Our Mission:
To achieve improved pregnancy outcomes, improved infant/toddler growth and development, and self-sufficient healthy families.
Bright start... big difference.

Bright Start Home Visiting is a program of the Office of Child and Family Services in the Department of Health. Registered nurses meet with at-risk families during pregnancy and until their child turns two or three years old. Bright Start uses the evidence-based Nurse Family Partnership curriculum, and specially trained nurses provide:

- Prenatal, maternal, infant and toddler health assessments
- Health and safety education
- Parent support
- Assistance in setting and reaching life goals
- Developmental screening
- Links with community resources

Department of Health Goal 1

IMPROVE THE QUALITY, ACCESSIBILITY, AND EFFECTIVE USE OF HEALTH CARE

HOME VISITING GOAL 1: Improve pregnancy related outcomes for first-time pregnant women served by the program in identified at-risk communities.

OBJECTIVE 2: Ensure that 100% of pregnant women have been referred to prenatal care or have completed a prenatal visit by 28 weeks gestation by September 30, 2017

Rationale: Early and regular prenatal care is an important part of improving pregnancy and health outcomes for the mother and baby. Regular prenatal care helps the health care provider monitor the pregnancy and identify and manage any potential health problems before they become too serious. Babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die than those whose mothers received prenatal care.

Key Strategies

1. Nurses will assess all pregnant women for their use of prenatal care at the first home visit and at each subsequent pregnancy visit
2. Each local agency will maintain a list of local prenatal care providers to refer clients to if they have not yet completed a visit
3. Nurses will be familiar with alternative methods of prenatal care delivery within their service areas, such as Centering Pregnancy classes and telehealth options
4. Nurses will explore barriers to accessing care and/or completing visits with clients and refer as needed to patient navigators, Medicaid, Community Health Clinics, transportation, mental health resources, domestic violence support, and others
HOME VISITING GOAL 1: Improve pregnancy related outcomes for first-time pregnant women served by the program in identified at-risk communities.

OBJECTIVE 1: Reduce the number of women who smoke during pregnancy by a 20% or greater reduction in the percentage of women smoking from intake to 36 weeks pregnancy by September 30, 2017.

Rationale: Prenatal use of tobacco has been associated with various adverse birth outcomes such as low birth weight, preterm delivery and spontaneous abortion. Home Visiting with pregnant women by nurses trained in goal setting, motivational interviewing, resource referral and the health effects of smoking during pregnancy is a prime strategy to address this objective.

Key Strategies

1. Each participant’s tobacco use will be assessed at the program’s recommended time points at minimum, and more frequently if needed
2. Nurses will complete a referral to QuitLine services for all women who state they are tobacco users
3. Annual training for all Bright Start team members from the DOH Tobacco Prevention and Control Coordinator and QuitLine Coordinator on program updates, referral system, motivational interviewing, and goal setting
4. Access technical assistance from the Nurse Family Partnership National Service Office via the nurse consultant to address specific site needs
5. Implement service delivery strategies suggested by Continuous Quality Improvement work and the DOH Tobacco Control workgroup as appropriate to home visiting services
OBJECTIVE 3: Reduce the percentage of low birth weight (LBW) babies born into the program to 7.8% or less of all births by September 30, 2017

Rationale: Birth weight is used as an indicator of infant health, with the occurrence of infant death and disability highly correlated with low birth weight.

Key Strategies

1. Home Visiting nurses will assess all pregnant women for the following risk factors at each prenatal visit: weight gain or loss, signs of preterm labor, nutritional intake, stress level, and other risk factors for delivering a low birth weight baby
2. Home Visitors will receive technical assistance from Maternal Child Health program staff and federal technical assistance providers on signs/symptoms of preterm labor and other complications of pregnancy
3. Home visitors will facilitate early referrals to primary care providers for women identified as at-risk for delivering a low birth weight baby
4. During monthly technical assistance calls with the Nurse Family Partnership nurse consultant, each site coordinator will address the team’s rate of low birth weight infants on the site’s Operational Efficiency Dashboard to discuss progress toward meeting the stated objective

HOME VISITING GOAL 2: Improve the health and development of infants and children enrolled in the program in identified at-risk communities.

OBJECTIVE 1: Provide safe sleep education to 100% of women enrolled in the program through the end of their pregnancies using the State’s safe sleep education plan by September 30, 2017

Rationale: South Dakota infants have a high post neonatal death rate and reducing infant mortality is an area of focus for the Department of Health. One of the leading causes of preventable infant deaths is an unsafe sleep environment.

Key Strategies

1. Home Visitors will complete OCFS standard training in the Cribs for Kids screening, education, and crib distribution program
2. Families identified with no resources for a safe sleep environment for their infant receive a Pack’n Play
3. Home Visitors will be part of their OCFS region-specific Infant Mortality education plans in partnership with other service-delivery programs
4. The program will provide access to culturally specific education materials and staff training in tribal service delivery areas
5. Implement service delivery strategies that show promising outcomes by Continuous Quality Improvement work as appropriate to home visiting services
OBJECTIVE 3: Increase the percentage of women who initiate breastfeeding to 81.9% and the percentage who continue to breastfeed at six months to 60.6% by September 30, 2017

Rationale: Breast milk is considered the ideal form of infant nutrition, with the practice of breastfeeding demonstrating wide-ranging benefits for infants’ general health, immune systems and development.

Key Strategies

1. Coordination with WIC services, including Peer Counselors where available, encouraging mothers who work or return to school to access breast pumps through WIC or through their insurance
2. Home Visitors will participate in OCFS annual breastfeeding training update
3. Home Visitors will address strategies to continue breastfeeding with mothers who encounter issues that may lead them to consider quitting
4. Implement service delivery strategies that show promising outcomes by Continuous Quality Improvement projects as appropriate to home visiting services

OBJECTIVE 4: Increase the percentage of parents completing the Ages and Stages Questionnaire measuring children’s learning and development at 18 months to 68.4% or greater by September 30, 2017

Rationale: The Ages and Stages Questionnaire (ASQ) is a developmental screening tool that is administered at several time points in the Home Visiting program. Scores on these assessments will provide the Nurse Home Visitor with a framework for monitoring or referring the child for further evaluation of developmental concerns.

Key Strategies

1. Nurse Home Visitors will complete ASQ screening tools with all children enrolled in home visiting at the minimum of the time periods required by NFP
2. The Home Visiting ASQ team lead is responsible for training new home visiting staff on administering the tool
3. Each team will maintain a list of resource referral partners for children identified as needing further follow up for developmental concerns
Department of Health Goal 3

PREPARE FOR, RESPOND TO, AND PREVENT PUBLIC HEALTH THREATS

HOME VISITING GOAL 2: Improve the health and development of infants and children enrolled in the program in identified at-risk communities.

OBJECTIVE 3: Ensure that the completion rate for recommended immunizations exceeds 90% for 2-year olds who have been served by the program by September 30, 2017

Rationale: Up-to-date immunization of children is a significant preventive health measure, which reduces the number of infections from vaccine-preventable diseases.

Key Strategies
1. Home Visitors will assess each child's vaccination status at 6, 12, 18 and 24 months of age
2. Using parent education, goal setting and motivational interviewing, Nurse Home Visitors will address issues that prevent families from vaccinating their children
3. Sites will maintain a list of referral resources, including health care providers, OCFS vaccine clinics, mobile clinics, transportation, Medicaid and ACA patient navigators

Department of Health Goal 4

DEVELOP AND STRENGTHEN STRATEGIC PARTNERSHIPS TO IMPROVE PUBLIC HEALTH

HOME VISITING GOAL 3: Improve early childhood comprehensive system development

OBJECTIVE 1: For clients with an identified need at intake, maintain that 100% of those clients are referred for services within six months by September 30, 2017.

Rationale: Nurses delivering home visiting services in the state are able to meet some - but not all - of the needs of families enrolled in the program. Effective program implementation is dependent on a system of resources that is specific to each community.
**Key Strategies**

1. Maintain and track Memorandums of Understanding (MOU's) with community partners to ensure understanding of services available and referral processes.

2. Nurses will record referrals made and client follow up at each home visit, and teams will review data system reports for trends in referrals and reasons clients may not follow through with a referral.

3. Program managers will work with each site to identify gaps in resources in each community and assist in looking for alternative resources. Identified service gaps will be shared with state-level partners.

4. Teams will maintain a list of resources available in the community and update it annually. If available, teams will provide clients with community-developed resource listings (such as the 211 Helpline or local community guides).

**OBJECTIVE 2:** Each Home Visiting service area will have an established local Community Advisory Board by September 30, 2017

*Rationale:* A Community Advisory Board is a group of committed individuals and organizations, whose expertise can advise, support and sustain the program over time.

**Key Strategies**

1. In service areas without a current advisory board in place, utilize existing partnerships with local service providers and existing programs that focus on serving low-income families and children to establish a Community Advisory Board.

2. Continue a minimum of quarterly attendance by the local Home Visitors and/or Site Coordinators at Community Advisory Board meetings.

**OBJECTIVE 3:** The state-level Child and Family Services Interagency Workgroup will add members from three additional agencies in its transition from the State Home Visiting Advisory Board.

*Rationale:* There is support from OCFS leadership, as well as interest from the former State Home Visiting Advisory Board, in building connections among a wider scope of state-level agencies and services that work to support high-risk families and young children.

**Key Strategies**

1. Identify a health care provider who will commit to participation in the Workgroup.

2. Identify a representative from a state-level position in a child injury prevention program who will commit to participation in the Workgroup.

3. Identify a representative from a state-level position in the DSS Office of Child Protection who will commit to participation in the Workgroup.
Department of Health Goal 5

MAXIMIZE THE EFFECTIVENESS AND STRENGTHEN INFRASTRUCTURE OF THE DEPARTMENT OF HEALTH

The Bright Start Home Visiting Program is committed to providing high-quality services, with specially trained nurses who implement the evidence based program with fidelity to the model. All home visiting nurses and site coordinators complete specialized training provided by the Nurse Family Partnership National Service Office and receive ongoing opportunities for training and technical assistance.

The Bright Start Home Visiting Program is also committed to improving program quality by using Continuous Quality Improvement. The implementation of a CQI process as a standard part of South Dakota's Home Visiting program provides a structure for attaining fidelity and positive outcomes.

Guiding Principles

**DOH Vision**

* Healthy People
* Healthy Communities
* Healthy South Dakota

**Office of Child and Family Service**

 Serve with integrity and respect
 Eliminate health disparities
 Demonstrate leadership and accountability
 Focus on prevention and outcomes
 Leverage partnerships
 Promote innovation

**Bright Start services are available in the following areas:**

* Pennington County
* Butte and Lawrence Counties
* Pine Ridge Reservation
* Lyman, Stanley & Hughes County
* Beadle County
* Roberts, Marshall & Day Counties
* Sioux Falls Metro Area

for baby’s sake

Healthier moms + Healthier babies