SOUTH DAKOTA
FY 2025 MATERNAL AND CHILD HEALTH BLOCK GRANT
SUMMARY

The South Dakota Department of Health (DOH) is seeking public input as it prepares its FY 2025 Maternal and Child Health (MCH) Block Grant submission to the U.S. Department of Health and Human Services' Maternal and Child Health Bureau (MCHB). This application is required for continuation of federal funds for the state's Title V program which serves mothers, pregnant women, infants, children, adolescents, and children with special health care needs. The following information provides a summary of the South Dakota MCH Block Grant annual plan including activities to address priority needs and performance measures.

The DOH receives approximately $2.2 million dollars annually to assure access to preventive and primary health care services for the required population groups of: (1) preventive and primary care services for pregnant women, mothers and infants; (2) preventive and primary care services for children; and (3) services for children with special health care needs (CSHCN). Federal law requires each state to allocate a minimum of 30 percent of available funds to services for children with special health care needs, and a minimum of 30 percent of available funds to services for children and adolescents.

The following priority needs identified for the South Dakota MCH block grant were based on the five-year needs assessment completed for FY 2021-2025 MCH Block Grant cycle. The priority needs cross the five population domains – Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, Children with Special Health Care Needs, with a sixth priority need that falls into the Cross-Cutting & Systems Building domain area:

- Women/Maternal Mental Health and Substance Misuse
- Infant Safe Sleep
- Parenting Education and Support
- Youth Mental Health/Suicide Prevention
- Healthy Relationships
- Access to Care and Services for Children
- Data Sharing and Collaboration

The federal MCHB offered 15 national performance measures (NPMs) covering the five population domains. States were required to choose five out of the 15 NPMs to address during the five-year cycle (2021-2025) with at least one NPM from each population domain. South Dakota selected the following five measures below:

- NPM 1 – Percent of women with past year preventive medical visit
- NPM 5 –
    - A) Percent of infants placed to sleep on their backs
    - B) Percent of infants placed to sleep on a separate approved sleep surface
    - C) Percent of infants placed to sleep without soft objects or loose bedding

- NPM 6 – Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool
- NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
- NPM 11 – Percent of children with and without special health care needs having a medical home

In addition, states were allowed to develop one or more state performance measures (SPMs) to address priority needs that were not adequately represented under the national performance measures.
South Dakota developed the following SPMs:

- Healthy Relationships
- Maternal & Child Health (MCH) data is collaborative, equitable, and shared widely

The State also developed a five-year State Action Plan to assist in aligning program strategies and activities with identified needs and performance measures. Each year the state will update on progress toward the identified measures and implement changes to strategies and activities as appropriate. **FY25 is the last year of the current five-year cycle**. **A statewide needs assessment is currently underway to select new priorities and NPMs to begin in FY26.**

If commenting, please review the priority needs as well as the federal and state-negotiated performance measures (above) and provide comments on suggested changes and potential actions to address any of the priority needs. To provide comments write, e-mail, or FAX them to the:

South Dakota Department of Health
Office of Child and Family Services
Attn: Maternal and Child Health Program
615 E 4th St.
Pierre, SD 57501

Fax:(605) 773-3159 Email: DOHMCHBG@state.sd.us

All comments must be received by July 1, 2024, to be considered for the FY 2025 MCH Block Grant application.

To request a copy of the draft FY 2025 MCH Block Grant application, please write, fax, or email your request along with your name and address using the information above. It is estimated that a draft application will be available for distribution by August 1, 2024. Based on previous years, the application will be approximately 270 pages (including application text, supporting documents, forms, and budget).

Strategy 1.3: Increase depression screening and referrals to PCP among low-income women within OCFS Community Health offices	Research evidence-based initiatives, activities, and programs that improve maternal mental health equity.			

Maternal Child Health – Perinatal/Infant Domain
NPM 5

State Action Plan	Implementation Timeframe: October 1st, 2024, through September 30th, 2025.
NPM 5 A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	
State Priority Need: Safe Sleep	
Objectives: 1) Reduce the number of SUID deaths related to unsafe sleep environment from 139.8/100,000 in 2019 to 103.9/100,000 by 2025. (NVSS) 2) Increase the percent of infants placed to sleep without soft objects or loose bedding from 60.3% in 2021 to 66.3% by 2025. (PRAMS)	
Facilitator: **Workgroup Members:**	

	Activities	Status	ESM	Responsible person(s)
Strategy 5.1: Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media and print.	Continue to post safe sleep messages on Wake Safe DOH webpage and DOH Facebook and Instagram pages.			
	Continue to place ads in professional journals.			
	Continue to disperse safe sleep infographic (with data from CDR) to providers across the state to share with birthing families.			

Strategy 5.2: Collaborate with Community Health Offices across the state to educate birthing families/infant caregivers on evidence based safe sleep practices.	**Activities**	**Status**	**ESM**	**Responsible person(s)**
	Update safe sleep toolkit for OCFS staff.			
	Create safe sleep guidance for organizations in SD to bridge the gap in knowledge about available safe sleep resources.			
Strategy 5.3: Collaborate with diverse, multi-sector organizations/ agencies to promote safe sleep	**Activities**	**Status**	**ESM**	**Responsible person(s)**
	Collaborate with public health nurses who work in frontier and tribal communities to identify and create more culturally competent safe sleep resources.			
	Partner with Cribs for Kids and all SD birthing hospitals to promote bronze safe sleep certification within their system.		% of birthing hospitals that receive information on certification process that become safe sleep certified.	
	Identify new opportunities to promote infant safe sleep in South Dakota while focusing on rural communities and			

	communities with SUID disparities.			

Maternal Child Health – Child Domain

State Action Plan	**Implementation Timeframe:** October 1st, 2024 through September 30th, 2025
NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
State Priority Need: Parenting education and support	
Objective(s): Increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year from 22.3% (2019-2020) to 29.4% by 2025. (NSCH)	
Workgroup Members:	

Strategy :	Activities	Status	ESM	Responsible person(s)
6.1 Promote developmental screenings and related materials through service delivery programs within the Office of Child and Family Services	Encourage Public Health staff to connect English and Spanish speaking families with needed technology to apps including CDC Milestone Tracker app, Bright by Text app, Text4Baby			
	Ensure public health offices have adequate hard copy resources such as trifold developmental screening cards, books, and milestone tracking handouts to distribute to families			
	Provide training to community health staff on early identification			

	Develop communications for public health offices to effectively promote Learn the Signs Act Early materials			
Strategy	**Activities**	**Status**	**ESM**	**Responsible person(s)**
6.2 Create new and promote existing parenting resources to support healthy children and families	Connect with medical providers, social workers, tribal communities, and community health workers to identify additional parenting resources and ways to equitably promote them			
	Review and promote existing DOH education materials to be used by partners and communities			
	Utilize the Bright Futures (AAP) guidelines to enhance Parenting Education and knowledge on the importance of preventative services and developmental screening in pediatric health care			
	Collaborate with ECCS to promote equitable and relevant resources for improved outcomes in first three years		# of ECHO series and related trainings completed	

Strategy	Activities	Status	ESM	Responsible person(s)
6.3 Collaborate with partners to identify gaps in parenting education and support and reduce duplication of efforts	Meet quarterly with Medicaid, Social Services, and Department of Education to coordinate services and prevent duplication of efforts			
	Collaborate with the DOH Home Visiting program and Public Health Offices to reduce duplication of and/or gaps in developmental screenings and referrals for evaluation between home visiting and other OCFS programs			
	Title V Child Health Coordinator will continue to strengthen partnership with HRSA ECCS Project Lead to enhance alignment and collaboration between MCH and other early childhood systems of care.			
	Assist State Libraries in the dissemination and integration of parenting education and support materials and content into youth services programs			

Maternal Child Health – Adolescent Domain
NPM 7.2

State Action Plan	**Implementation Timeframe:** October 1st, 2024 through September 30th, 2025
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	
State Priority Need: Suicide Prevention/Mental Health	
Objective(s): Decrease the adolescent suicide rate among 10 through 19-year-olds from 19.6 per 100,000 (2020-2022) to 12.8 per 100,000 in 2025. (NVSS) Decrease the percentage of 9th-12th graders who attempted suicide in the past 12 months from 12.3% in 2019 to 9.0% in 2025. (YRBS)	
Facilitator: **Workgroup Members:**	

	Activities	Status	ESM	Responsible person(s)
Strategy 7.2.1: Promote evidence-based programs and practices that increase protection from suicide risk	Provide informational training on the 211 and 988 suicide prevention and mental health resource in South Dakota			
	Collaborate with Hope Squad and DOH injury prevention coordinator to promote peer-to-peer outreach programs in schools			
	Connect partners with the Community Information Exchange (Nexus SD) for better connection to mental health providers, while addressing Social Determinants of Health			
Strategy 7.2.2: Develop and disseminate equitable and accessible Suicide Prevention and Mental Health education material,	Promote suicide prevention and mental health messaging for Cor Health social media		# of impressions and shares of posts focused on mental health and suicide	
	Utilize communication platforms to disseminate trainings and materials accessible to diverse parents and organizations working with young people 10 to 19 years old including vulnerable/underserved youth.			

resources, and messaging				
	Promote the positive effects of nutrition and physical activity on mental health			
Strategy 7.2.3: Develop partnerships with diverse, multi-sector local and state agencies to address youth mental health and suicide prevention among all South Dakota youth	**Activities**	**Status**	**ESM**	**Responsible person(s)**
	Continue to partner with organizations that were involved with the Title V Needs Assessment and build rapport with new organizations working with diverse youth in mental health and suicide prevention.			

Maternal Child Health – CYSHCN Domain

State Action Plan	**Implementation Timeframe:** October 1st, 2024 through September 30th, 2025
NPM 11- Percent of children with and without special healthcare needs, ages 0 through 17, who have a medical home.	
State Priority Need: Access to care and services	
Objective(s): Increase the percentage of CYSHCN who report receiving care in a well-functioning system from 20.9% (2019-20) to 21.5% by 2025. (NSCH)	
Facilitator: Kristy Jackson (CYSHCN Director)	

Strategy :	Activities	Status	ESM	Responsible person(s)
11.1 Enhance equitable family access to needed supports and services	Provide financial support to DHS respite care program for families of CYSHCN, and refer families to the program to enhance equitable access to respite services across the state			
	Provide financial support for operational costs of genetics outreach clinics in Rapid City, SD through partnership with Sanford Health and cover the cost of travel from Sioux Falls to Rapid City for the geneticists and genetics counselors to provide access to these services on the Western side of the state			

	Partner with DSS to support equitable provision of special needs carseats			
	Explore additional opportunities to link families to needed resources in our state			
	Provide financial support to eligible families of CYSHCN through Health KiCC program while exploring alternative resources for remaining participants. Initiate final phase out of program.			

Strategy	Activities	Status	ESM	Responsible person(s)
11.2 Identify and implement strategies to equitably advance medical home components for families of CYSHCN through access to family centered care coordination	Partner with Sanford Health to provide care coordination services for families of children with complex medical conditions at Sanford Children's Hospital			
	Collect and review data from Sanford Children's care coordination pilot to identify needs and health disparities. Utilize data for program planning and to work toward funding sustainability.			
	Explore new opportunities for expansion of care coordination services in the state, including the addition of a newborn		Percent of families who received effective care coordination (data source: NSCH)	

	screening coordinator who will bridge bloodspot and hearing into a one-stop shop for providers and families.			
Strategy	**Activities**	**Status**	**ESM**	**Responsible person(s)**
11.3 Coordinate the state newborn screening infrastructure focused on equitable testing and access to follow up services	Contract laboratory for newborn screening of all South Dakota births			
	Partner with Sanford Health to contract medical consultants, genetics counselors, a newborn screening coordinator, and a follow up nurse to address equitable and appropriate testing, treatment, and follow up for missed and presumptive positive bloodspot and hearing screens.			
	Partner with audiology community to develop protocols for new mandated hearing screen for newborns.			

	Convene NBS Advisory Committee Annually. Form subcommittee to review proposals to add new conditions to the panel.			

Maternal Child Health – Adolescent Domain
SPM 1

State Action Plan	**Implementation Timeframe:** October 1st, 2024 through September 30th, 2025
SPM 1 – Improve young people' (10-24 years) relationship by Increase the percentage of 10–19-year-olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 58.03% in 2022 to 60.74% by 2025. **Overall Goal -** Improve young peoples' (10 to 24 years) relationships by increasing education and support, STI prevention, and pregnancy prevention.	
State Priority Need: Healthy Relationships	
Objective(s): • Decrease the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics from 12.1% in 2022 to 11.5% by 2025. (EHR NetSmart) • Decrease the South Dakota teen birth rate, ages 15 through 19, from 17/1000 in 2021 to 16.56/1000 by 2025. (NVSS)	
Facilitator: **Workgroup Members:**	

Strategy 1.1:	**Activities**	**Status**	**ESM**	**Responsible person(s)**
Promote evidence-based programs and practices that increase healthy relationship skills, STI prevention, and pregnancy prevention	Partner with the Public Health Nurses to promote Teen Outreach programming within school and community partners serving youth 10 to 19, including vulnerable/underserved youth in rural communities.			
	Collaborate with South Dakota Family Planning Program, Rape Prevention Education, Title V Sexual Risk Avoidance Education, and Personal Responsibility Program Grants serving diverse populations.			
	Develop the Healthy Relationship evaluation plan to align with program			

	activity needs that will expand Healthy Relationships programs in South Dakota.			
Strategy 1.2: Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens	**Activities**	**Status**	**ESM**	**Responsible person(s)**
	Promote and expand PYD conference and trainings for organizations working with diverse youth on Healthy Relationship programming.			
	Collaborate with Youth Advisory Council on adolescent priorities and provide activities that emphasize health equity to integrate youth voice throughout Adolescent Activities.			
Strategy 1.3: Develop and disseminate equitable and accessible healthy relationship, STI prevention and pregnancy prevention materials, resources, and messaging	Develop and promote messaging for Cor Health social media.			
	Utilize communication platforms to disseminate trainings and materials accessible to diverse parents and organizations working with young people 10 to 24 including vulnerable/underserved youth.			
Strategy 1.4: Develop partnerships with diverse, multi-sector local and state agencies to address youth healthy relationships, STI	Continue to partner with organizations that were involved with the Title V Needs Assessment and build rapport with new organizations working with diverse youth on healthy relationship, STI prevention and pregnancy prevention.			

prevention, and pregnancy prevention among all SD youth				

Maternal Child Health – Cross-Cutting Domain

State Action Plan	**Implementation Timeframe:** October 1st, 2020 through September 30th, 2025
NPM or SPM **SPM #3 – Increase the extent to which data equity principles have been implemented in SD MCH data projects from 54.2% in 2021 to 59.6% in 2025.**	
State Priority Need: Data sharing and collaboration	
Objective(s): **Increase the number of new data sharing projects accomplished from zero to seven by September 30th, 2025.** **Increase the number of new partners that we collaborate with on data projects from zero to five by September 30th, 2025.**	
Workgroup Member Organizations: Missouri Breaks Research, Center for Prevention of Child Maltreatment, University of South Dakota, Great Plains Tribal Epi Center, SDDOH	

Strategy:	Activities	Status	ESM	Responsible person(s)
2.1 Provide access to *timely* data to internal partners and policymakers to support evidence-based decision making.	Update the OCFS internal dashboard to reflect the most current available data about Maternal and Child Health Indicators.			
	Identify items of OCFS internal dashboard that may be automatically updated based on real-time data; develop and implement automation.			
	Produce a report of Bright Start Indicators[1] that is updated every quarter.			
	Disseminate/advertise updates to internal dashboards and Bright Start Report to internal partners and policy makers.			

[1] First report covers July 2022 to March 2023.

Strategy	Activities	Status	ESM	Responsible person(s)
2.2 Provide access to *relevant* data to external partners and communities to support community-level initiatives for prevention.	Produce an epidemiologic report about maternal mortality covering 10 years, including data from the maternal mortality review committee (MMRC) meetings.			
	Produce an epidemiologic report about infant mortality covering 10 years, including data from the Child Death Review (CDR) committees' meetings.			
	Produce a report on PedNSS (Pediatric Nutrition Surveillance System) and PNSS (Pregnancy Nutrition Surveillance System) data which includes health and nutrition indicators on WIC participants.			
	Disseminate findings of mortality reports and of PedNSS and PNSS with communities across all SD regions.			
2.3 Make the application of data equity principles a required element for sharing data and of epidemiologic reports produced by OCFS so that communities, internal and external partners can use it in their own efforts to advance equity.	Standardize the OCFS data request process for both internal and external partners to better track requests and ensure data integrity.			
	Include qualitative data analysis of risk factors, social determinants of health and preventive recommendations in both infant and maternal mortality reports mentioned above.			
	Analyze social determinants of health from clients served by different OCFS programs who answered the Pregnancy Risk Assessments to understand the main inequities affecting OCFS clients and disseminate findings.			
	Update MCH data briefs by domain to reflect new NPMs and health inequities within these domains and disseminate findings.			

Strategy	Activities	Status	ESM	Responsible person(s)
2.4 Increase collaboration around American Indian data between state and tribal partners.	Engage with tribal leaders and learn their preferred method of sharing data about American Indians and/or of people who live in Tribal territory (i.e. PRAMS tribal reports).			
	Understand what tools the Tribes need to put data into action.			
2.5 Improve internal capacity to share data via referrals between different OCFS programs.	Identify key representatives of OCFS programs (WIC, pregnancy care, Bright Start, family planning, and other CHS services) who write referrals as part of their regular work.			
	Landscape: Collect information about referrals used between different OCFS programs.			
2.6 Increase Internal capacity for big data linkage.	Continue to analyze the linked PRAMS and Medicaid claims dataset to help inform maternal and infant care.			
	Link data of death records of women to birth records and fetal death records for enhanced surveillance of maternal deaths.			