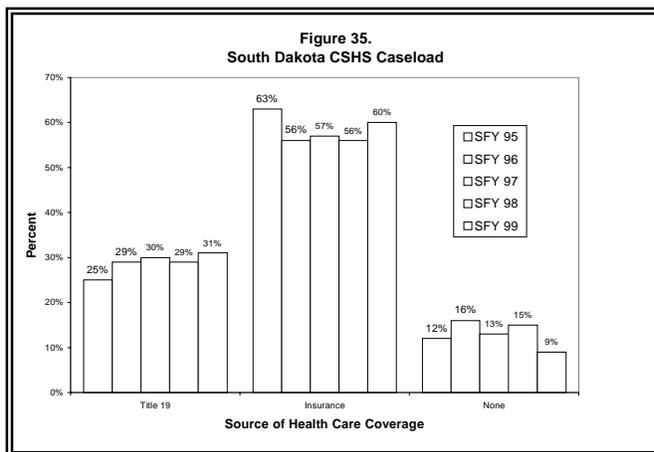
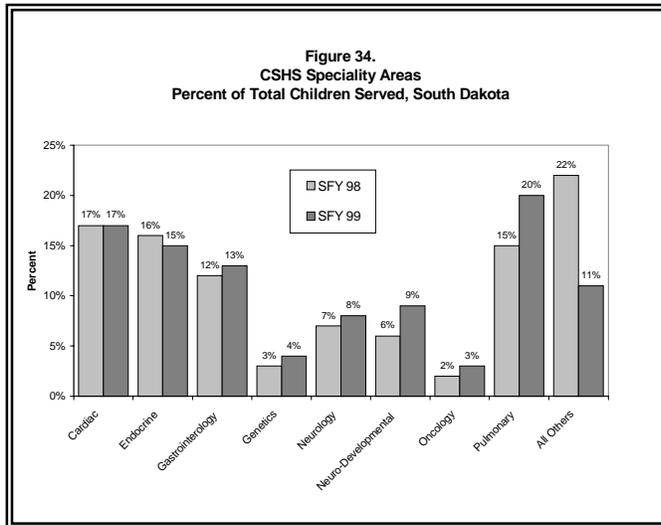
According to the NHIS-D survey results, children with existing special health care needs had three times as many days spent ill in bed and three times as many school absence days as other children. In the Newacheck and Halfon study, there was wide variation in the number of school absence days reported for children in different diagnostic groups. Children with infectious and parasitic diseases, neoplasms, and injuries were reported to have missed an average of six weeks or more of school annually. In contrast, children with sensory impairments, impairments related to speech and intelligence, or skin diseases were reported to have missed an average of less than one school day annually. Conditions most likely to lead to long-term attendance problems included digestive conditions, infectious and parasitic diseases, and genitourinary disorders.

Compounding the issues related to children with chronic medical conditions and how such conditions effect school activities, is the fact that, here again, differing categorical systems are utilized to identify CSHCN. Table 34 shows the number and percent of children in South Dakota, over a five year time span, who were receiving special education services and who had a health related condition listed as their primary condition.

Disabling Condition	1994-95		1995-96		1996-97		1997-98		1998-99	
	N	%								
Hearing Impaired/Deaf	150	1.2	138	1.1	126	1.0	120	1.0	113	0.9
Multiple Disabilities	416	3.2	431	3.4	441	3.6	459	3.7	507	4.0
Orthopedic Impairments	119	0.9	105	0.8	93	0.8	83	0.7	82	0.6
Visually Impaired	55	0.4	49	0.4	53	0.4	55	0.4	49	0.4
Other Health Impairments	157	1.2	200	1.6	211	1.7	260	2.1	320	2.5
Traumatic Brain Injuries	26	0.2	35	0.3	43	0.4	44	0.4	31	0.3
Other	11,985	92.8	11,745	92.4	11,242	92.1	11,392	91.8	11,624	91.3

Other conditions reported to the Office of Special Education as the primary disabling condition (but not included in this chart) are mental retardation, serious emotionally disturbed, specific learning disabled, autism, and speech/language impairments.

CSHS assists children with chronic medical conditions in accessing specialty care by sponsoring pediatric specialty outreach clinics in three locations in the state (Rapid City, Pierre, and Aberdeen). These outreach clinics enhance access to specialty care and reduce travel costs and time lost from work for families who have CSHCN. In addition, CSHS provides financial assistance on a cost-share basis for specialty care. Figure 34



illustrates the percent of children served through CSHS in the eight largest specialty areas. All other specialty areas (i.e., orthopedic, ophthalmology, children's rehabilitation, renal, craniofacial anomalies, myelodysplasia, and hemophilia) are listed under others.

The NHIS-D survey results showed that although most children with an existing special health care need had health insurance coverage in 1994, an estimated 11.2 percent were uninsured.

The South Dakota CSHS program has monitored the source of health care coverage for children served through the program for the past five years (SFY 95-SFY 99). Figure 35 illustrates the slight migration from no coverage to insurance or Medicaid in the past four state fiscal years. Review of patient charts indicated that CSHCN who are uninsured or underinsured tend to be in

families who are self-employed farmers and ranchers, or where the parents are employed in minimum wage type positions and either are not offered insurance coverage through their employer, or cannot afford such coverage.

According to the 1996 BRFSS, insurance (66.9%) and the family (35.8%) were the sources that commonly paid for the medical care of their children with special medical conditions (see Table 35). Medicaid was also a common form of payment at 17.8 percent. Since only 5.5 percent of respondents had a child in their household with a special medical condition, these results must be interpreted cautiously. These findings are somewhat lower than those of the CSHCN program statistics. The 1996 BRFSS respondents may include families that are not, but should be, involved in CSHS.

Table 35. Sources Paying for Health Care of Children with Special Medical Conditions, 1996	
Source	%
Insurance	66.9%
Family	35.8%
Medicaid	17.8%
CSHS	2.8%
IHS	8.4%
CHAMPUS	3.6%
Other	5.5%
# of households with children having medical condition = 115 (5.5% of respondents)	

In review of SSI statistics provided by the SSA, Office of Research, Evaluation and Statistics, almost 850,000 blind and disabled children were receiving SSI payment in December 1999. They made up 12.9 percent of the over 6.5 million SSI recipients at that time. The December data reflect a decrease of over 31,000 child recipients nationwide since June 1999. To be eligible for SSI payments as a child, an individual must be under age 18, unmarried, and must meet the applicable SSI disability, income, and resource criteria. The average SSI payment received by SSI children in December 1999 was \$431. In December 1999, 15 percent of the children receiving SSI were under five years old.

The SSA provided each state with state-specific information regarding the children receiving SSI payments and percentage distribution by selected characteristics (see Table 36).

Table 36.		
Number of Children in South Dakota Receiving Federally Administered SSI Payments and Percentage Distribution By Selected Characteristics December 1999¹		
Selected Characteristics	Number	Percent
Total	2,010	100.0
Age		
Under 1 year	30	1.5
1	80	4.0
2	50	2.5
3	80	4.0
4	70	3.5
5	30	1.5
6	80	4.0
7	140	7.0
8	160	8.0
9	120	6.0
10	110	5.5
11	160	8.0
12	140	7.0
13	110	5.5
14	180	9.0
15	100	5.0
16	160	8.0
17	210	10.4
Sex		
Male	1,250	62.2
Female	760	37.8
Living Arrangements		
Own household	520	25.9
Another's household	40	2.0
Parent's household	1,350	67.2
Medicaid institution	100	5.0
Citizenship Status		
Citizen	2,000	99.5
Noncitizen	10	0.5
¹ Based on a 10-percent sample file. Table produced by SSA, OP, ORES, DSSA. Contact Clark Pickett, (410) 965-9016 for further information		

Table 37 compares SSI child recipients nationwide with South Dakota recipients with age breakdowns.

Table 37.				
Children Receiving Federally Administered SSI Payments				
December 1999				
Age	U.S.		South Dakota	
	#	%	#	%
Less than 3 years old	63,400	8%	160	8%
3-5 years old	103,350	12%	180	9%
6-12 years old	388,720	46%	910	45%
13-17 years old	288,000	34%	760	38%
TOTAL	843,470	100%	2,010	100%

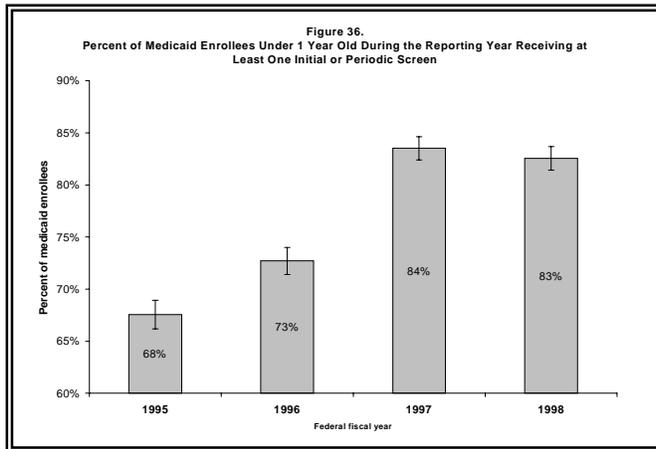
Children with chronic medical conditions are particularly at risk for nutrition problems. Factors impacting nutritional status include feeding problems, anemia, and need for supplementary nutrition or special diets. Nutrition services can improve the health status of children with special health needs, and often can decrease the severity and improve the outcomes for children with chronic conditions and disabling illnesses.

3.2 Health Status Indicators

HEALTH STATUS INDICATORS

HSI #01. The rate per 10,000 for asthma hospitalizations (ICD-9 Codes: 493.0-493.9) among children less than five years old.

See Core Health Status Indicator (Form C1) in Section V.5.4.



HSI #02A. The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

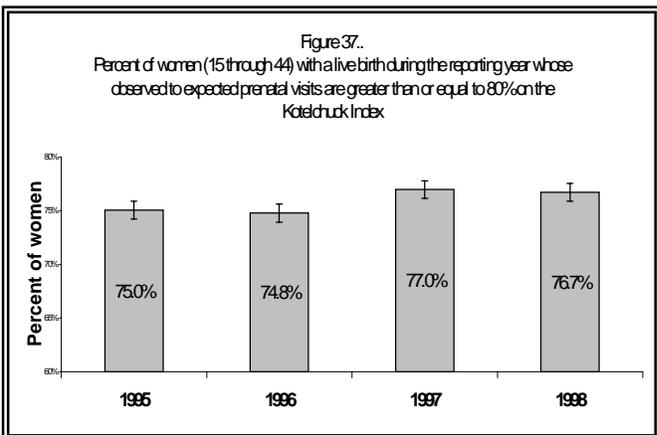
In South Dakota, the goal is to increase the adequacy of primary care for Medicaid enrollees. Between 1995 and 1998, the percent of infants enrolled in Medicaid who received at least one initial or periodic

screen increased dramatically from 68 percent to 83 percent (see Figure 36). This increase may be attributed to improvements in access to primary health care services in rural areas and increased public awareness of rural providers.

HSI #02B. The percent Children's Health Insurance Program (CHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

The CHIP program began in South Dakota on July 1, 1998. Therefore, the DOH is unable to use this as an indicator at this time.

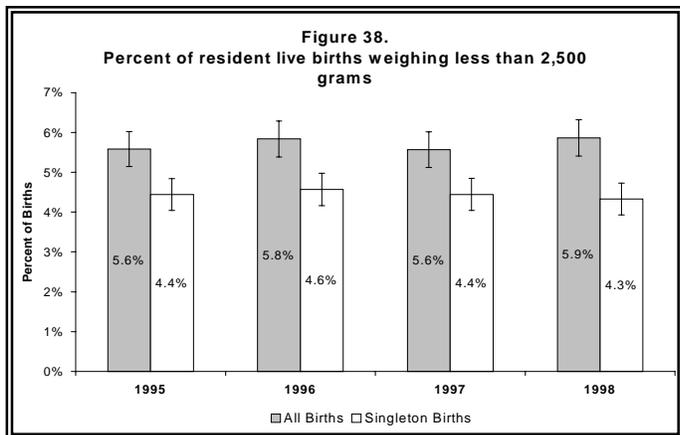
HSI #03. The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.



percent of South Dakota women receiving adequate prenatal care has increased since 1995 (see Figure 37).

HSI #04A. The percent of live births weighing less than 2,500 grams.

HSI #04B. The percent of live singleton births weighing less than 2,500 grams.



include the age of the mother, smoking, poverty, inadequate prenatal care, multiple births, or substance abuse.

Overall, there has been little change in the percentage of low birth weight babies over the four-year reporting period (see Figure 38). During this period, South Dakota had an average of 10,347 births and 10,064 live singleton births. The DOH noted a slight increasing trend in the percentage of low birth weights among all births and a slight decreasing trend among the singleton births. Neither trend, however, was significant.

- HP 2010 Objective: Increase to at least 90 percent of all live-birth infants whose mothers receive adequate prenatal care.

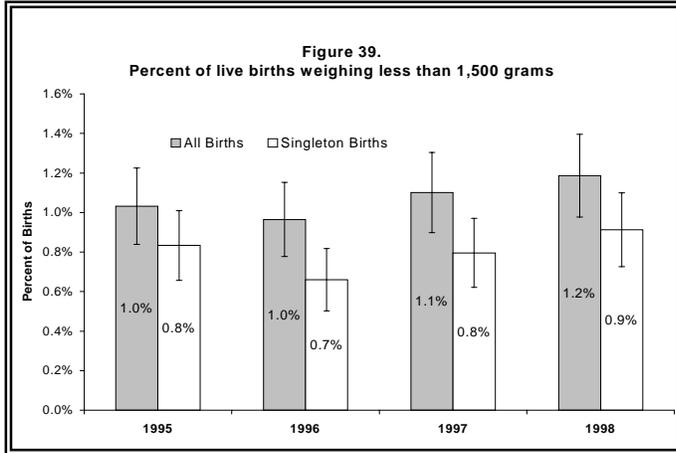
Adequate prenatal care is vital for the success of the pregnancy and the well-being of the child and mother. It is the goal of the DOH to increase the adequacy of prenatal care utilization among South Dakota mothers. The

- HP2010 Objective: Reduce low birth weight births to no more than 5 percent of all live births.

The DOH goal is to reduce the percent of babies born with low birth weight. Low birth weight (<2,500 grams or 5 pounds 6 ounces) is observed in infants with growth deficiencies or preterm birth. Risk factors for low birth weight status

HSI #05A. The percent of very low birth weight live births.

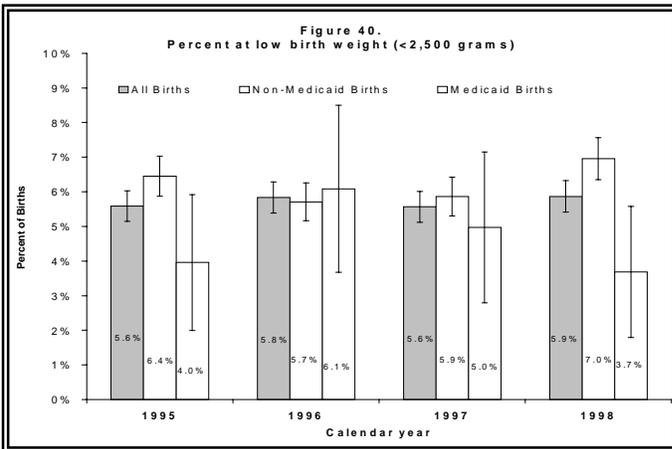
HSI #05B. The percent of very low birth weight live singleton births.



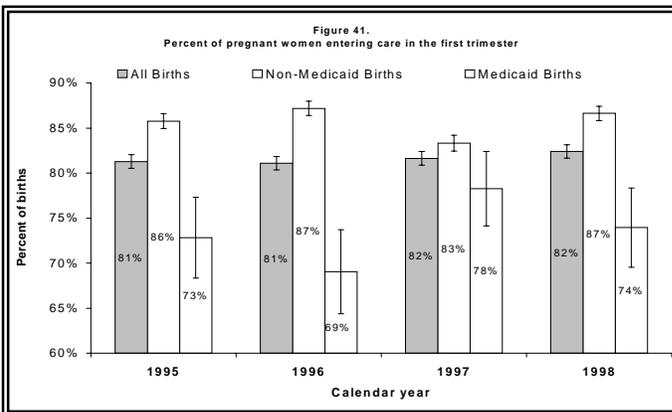
The HP 2010 Objective calls for a reduction in very low birth weight births to no more than 0.9% of all live births. Very low birth weight (<1,500 grams) is associated with preterm birth. Risk factors include low pre-pregnancy weight of the mother, prior preterm births and prior spontaneous abortion. By looking at only the singleton births, the influence of the multiple birth babies is removed. In South Dakota,

the goal is to reduce the percent of very low birth weight infants.

The percentage of very low birth weight infants has increased slightly over the reporting period among all infants and among singleton birth infants (see Figure 39).



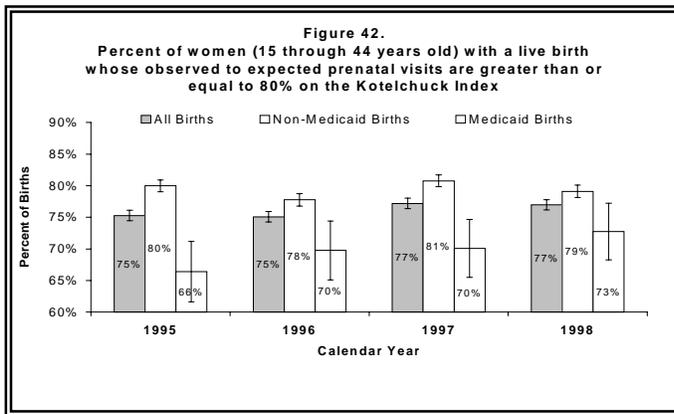
A sample of 400 Medicaid births was selected from the Medicaid paid deliveries for each of the calendar years 1995 through 1998. The average number of Medicaid paid deliveries over the time span 1995 through 1998 was approximately 3,500. A sample size of 350 would provide a sampling error of approximately $\pm 5\%$. 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.



HSI #06. Comparison of health status indicators for Medicaid, non-Medicaid, and all 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. 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 (see Figure 40).

Among all pregnant women, the percent entering care during their first trimester increased slightly from 81 to 82 percent (see Figure 41). The percentage of women with Medicaid who had first trimester care was significantly below the non-Medicaid women every year.



In the 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 (see Figure 42). The disparity, however, was decreasing steadily from a 16 percent gap in 1995 to a 6 percent difference in 1998.

HSI #07. The percent of poverty level for eligibility in the State’s Medicaid and CHIP programs for infants (0 to 1), children, and pregnant women.

	1995		1996		1997		1998	
	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Infants	133%	NA	133%	NA	133%	NA	133%	NA
Children	133% or 100%*	NA	133% or 100%**	NA	133% or 100%**	NA	133% or 100%**	133%
Pregnant Women	133%	NA	133%	NA	133%	NA	133%	NA

* 1995 under age 6 133%, age 6 or older born after 6/30/79 100%
 ** 1996-1998 under age 6 133%, age 6 through 18 100%
 **** CHIP implemented 7/1/98

HSI #08. The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

See Core Health Status Indicator (Form C2 – Medicaid and CHIP data) table in Section V.5.4.

DEVELOPMENTAL HEALTH STATUS INDICATORS (DHSI)

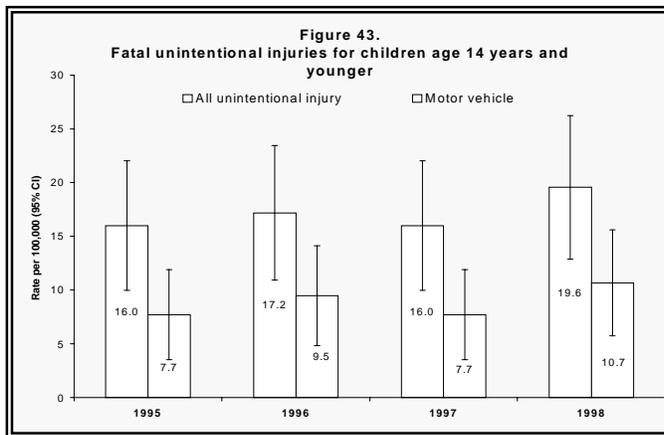
DHSI #01. Fatal Unintentional Injuries

DHSI #01A. The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

DHSI #01B. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger.

DHSI #01C. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

- HP 2010 Objective: Reduce deaths caused by motor vehicle crashes to no more than 4.2 deaths per 100,000 children 0-14 years.
- HP 2010 Objective: Reduce deaths caused by motor vehicle crashes for 15-24 year olds to no more than 25.4 per 100,000 adolescents aged 15-24.



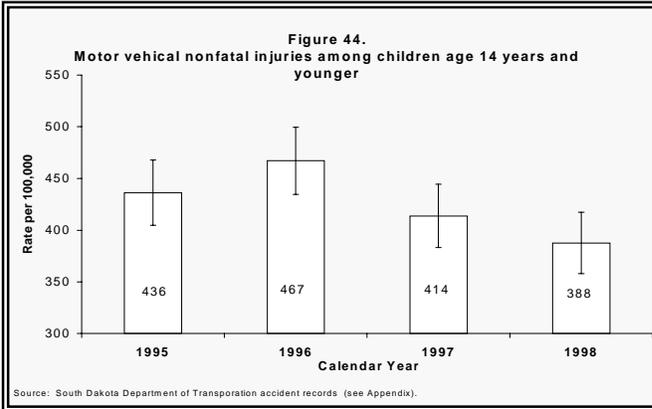
The DOH goal is to reduce the number of deaths due to unintentional injuries and motor vehicle accidents among children 14 years old and younger. The HP 2010 objective is to reduce the motor vehicle crash death rate to no more than 4.2 per 100,000 children aged 0-14 years. In South Dakota, unintentional injuries are a leading cause of death among children

and the rate is increasing for all unintentional injury deaths, including motor vehicle injury deaths (see Figure 43). Motor vehicle fatalities made up 52 percent of all fatal unintentional injuries of children during the four-year reporting period. In South Dakota, the rate is higher – averaging 8.9 per 100,000 over the reporting period – and the trend is increasing slightly. This increasing trend may be due to the increased speed limit from 65 to 75 on the interstate and 55 to 65 on the state roads that went into effect April 1, 1996. In addition, from October 1996 to March 1997, South Dakota weather conditions were severe, contributing to more crashes.

Motor vehicle crash fatalities for adolescents aged 15-24 averaged 42 deaths per year in South Dakota from 1995 to 1998 and is the number one cause of mortality for this age group. South Dakota's rate of 43 per 100,000 exceeds the HP 2010 objective and appears to be on an upward trend. Of the adolescents who died in motor vehicle crashes, 74 percent were not using safety restraints, 14 percent were using either lap belts, shoulder harnesses or both, and 14 percent were unknown.

DHSI #02. Nonfatal Unintentional Injuries

DHSI #02A. *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

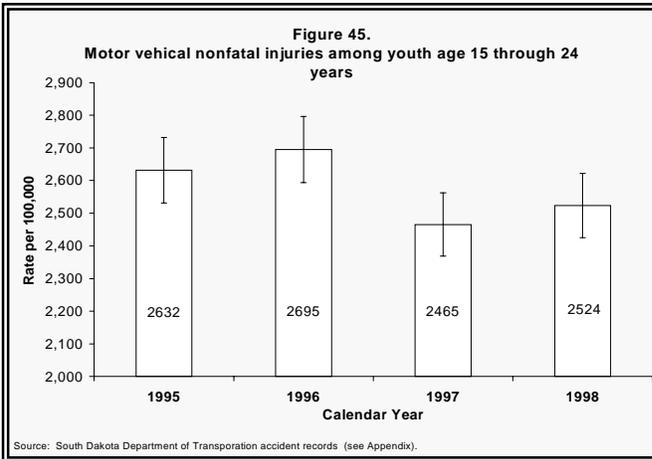


DHSI #02B. *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

DHSI #2C. *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

- HP2010 Objective: Reduce nonfatal injuries caused by vehicle crashes to 1,000 nonfatal injuries per 100,000 population.

The DOH goal is to reduce the number of nonfatal injuries among children due to motor vehicle crashes. In South Dakota, there is a downward trend in reducing nonfatal injuries caused by motor vehicle crashes for children 14 years of age and younger (see Figure 44.).

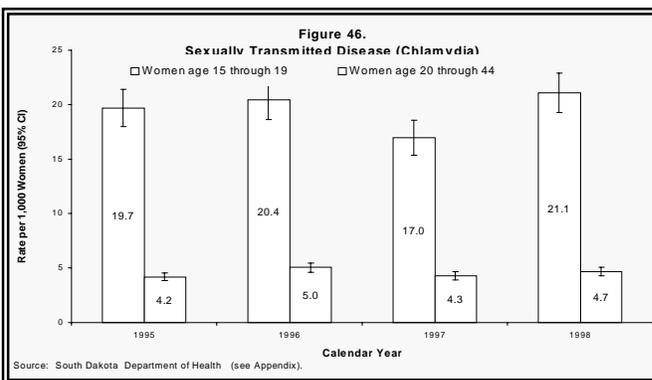


According to South Dakota Department of Transportation accident records, the

number of nonfatal motor vehicle injuries among youth aged 15-24 has also experienced a downward trend over the four-year reporting period (see Figure 45).

DHSI #03. Chlamydia

DHSI #03A. *The rate per 1,000 women aged 15 though 19 years with a reported case of chlamydia.*



DHSI #03B. *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

- HP2010 Objective: Reduce the proportion of females 15 to 24 years and attending family planning clinics with *Chlamydia trachomatis* infections to 3 percent.

Chlamydia infection is the most commonly reported STD in South Dakota.

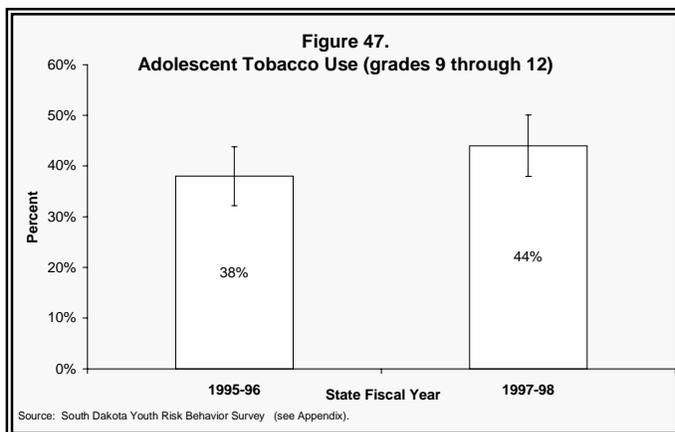
Among South Dakota teenage girls (15 through 19 years old) the average rate of reported chlamydia from 1995 to 1998 was 19.5 cases per 1,000; and the rate among South Dakota women was 4.5 cases per 1,000 women 20 through 44 years old (see Figure 46). Over the four-year reporting period the rate of chlamydia among South Dakota's women has remained stable. In both 1998 and 1999, Native Americans were disproportionately affected with chlamydia with 46 percent of all cases being Native American compared to their 8 percent share of the population.

DHSI #04. The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

- HP2010 Objective: Reduce the proportion of children with dental caries experience either in their primary or permanent teeth to 42 percent.
- HP 2010 Objective: Reduce the proportion of children with untreated dental decay in their primary or permanent teeth to 21 percent.

Dental caries is one of the most common diseases and for children in low-income families dental care is often inadequate. The state goal is to increase dental health services to EPSDT eligible children aged 6-9 years (see Section III.3.1.2.4 for more detail).

DHSI #05. The percent of adolescents in grades 9 through 12 who reported using tobacco products in the past month.



Cigarette smoking is the single most preventable cause of death with an estimated 1 in 5 deaths caused by tobacco use. Our goal is to decrease tobacco use among 9th-12th grade students. In South Dakota High School tobacco use has increased from 38 percent in 1995 to 44 percent in 1997 (see Figure 47) (see Section III.3.1.2.4. for more detail).

DHSI #06. Infants and children aged 0 through 24 years enumerated by sub-population of aged group, race, and ethnicity.

See Developmental Health Status Indicator Form D2 – Demographic Data in Section V.5.6.

DHSI #07. Live births to women (of all ages) enumerated by maternal age, race, and ethnicity.

See Developmental Health Status Indicator Form D2 – Demographic Data in Section V.5.6.

DHSI #08. Deaths of infants and children aged 0 through 24 years enumerated by age subgroup, race, and ethnicity.

See Developmental Health Status Indicator Form D2 – Demographic Data in Section V.5.6.

DHSI #09. Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity.

See Developmental Health Status Indicator Form D2 – Demographic Data in Section V.5.6.

DHSI #10. Geographic living area for all children aged 0 through 19 years.

See Developmental Health Status Indicator Form D2 – Demographic Data in Section V.5.6.

DHSI #11: Percent of the State population at various levels of the federal poverty level.

See Developmental Health Status Indicator Form D2 – Demographic Data in Section V.5.6.

DHSI #12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.

See Developmental Health Status Indicator Form D2 – Demographic Data in Section V.5.6.

3.2.1 Priority Needs

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 eight MCH priority needs:

- Reduce unintended pregnancies.
- Reduce infant mortality.
- Improve pregnancy outcomes.
- Reduce morbidity and mortality among children and adolescents.
- Improve the health of, and services for, CSHCN through comprehensive services and support.
- Improve adolescent health and reduce risk taking behaviors (i.e., intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization).
- Improve state and local surveillance and data collection and evaluation capacity.

- Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CSHCN. The priority setting process is seen as an ongoing and evolving process. Seven main functional areas can be noted when evaluating the proposed strategies – education (client, provider, community), interagency coordination, data issues, direct services, public-private partnerships, information and referral, and quality assurance. Technical assistance from MCHB will be utilized to further review and analyze data. Ongoing collaboration with further evaluation of proposed strategies and activities to address identified needs as well as ongoing data collection and assessment is occurring and will assist in the further development and refinement of the FY 2001 MCH comprehensive needs assessment. Technical assistance will help identify specific strategies for each priority need and to positively impact and improve the health status of the MCH population.

3.3. Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

See forms in Section V.5.4.

3.3.2 Other Requirements

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 the 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. In addition, the entire block grant is being spent out within a 12-month period. This has required a need to recognize other match sources and shifts in the amounts of these match funds.

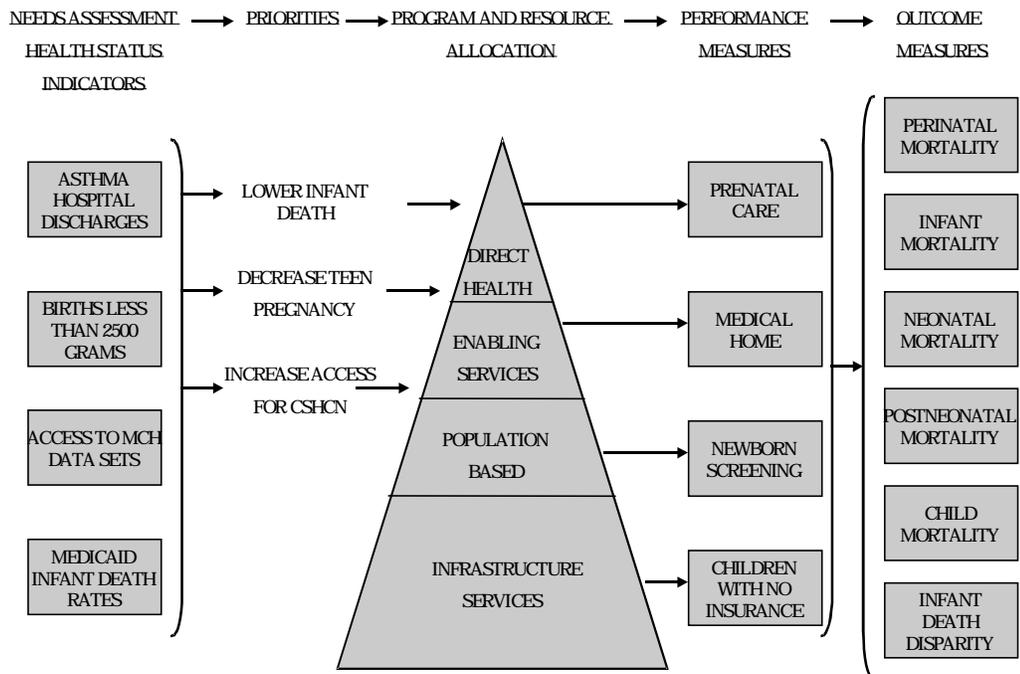
Budget development is subject to rules and requirements set by BFM that dictate both the process and content of the budget, including availability of funds and limitations on authorization levels. State MCH Programs were first required to use the current format of reporting budgets and expenditures, 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. This is a work in progress for the state and the DOH continues to move to accounting programs that will allow for more easily reflect the 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 and providing MCH services and activities. CHNs, dietitians, nutritionists, CSHS nurses, and social workers provide MCH services statewide to assure a local delivery system of 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.
- **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 Bright Start home visits, newborn metabolic screening, newborn hearing screening, genetics, 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, perinatal newsletters, 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.

3.4 Performance Measures

TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM



3.4.1 National "Core" Five Year Performance Measures

3.4.1.1 Five Year Performance Targets

See Form 11 in Section V.5.4.

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

See Form 11 in Section V.5.4.

**FIGURE 48.
PERFORMANCE MEASURES SUMMARY SHEET**

Core Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) 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.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible				X		X	

children who have received a service paid by the Medicaid Program							
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

Negotiated Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) Percent of women on WIC or Baby Care who smoked prior to pregnancy and report that they stopped during pregnancy.	X						X
2) Percent of women on WIC or Baby Care who report not drinking alcohol upon knowledge of pregnancy.	X						X
3) Identify issues and trends that may impact access to health care for CSHCN and their families.		X				X	
4) The rate (per 1,000 births) of children under age 1 who die as a results of Sudden Infant Death Syndrome.			X		X		
5) Percent of pregnancies which are unintended (mistimed or unwanted) and result in a live birth or abortion.			X				X
6) Percent of high school youth who self-report taking a drink in the past 30 days.			X				X
7) Percent of high school youth who self-report tobacco use in the past 30 days.			X				X
8) The rate of deaths to adolescents aged 15-19 caused by motor vehicle crashes per 100,000 adolescents.			X				X
9) Percent of children and adolescents who are overweight or obese.				X		X	
10) Percent of adolescents with disordered eating.				X		X	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
 IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.2 Discussion of State Performance Measures

South Dakota has developed ten performance measures that relate directly to identified priority needs (see Section III.3.2.1.). Detailed information on these performance measures is provided in Section V.5.10.

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. This is necessary to effectively impact the priority needs. Thus, it is difficult to categorize a selected priority need into one level of the service pyramid.

DIRECT HEALTH CARE SERVICES

- **SPM #01: Percent of women on WIC or Baby Care who smoked prior to pregnancy and report they stopped during pregnancy.**

Smoking during pregnancy increases the risk of miscarriage, stillbirth and preterm/low birth weight 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 on WIC or Baby Care 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 as is 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.

ENABLING SERVICES

- **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.

POPULATION-BASED SERVICES

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

From 1995 to 1998, SIDS deaths averaged 18 deaths out of 82 infant deaths per year. From 1995 to 1998, SIDS deaths to Native Americans averaged 4.6 per 1,000 live births compared to the average of White SIDS deaths of 1.3 per 1,000 live births. 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.

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

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.

- **SPM #06: Percent of high school youth who self-report taking a drink in the past 30 days.**

Studies show that certain adolescent risk behaviors are associated in predictable ways and that involvement in one type of risk behavior increases the likelihood of becoming involved in other risk behaviors. DOH staff, in collaboration with DECA and DHS staff, are working with South Dakota schools and communities to address adolescent substance use. The 1999 YRBS indicates that 46% of the respondents reported that they had one or more drinks of alcohol in a row, within a couple of hours on one or more of the past 30 days.

- **SPM #07: Percent of high school youth who self-report tobacco use in the past 30 days.**

Smoking is responsible for one in six adult deaths in the U.S. and is the single most preventable cause of death. The 1999 YRBS indicates that 44 percent of the respondents report smoking one or more cigarettes in the past 30 days. Initiation of smoking usually begins between grades 6 to 9 with minimal initiation after high school. DOH, DECA and DHS are working collaboratively to address adolescent tobacco use.

- **SPM #08: The rate of deaths to adolescents aged 15-19 caused by motor vehicle crashes per 100,000 adolescents.**

Motor vehicle crashes are the leading cause of death among adolescents aged 15-19 in South Dakota. In 1999, the motor vehicle death rate was 51.4 per 100,000 adolescents aged 15-19 – accounting for 42.6% of all deaths to adolescents.

INFRASTRUCTURE BUILDING SERVICES

- **SPM #09: Percent of children who are overweight.**

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.

- **SPM #10: Percent of adolescents with disordered eating.**

Disordered eating covers a spectrum of issues from unhealthy dieting and concern about body image to life-threatening eating disorders that meet DSM IV Diagnostic Criteria. Disordered eating is a growing problem that affects both males and females and crosses socioeconomic and racial/ ethnic lines. The major medical

complications are cardiac arrhythmia, dehydration and electrolyte imbalances, delayed growth and development, endocrinologic disturbances, gastrointestinal problems, osteopenia and osteoporosis, and protein/calorie malnutrition and its consequences. Activities related to this performance measure will reduce morbidity and mortality among children and adolescents, improve adolescent health and reduce risk-taking behavior.

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.

3.4.2.3 Five Year Performance Targets

See forms 11 and 16 in Section V.5.4.

3.4.2.4 Review of State Performance Measures

In the past, the state performance measures were reviewed through the MCHB approval process and were deemed appropriate. The state performance measures respond to the four levels of the pyramid and are related to the outcome measures. As a result of the needs assessment process, state performance measures were revised to more accurately reflect the needs of the state's MCH population. Detail sheets have been

completed for each of the ten state performance measures and the state outcome measure which deals with infant mortality in the Native American population. Objectives and indicator data are provided for the state performance and outcomes measures.

3.4.3 Outcome Measures

See Forms 12 and 16 in Section V.5.4.

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

4.1 Program Activities Related to Performance Measures

DIRECT HEALTH CARE

CPM #01: 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. (Capacity)

Services for CSHCN

- Provide information, referral and linkage to all SSI applicants identified through the SSI transmittal process who have a chronic medical or other disabling condition.
- Continue the joint powers agreements with DHS and SSA to assure that SSI child beneficiaries and potential beneficiaries under the age of 18 are provided appropriate outreach, referral, disability determination, and rehabilitation services. CSHS serves a large number of SSI child beneficiaries through care coordination and outreach clinics. Data collection efforts continue to reflect these activities.
- Collaborate with DHS, SSA, CHIP, and Medicaid to assist in provision of rehabilitation services as child eligibility for SSI and Medicare undergoes revisions.

CPM #02: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. (Capacity)

Services for CSHCN

- Pilot use of telemedicine for clinical consultation in CSHS.
- Conduct outreach pediatric specialty clinics at the four regional CSHS sites. Shortage of certain sub-specialists, increasing demand and caseloads and increasing costs to conduct these clinics are challenges CSHS faces in providing these clinics which are a critical component to access to specialty care that is family-centered and community-based.

- Provide financial assistance on a cost-share basis according to family size and income based on federal poverty guidelines. Implementation of CHIP resulted in only a small increase in Medicaid coverage for some of the children CSHS currently provides financial assistance. Meanwhile, the number of families that participate in the CSHS program at the 100 percent and 75 percent of cost-share levels for financial assistance continues to grow. These families either have no coverage or high deductibles. The cost of ongoing medical treatment is a financial burden to these families.
- Continue to provide coordination of care in a multi-disciplinary manner by trained nurses, social workers and dietitians.
- Make referrals/linkages to Birth to Three, Medicaid, SSI, schools, and other programs/agencies as appropriate.

SPM #01: The percent of women on WIC or Baby Care who smoked prior to pregnancy and report they stopped during pregnancy. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Collaborate with agencies such as March of Dimes, South Dakota Perinatal Association and CHCA to educate professionals and the public about the risks associated with smoking during pregnancy.
- Collaborate with the Bright Start Home Visitation program to educate on risk factors associated with smoking during pregnancy.
- Provide education and referral services to Bright Start Home Visitation clients identified as using tobacco.
- Risk assess pregnant clients and provide case management services through Baby Care or Bright Start. Provide tobacco cessation education and referral services to those clients identified as using tobacco.
- Improve case management services provided through Baby Care and Bright Start by means of policy development/revisions and quality assurance activities.
- Conduct the Perinatal Health Risk Assessment survey of new mothers to collect data regarding smoking and exposure to second-hand smoke during pregnancy.
- Improve data collection regarding risks and pregnancy outcomes through updates of computer systems.

SPM #02: Percent of women on WIC or Baby Care who report not drinking alcohol upon knowledge of pregnancy. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Risk assess pregnant clients and provide case management services through Baby Care and Bright Start. Provide education and referral services to those clients identified using alcohol.

- Collaborate with agencies such as March of Dimes, South Dakota Perinatal Association and CHCA to educate professionals and the public about the risks associated with drinking alcohol during pregnancy.
- Conduct Perinatal Health Risk Assessment survey of new mothers to collect data on the use of alcohol during pregnancy.
- Improve case management services provided through Baby Care or Bright Start by means of policy development/revisions and quality assurance activities.
- Improve data collection regarding risks and pregnancy outcomes through update of computer systems.
- Collaborate with March of Dimes to develop training modules for OCHS staff to address substance use during pregnancy.
- Provide home visits under the Bright Start Home Visitation Program to pregnancy women at risk and provide education and referral services to those clients identified as using alcohol.

ENABLING SERVICES

CPM #03: The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home". (Capacity)

Services for CSHCN

- Assist families identify a primary care physician if the child does not already have one.
- Maintain ongoing working relationships with physicians through networking and outreach activities to facilitate identification and referral of CSHCN.
- Communicate regularly with health care providers and families regarding medical follow-up and treatment of CSHCN.
- Collaborate with USD School of Medicine, Office of Rural Health, CHCA, and the Academies of Pediatrics and Family Practice in the provision of family-centered, community-based care for CSHCN.
- Enhance CSHS capacity to identify all CSHCN in the state. In addition, through networking activities, CSHS staff will continue to provide education about the ongoing primary and preventive health care needs of CSHCN and the role this plays in improving the health status of these children.
- Utilize a multi-disciplinary team of pediatric sub-specialists, nurses, social workers, and dietitians to provide care coordination and follow-up for CSHCN and their families.
- Collaborate with UAP, South Dakota Parent Connection and other parent groups regarding the importance of a medical home for CSHCN and for assistance in the identification and referral of CSHCN.

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

Services for CSHCN

- Collaborate with UAP, Parent Connection and other interested parties on a variety of projects to assist families of CSHCN including, but not limited to, development of a record keeping system for families of CSHCN, development and use of fact sheets about various programs and conditions, and training opportunities for providers and parents.

POPULATION-BASED SERVICES

CPM #04: Percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g., the sickle cell disease)(combined)]. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Screen all infants born in South Dakota for inheritable disease/metabolic disorders as required by law. The newborn screening coordinator will collaborate with health care providers, hospitals and the centralized laboratory to make information available as needed to parents and guardians of newborns regarding the necessity and benefits of newborn screening. Compare submitted laboratory reports with the birth records and follow-up with hospital of birth or physician for infants who do not have testing completed.
- Refer newborn infants identified through the newborn screening program with positive screening results for follow-up testing and any needed medical treatment. The protocols for follow-up on abnormal test results will be reviewed and continue to be implemented.
- Evaluate and enhance, as necessary, data collection methods in order to meet reporting requirements.
- Monitor progress of new screening mechanisms for metabolic disorders and evaluate the appropriateness of adding disorders to the screening program.
- Educate providers regarding metabolic disorders and the Newborn Screening program.
- Provide ongoing evaluation of the South Dakota Newborn Screening program.

Services for CSHCN

- Refer infants diagnosed with a metabolic disorder into the CSHS clinics to be followed by the pediatric endocrinologist, dietitian, social worker, and nursing staff. Protocols for follow-up of diagnosed infants and children will be developed and implemented. Ongoing communications with primary care physicians, program staff and CSHS staff will be maintained.

CPM #05: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Serve on local community immunization workgroups to assess immunization needs and facilitate development of plans to immunize children. There are currently 16 local immunization coalitions across the state.
- Continue state role as a universal vaccine provider. South Dakota is one of a limited number of states that is a universal vaccine provider. ODP distributes federally-funded vaccine free of charge. The OCHS/PHA nurses administer a large amount of the vaccine and coordinate numerous activities to raise public awareness about the importance of immunizations.
- Facilitate distribution of educational information on the importance of immunizations through community workgroups, hospitals, daycare providers, schools, Head Start, Healthy Start, prenatal classes, and others.
- Collaborate with DSS to assess the immunization status of children receiving public assistance through the TANF program and in the general Medicaid population of children under age two.
- Collaborate with the ODP to assure implementation of the DOH varicella initiative. The South Dakota Legislature passed a law effective July 1, 2000 requiring all children entering kindergarten to show either documentation of receipt of varicella vaccine or a reliable history of chickenpox disease prior to school entry.
- Work with the ODP Immunization Program to complete provider-based immunization coverage assessments for each public immunization delivery site. This process will provide an opportunity to assess each community health nursing office for immunization coverage. Data will be used in future planning for local public health offices as well as at the program level.
- Assure access to immunizations for infants and children receiving home visits under the Bright Start Home Visitation Program.

Preventive/Primary Care Services for Children and Adolescents

- See activities for CPM #05 under *Preventive/Primary Care Services for Pregnant Women, Mothers and Infants*.

CPM #06: The rate of birth (per 1,000) for teenagers aged 15 through 17 years. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- 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 home visits through the Bright Start Home Visitation Program to pregnant teens and provide education to assure healthy pregnancy outcomes, access to medical care and referral to other services (i.e., family planning, WIC, CHIP, etc.).
- Continue to support continuation programs funded with Abstinence Education grant dollars and explore new and innovative abstinence projects.
- Provide asset and resiliency information and materials to all abstinence grantees discussing the importance of increasing the protective factors among youth and their relationship to decreasing risk factors among youth.
- Participate on advisory panel for a cooperative agreement between AMCHP and DASH with the main focus on decreasing risk taking behaviors of adolescents.
- Continue to provide technical assistance to address teen pregnancy and its related risk factors upon request.
- Participate as a members of the DECA Comprehensive School Health State Advisory Committee and the Interagency Workgroup. The committee is comprised of individuals representing schools and organizations throughout the state that work with school age children and youth.
- Collaborate and support the development, interpretation and dissemination of the 2001 YRBS with DECA.

CPM #07: Percent of third grade children who have received protective sealants on at least one permanent molar tooth. (Risk Factor)

Preventive/Primary Care Services for Children and Adolescents

- Facilitate discussions and planning with various partners, including SDDA, Delta Dental and Medicaid utilizing data from the South Dakota Oral Health Survey of School Children, data collected for the MCH Block Grant Needs Assessment and data available through SDDA and Delta Dental/Medicaid.
- Continue to provide health education on dental/oral health in school classrooms.
- Facilitate education/training opportunities to update DOH staff and other providers on oral/dental health issues and state of the art treatment.

- Work with SDDA to distribute information to dentists and dental hygienists on oral health-related performance measures, HP 2010 objectives and collection of data to measure progress towards those objectives.

CPM #08: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children. (Risk Factor)

Preventive/Primary Care Services for Children and Adolescents

- Coordinate with the Office of Highway Safety to support special needs child passenger seats in South Dakota and information on where to obtain child passenger seats in specific areas of the state.
- Coordinate with regional CSHS offices to distribute special needs car seats to children whose medical conditions require special seating for safety purposes.
- Collaborate with the Office of Highway Safety to secure passage of a primary seat belt law for children under the age of 18 years old.
- Collaborate with the Office of Highway Safety to educate the public on the importance of using booster seats (instead of the regular seatbelt system) for children aged 4-8 years old.
- Continue to discuss child passenger safety information with parents during well child assessments, home visits, prenatal classes, and health education classes provided by OCHS staff.
- Educate parents in the Bright Start Home Visitation Program of the importance and proper usage of child passenger safety seats.
- Meet quarterly with an in-house workgroup, Office of Highway Safety, EMSC, IHS, and law enforcement to collaborate on injury prevention activities and available data in the state.
- See activities for SPM #8 under *Preventive and Primary Care Services for Children and Adolescents*.

CPM #09: Percentage of mothers who breastfeed their infants at hospital discharge. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Continue representation on the South Dakota Breastfeeding Coalition. The goal of the coalition is to provide a networking system for breastfeeding education and promotion and direction for promoting breastfeeding in South Dakota.
- Educate mothers in the Bright Start Home Visitation Program on the benefits of breastfeeding.
- Provide information to health professionals, hospitals, worksites, and the public to promote breastfeeding.

- Compile list of breastfeeding classes available in South Dakota for use by DOH staff. Schedule of classes will also be made available on the DOH web site.
- Collaborate with WIC for breastfeeding promotion to develop, purchase and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.
- Collaborate with the WIC Program for the purchase and distribution of electric breast pumps for loan, manual breast pumps, breast shells, and other breastfeeding aids.
- Utilize newborn screening lab slip to collect data of breastfeeding. Questions have been added to the lab slip to gather necessary data for reporting requirements and program planning.
- Analyze data from newborn screening forms regarding breastfeeding initiation rates per hospital of birth.

CPM #10: Percentage of newborns who have been screened for hearing impairment before hospital discharge. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Develop state infrastructure necessary to provide technical assistance and program support to physicians, hospitals, parents, and others to facilitate newborn infant hearing screening according to the workplan for the South Dakota Newborn Hearing Screening grant application.
- Provide technical assistance to facilities not currently providing hearing screening.
- Develop recommended screening protocols and guidelines for newborn hearing screening for use in South Dakota hospitals.
- Develop reporting mechanisms to collect newborn hearing screening data.
- Develop procedure for linking newborn screening program with the infant's medical home, family support and early intervention (Part C).
- Develop and implement plan for professional and parent/public education regarding newborn hearing screening, diagnosis and early intervention.
- Collect, analyze and report on the status of newborn hearing screening and the extent to which the program is linked to the infant's medical home, family support and early intervention.

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

Preventive/Primary Care Services for Children and Adolescents

- Promote the *Back to Sleep* Campaign to educate others on how to reduce SIDS deaths in the state and the importance of laying babies on their back to sleep.

- Collaborate with the Governor's Bright Start Program to include SIDS and *Back to Sleep* materials in the welcome box for parents with newborn babies in the state.
- Collaborate with Bright Start nurses in Sioux Falls and Rapid City, 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.
- Include questions on the Perinatal Health Risk Assessment survey regarding *Back to Sleep* information.
- Collaborate with Infant Loss Center to develop a plan 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 the DOH Data, Statistics and Vital Records unit to map out location and race of SIDS deaths in the state.

SPM #05: Percent of pregnancies which are unintended (mistimed or unwanted) and result in live births or abortions. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Collaborate with Title X Family Planning program to provide family planning services to populations at high risk for unintended pregnancy.
- Provide community education to adults regarding reproductive health and family planning topics.
- Include questions related to intendedness of pregnancy on the Perinatal Health Risk Assessment survey.
- Provide counseling, education, medical, and contraceptive services to women at risk of unintended pregnancy (low income and adolescents). These women are seen at WIC clinics, Baby Care, schools, health fairs, postpartum visits, family planning offices, etc.
- Provide outreach educational activities to schools and community groups.
- Collaborate on abstinence-only grant activities.
- Provide education to professionals working with target populations regarding the issue of unintended pregnancy and programs that work to reduce unintended pregnancy.
- Collaborate with Title X family planning *Don't Kid Yourself* campaign targeting 18-24 year old women and men to change behaviors to reduce unintended pregnancy.
- Collaborate with Medicaid and managed care organizations to assure contraceptive coverage.

- Distribute information to health professionals and interested partners obtained through the Perinatal Health Risk Assessment Survey regarding the intendedness of pregnancy in South Dakota.

SPM #06: Percent of high school youth who self-report taking a drink in the past 30 days. (Risk Factor)

Preventive/Primary Care Services for Children and Adolescents

- Provide interpretation of current YRBS data, drawing correlations between the various risk factors and adolescent mortality and morbidity.
- Continue to develop analysis of the asset and resiliency questions in the 1999 YRBS and their relationship to the risk factor results of that survey. It is believed that as assets increase in youth, there will be a proportional decrease in associated risk factors.
- Participate as a members of the DECA Comprehensive School Health State Advisory Committee and the Interagency Workgroup. The committee is comprised of individuals representing schools and organizations throughout the state that work with school age children and youth.
- Participate on the Injury Prevention Workgroup consisting of representatives from DOH, DECA, Highway Patrol, EMS, EMSC and the Office of Highway Safety to identify issues related to youth alcohol use and injury prevention.
- Coordinate with DHS to identify issues, trends and barriers affecting adolescent alcohol use. Assist DHS with the review of approximately 150 Safe and Drug Free School applications.
- Participate as a member of DHS Division of Alcohol and Drug Abuse Advisory Council.
- Provide technical assistance to Public Health Alliance Community Health Councils as well as other communities to address health issues related to children and adolescents such as suicide, teen pregnancy, eating disorders, and substance abuse.
- Provide funding for comprehensive school health education curriculum and teacher training through a MOA with DECA. The comprehensive school health curriculum is intended for a planned, sequential curricula designed to motivate and assist students maintain and improve their health, prevent disease and reduce health-related risk behaviors.
- Collaborate and support the development, interpretation and dissemination of the 2001 YRBS with DECA.

SPM #07: Percent of high school youth who self-report tobacco use in the past 30 days. (Risk Factor)

Preventive/Primary Care Services for Children and Adolescents

- Provide interpretation of current YRBS data, drawing correlations between the various risk factors and adolescent mortality and morbidity.
- Continue participation on DHS South Dakota Tobacco Education Project (formally the IMPACT Coalition).
- Coordinate with DHS to identify issues, trends and barriers affecting adolescent tobacco use. Assist DHS with the review of approximately 150 Safe and Drug Free School applications.
- Participate as a members of the DECA Comprehensive School Health State Advisory Committee and the Interagency Workgroup. The committee is comprised of individuals representing schools and organizations throughout the state that work with school age children and youth.
- Provide materials, information and linkages on youth tobacco use (i.e., *Kick Butts Day* materials and information on the DHS Regional Tobacco Coordinators) to OCHS/PHA field offices.
- Provide technical assistance to Public Health Alliance Community Health Councils as well as other communities to address health issues related to children and adolescents such as suicide, teen pregnancy, eating disorders, and substance abuse.
- Provide funding for comprehensive school health education curriculum and teacher training through a MOA with DECA. The comprehensive school health curriculum is intended for a planned, sequential curricula designed to motivate and assist students maintain and improve their health, prevent disease and reduce health-related risk behaviors.
- Collaborate with partners on Tar Wars program for fifth grade classrooms statewide.
- Collaborate and support the development, interpretation and dissemination of the 2001 YRBS with DECA.

SPM #08: The rate of deaths to adolescents aged 15-19 caused by motor vehicle crashes per 100,000 adolescents. (Risk Factor)

Preventive/Primary Care Services for Children and Adolescents

- Explore possibility of developing a state plan to address unintentional and intentional injury prevention.
- Participate on the Injury Prevention Workgroup consisting of representatives from DOH, DECA, Highway Patrol, EMS, EMSC and the Office of Highway Safety to identify issues related to youth alcohol use and injury prevention.

- Provide interpretation of current YRBS data, drawing correlations between the various risk factors and adolescent mortality and morbidity.
- Explore possible funding sources outside of the DOH to develop and enhance injury prevention activities.

INFRASTRUCTURE BUILDING

CPM #11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care. (Capacity)

Services for CSHCN

- Assist in the identification and referral of CSHCN and their families to Medicaid, CHIP and SSI and with completion of application as needed.
- Maintain ongoing communication with the major insurance carriers in the state, initiate provider agreements as appropriate and facilitate understanding of the needs of CSHCN.

CPM #12: Percent of children without health insurance. (Capacity)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- See activities for CPM #12 under *Preventive/Primary Care Services for Children and Adolescents*.

Preventive/Primary Care Services for Children and Adolescents

- Collaborate with DSS to assure that information regarding the expansion of the M-CHIP is distributed to DOH staff and communities. Effective July 1, 2000, DSS will expand the M-CHIP to cover uninsured children through age 18.
- Continue quarterly meetings with Medicaid/CHIP to facilitate and coordinate outreach efforts.
- Maintain interagency agreement with DSS to establish and assure referral mechanisms between agencies. The intent of the agreement is to maximize utilization of services and assure that the services provided under Title XIX are consistent with the needs of the recipients. The agreement also assures that the two programs' objectives and requirements are being fulfilled. Included in the agreement is outreach. Ongoing activities of field staff in both OCHS and OPHA include referral to Medicaid. Pursue ongoing discussion with Medicaid to assure appropriate training for field staff in assisting with implementation of CHIP and the new CHIP-NM.
- Work with DSS/CHIP outreach workers to enhance identification of potential eligibles.

- Provide CHIP applications in OCHS/PHA field offices and assist in completion of forms as appropriate.

CPM #13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. (Process)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- See activities for CPM #13 under *Preventive/Primary Care Services for Children and Adolescents*.

Preventive/Primary Care Services for Children and Adolescents

- Collaborate with local DSS staff on outreach efforts for CHIP including the simplified mail-in application for medical coverage of both children and pregnant women. OCHS/PHA offices serve as sites for families to access application packets.
- Maintain interagency agreement with DSS to assure that Title XIX and Title V services are consistent with the needs of recipients and that the objectives and requirements of the programs are met.
- Provide ongoing education to families regarding primary and preventive care for their children and assure that children seen in public health agencies have a medical home.

CPM #14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program. (Process)

Services for CSHCN

- Solicit family member participation in workgroups addressing program activities. Mentoring and training will be provided as needed and/or requested. Travel costs will be reimbursed.
- Provide financial support (including technical assistance, reimbursement for travel and child care costs) for CSHS-sponsored parent activities, focus groups or other parent groups.
- Solicit input from family members informally throughout the year at clinics, during home visits and at local network and other outreach meetings regarding the needs and issues of families of CSHCN.
- Identify family members to utilize for staff inservice training on provision of family-centered care, care coordination, home visiting, cultural responsiveness, etc.
- Collaborate with South Dakota Parent Connection, UAP and the DHS Family Support Project regarding family involvement and input activities including training, record keeping and a mentor family directory.

- Collaborate with South Dakota Parent Connection to:
 - identify and recruit parents of children with chronic medical conditions and disabling illnesses who would be available to provide peer support and consultation for families receiving services through CSHS;
 - provide a family perspective to CSHS staff regarding program, policies and procedures at the state, regional and community levels;
 - enhance the statewide network of peer support and information to parents of CSHCN by: (1) maintaining a statewide database of support parents, groups and programs within the state and providing this information to parents as requested; (2) providing parent-to-parent training in each of the four CSHS regions to build the skills of supporting or mentor parents; (3) linking parents throughout the state with trained supporting parents in their region/community;
 - provide ongoing training opportunities for CSHS staff and other health care professionals with the goal of enhancing their knowledge and understanding of family-centered concepts and increase their ability to effectively implement family-centered care;
 - assist CSHS in increasing awareness of the program and its functions;
 - participate in ongoing linkages between web sites for the DOH and Parent Connection; and
 - assist CSHS develop and maintain mechanisms for early identification of CSHCN.

CPM #15: Percent of very low birth weight live births. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Collaborate with physician and hospital groups to identify issues surrounding delivery of very low birth weight infants.
- Assess all pregnant women seen at OCHS/PHA sites for risks affecting pregnancy outcomes and provide ongoing patient education to clients on signs of preterm labor.
- Collaborate with the Bright Start Home Visitation Program to educate pregnant women enrolled in the program of signs of preterm labor.

CPM #16: The rate (per 100,000) of suicide deaths among youths aged 15-19. (Risk Factor)

Preventive/Primary Care Services for Children and Adolescents

- Update and revise the suicide prevention resources available on the DOH web site as needed.
- Collaborate with DECA to mail Suicide Prevention Packets as requested.

- Work with CDC to provide analysis and interpretation of state specific suicide data. This technical assistance will include a planning site visit from CDC.
- Explore possibility of developing a state plan to address injury prevention including youth suicide.
- Attend meetings of Aberdeen Area IHS Suicide Workgroup and provide technical assistance as requested.
- Provide educational sessions at a variety of conferences/workshops across the state.
- Provide technical assistance to Public Health Alliance Community Health Councils as well as other communities to address health issues related to children and adolescents such as suicide, teen pregnancy, eating disorders, and substance abuse.
- Participate as a members of the DECA Comprehensive School Health State Advisory Committee and the Interagency Workgroup. The committee is comprised of individuals representing schools and organizations throughout the state that work with school age children and youth.
- Provide interpretation of current YRBS data, drawing correlations between the various risk factors and adolescent mortality and morbidity.

CPM #17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

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

CPM #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. (Risk Factor)

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- 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 Home Visitation Program to facilitate access to early and regular prenatal care for pregnant women enrolled in the program.
- Include questions on the Perinatal Health Risk Assessment survey regarding month prenatal care began.

- Compare data collected from the Perinatal Health Risk Assessment with data collected on birth certificates.
- Distribute information obtained from the Perinatal Health Risk Assessment regarding access to prenatal care to health professionals and interested partners.

SPM #09: Percent of children who are overweight. (Process)

Preventive/Primary Care Services for Children and Adolescents

- 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 educational information and materials to DOH staff for use with parents and schools on how to increase physical activity for all ages of children.
- Promote the use of new CDC growth charts among health professionals and assist with interpretation.
- Collaborate with IHS to address overweight issues of Native American children.
- Collaborate with DECA, Head Start, WIC, day cares, and after-school programs to address overweight children.
- Facilitate appropriate referral of very obese children to medical providers for treatment.
- Work with the Bright Start Home Visitation Program to educate parents enrolled in the program on the importance of good nutrition and physical activity for their children.

SPM #10: Percent of adolescents with disordered eating. (Process)

Preventive/Primary Care Services for Children and Adolescents

- Collaborate with DECA and others to address potential disordered eating while addressing overweight and obesity issues.
- Promote healthy eating and appropriate physical activity habits to students, parents, teachers, coaches, and others.
- Work with IHS regarding binge eating by Native American youth and appropriate interventions.
- Promote use of new CDC growth charts among health professionals and assist with interpretation.

4.2 Other Program Activities

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants

- Promote *Back to Sleep* campaign with DOH staff, registered and licensed day cares, Head Starts, and other entities in the state as appropriate.

- Collaborate with March of Dimes and other partners to promote the role of folic acid in the prevention of neural tube birth defects.
- Collaborate with USD School of Medicine regarding the state genetics program to provide genetic and teratogen risk education and counseling to health care providers, consumers and other interested groups.
- Facilitate involvement of DOH staff and the state genetics coordinator on issues related to MCH activities.
- Promote activities to increase the use of the teratogen hotline.
- Collaborate with other state agencies and the USD State Data Center in the development of the South Dakota KIDS COUNT resource. Indicators include low birth weight, infant mortality, child death, teen violent deaths, births to single teens, school drop-outs, poverty, and single parent families.
- Collaborate with the Infant Loss Center to provide education programs and support for families and professionals.
- Participate in numerous outreach and public education activities throughout the year. These include presentations at interagency meetings, inservices to staff from other agencies, the private sector, health fairs, and networking activities with other health care and related providers.
- Facilitate ongoing training opportunities for DOH staff and other health care providers via RDTN, satellite downlinks conferences, etc.

Preventive/Primary Care Services for Children and Adolescents

- Collaborate with DECA to promote injury prevention information at the Coordinated School Health Interagency Workgroup, State Advisory Group and with the Color Me Healthy calendar.
- Coordinate *DTYM* program and provide materials to promote bicycle and helmet safety.
- Coordinate with EMS, EMSC, IHS, and the Office of Highway Safety to centralize injury prevention activities and develop a statewide plan to address injury.
- Provide injury prevention data and information through displays, speaking events, DOH web sites, etc.
- Serve as the state contact to distribute CPSC safety information and alerts to OCHS/PHA offices, nutritionist, family planning offices, CSHS offices, and DSS Office of Child Care Services.
- Provide technical assistance to DOH staff, communities and schools relating to child health injury prevention information.
- Promote Poison Control Week, Child Passenger Safety, Recall Round Up, and other special events and information with DOH staff.

- Collaborate with communities to reduce falls on play equipment by sharing CPSC final guidelines for playground safety to assist communities in making their playgrounds safer.
- Collaborate with Sioux Valley Health Systems to assure ongoing access to the poison control number and center for South Dakota families.
- Collaborate with DSS Office of Child Care Services to implement the Healthy Child Care Grant for South Dakota.
- See Other Program Activities under *Preventive/Primary Care Services for Pregnant Women, Mothers and Infants*.

Services for CSHCN

- Provide financial support for the state Respite Care Program for the provision of respite care services for families who have children with chronic, complex medical conditions. CSHS staff will assist with referrals to respite care for those children served through CSHS. The CSHS director continues to represent the DOH as a member of the advisory group for respite care services in the state.
- Continue representation on the South Dakota Interagency Coordinating Council for Birth to Three. Early intervention concerns are addressed and collaborative activities are enhanced through the ongoing efforts of this council.
- Participate in identification and Child Find activities which are coordinated at the local level through school districts and SPoCs. OCHS/PHA staff participate in Child Find activities through the use of R-PDQ, screening activities and by making appropriate referrals.
- Improve collaboration of care for CSHCN through linkages with other agencies, programs and providers. Activities include staff inservices, updating appropriate interagency agreements, networking and outreach encounters, and multidisciplinary training opportunities.
- Participate in numerous outreach and public education activities throughout the year. These include presentations at interagency meetings, inservices to staff from other agencies, the private sector, health fairs, and networking activities with other health care and related professionals.
- Represent DOH and advocate for the needs of CSHCN on various advisory groups and committees.
- Continue activities to enhance CSHS capacity for data collection and analysis.
- Enhance identification and referral processes and improve systems of care for CSHCN through linkages with other state agencies and programs, physicians and other providers in the private sector. Needs assessment, planning, evaluation, standards of care, and policy development are ongoing.

- Conduct DOH staff training needs assessment and utilize results in planning for the department's annual public health conference.
- Facilitate ongoing training opportunities for DOH staff and other health care providers via RDTN and satellite downlinks.

4.3 Public Input

State performance measures were developed based on the state's comprehensive needs assessment. The DOH made the FY 2001 MCH block grant available for public review and comment by providing copies to various health care professionals, health-related agencies and organizations and consumers with a particular interest in MCH issues (see Section V.5.3. for a complete mailing list). Drafts were distributed on June 23, 2000 with a request for comments to be submitted to the DOH by July 7, 2000. Comments and recommendations were incorporated into the final draft of the application. All comments and recommendations are on file at the DOH and available upon request.

4.4 Technical Assistance

The South Dakota Title V program is committed to assuring that all MCH populations in the state receive the highest quality care and have optimal health. The state Title V program is requesting technical assistance for the following:

- Data Systems Integration – Link birth and death records to Medicaid and newborn screening.
- Systems Review Planning – Develop indicators for reporting progress in infrastructure and systems development.
- Oral Health Needs Assessment – Collaborate with CDC to conduct new survey to gather additional data for analysis and comparison with 1996 Oral Health Needs Assessment data.
- Health Care Reform Wrap-Around Services – Collaborate with DSS CHIP-NM program to enhance outreach efforts.
- Suicide Prevention – Collaborate with CDC and Children's Safety Network to further assess suicide data and provide technical assistance to state program staff and communities.

V. SUPPORTING DOCUMENTS

5.1 Glossary

Adequate prenatal care – Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds – The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment – (see “Needs Assessment”)

Capacity – Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives – Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) – Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)]*

Carryover (as used in Forms 2 and 3) – The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services – For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4))*

Children – A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) – (For budgetary purposes) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) – Constructs of a Service System

1. *State Program Collaboration with Other State Agencies and Private Organizations.* States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.
2. *State Support for Communities.* State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical

assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. *Coordination of Health Components of Community-Based Systems.* A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.
4. *Coordination of Health Services with Other Services at the Community Level.* A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals – Authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community – A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-Based Care – Services provided within the context of a defined community.

Community-Based Service System – An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination – (see Care Coordination Services)

Culturally Sensitive – The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent – The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries – Women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services – Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and

pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services – Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – A program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-Centered Care – A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) – (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) – The monies provided to the States under the Federal Title V Block Grant in any given year.

Frontier County – Counties with a population density at or below six persons per square mile.

Government Performance and Results Act (GPRA) – Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System – The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants – Children under one year of age not included in any other class of individuals.

Infrastructure Building Services – The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development,

monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions – As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index – An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) – Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income – An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services – (see “Types of Services”)

Measures – (see “Performance Measures”)

Needs Assessment – A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining: 1) what is essential in terms of the provision of health services; 2) what is available; and, 3) what is missing

Objectives – The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) – Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) – Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives – Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure – The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator – The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure – A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement – The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives – A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services – Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS (Pregnancy Risk Assessment Monitoring System) – A surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services – Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care – The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual’s or family’s health care services.

Process – Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, “Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?”

Process Objectives – The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) – Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Resident Pregnancies – Total resident births, fetal deaths and abortions.

Risk Factor Objectives – Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors – Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

Rural County – Counties with a population density of over six persons per square mile but no population centers of 50,000 or more.

South Dakota Children's Health Insurance Program (CHIP) – Program to expand the state Medicaid program to cover uninsured children through age 18 whose family incomes are at or below 200% of the FPL.

SDIIS (South Dakota Immunization Information System) – This system is a computerized network of private and public health care providers that allows the DOH to document and monitor individual immunization events for children in the state.

SDSU – South Dakota State University.

State – As used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) – The State's required matching funds (including overmatch) in any given year.

Systems Development – Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) – The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to – The unduplicated count of infants who were eligible for the State’s Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to – The number of pregnant women who delivered during the reporting period who were eligible for the State’s Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under – Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under – The unduplicated count of infants provided a direct service by the State’s Title V program during the reporting period.

Total MCH Funding – All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant’s* funds (carryover from the previous year’s MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO’s, etc.).

Types of Services – The major kinds or levels of health care services covered under Title V activities. See individual definitions under “Infrastructure Building”, “Population Based Services”, “Enabling Services” and “Direct Medical Services”.

UAP – University Affiliated Physicians

USD – University of South Dakota

Urban County – Counties having a population center of 50,000 or more.

Women of Childbearing Age – Females aged 15-44.

YRBS (Youth Risk Behavior Survey) – A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or

other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and

contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

- 5.3 Other Supporting Documents**
- 5.4 Core Health Status Indicator Forms**
- 5.5 Core Health Status Indicator Detail Sheets**
- 5.6 Developmental Health Status Indicator Forms**
- 5.7 Developmental Health Status Indicator Detail Sheets**
- 5.8 All Other Forms**
- 5.9 National "Core" Performance Measure Detail Sheets**
- 5.10 State "Negotiated" Performance Measure Detail Sheets**
- 5.11 Outcome Measure Detail Sheets**