Maternal Child Health – Women Domain
NPM 1

SOUTH DAKOTA DEPARTMENT OF HEALTH

State Action Plan	Implementation Timeframe: October 1st, 2023, through September 30th, 2024
NPM #1 Percent of women, ages 18-44 with a preventive medical visit in the past year	
State Priority Need: Mental Health/Substance Misuse	
Objective(s): Increase the proportion of women receiving a Well Women visit annually from 77.4% in 2021 to 85.4% by 2025. (BRFSS)	
Facilitator: **Workgroup Members:**	

	Activities	Status	ESM	Responsible person(s)
Strategy 1.1: Develop partnerships with diverse, multisector stakeholders to promote preventative care for women of childbearing age.	Utilize social media to promote the importance of yearly well women visits.		# of messages developed promoting well women care.	
	Expand the NPM #1 workgroup to include partners and community members who are committed to this work.			

	Activities	Status	ESM	Responsible person(s)
Strategy 1.2: Create toolkit of resources on Maternal Mental Health/Substance Misuse and Health Equity for OCFS field offices.	Collaborate with multisector partners to identify a substance use screening tool for women of childbearing age.			
	Provide motivational interviewing training for OCFS staff through DSS SBIRT grant			

Strategy 1.3: Increase depression screening and referrals to PCP among low-income women within OCFS Community Health offices	Develop policy for screening postpartum Medicaid-eligible women for depression within OCFS Community Health offices.		% of women with positive depression screen who are referred to their PCP within OCFS Community Health offices	
Strategy 1.4 Develop a policy recommendation with Department of Social Services (DSS) to create Maternal Medical Homes	Conduct literature search and research other evidence-based programs related to pregnancy medical homes.			
	Collaborate with DSS Medical Home Team to develop policies for Maternal Medical Home within the OCFS.			

Maternal Child Health – Perinatal/Infant Domain
NPM 5

SOUTH DAKOTA DEPARTMENT OF HEALTH

State Action Plan	**Implementation Timeframe:** October 1st, 2023 through September 30th, 2024
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 66.33% by 2025. (PRAMS)	
Facilitator: Jill Munger (DOH – MCH Infant Domain Coordinator/CDR Coordinator) **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 For Baby's Sake and DOH Facebook 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.			Workgroup members

Maternal Child Health – Perinatal/Infant Domain
NPM 5

SOUTH DAKOTA DEPARTMENT OF HEALTH

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)**
	Develop a safe sleep policy for health professionals working with pregnant and postpartum families within the Office of Child and Family Services (OCFS).			
	Provide guidance to OCFS Community Health Nurses in evaluating and updating their offices' plan for decreasing infant mortality.			
Strategy 5.3: Collaborate with diverse, multi-sector organizations/ agencies to promote safe sleep	**Activities**	**Status**	**ESM**	**Responsible person(s)**
	Develop new partnerships within tribal communities where SUID disparities exist to address barriers to safe sleep.			I
	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.	

Updated: 6/14/23

Maternal Child Health –Child Domain

SOUTH DAKOTA DEPARTMENT OF HEALTH

State Action Plan	**Implementation Timeframe:** October 1st, 2023 through September 30th, 2024
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 Utilize Community Health offices and Bright Start Home Visiting Program to provide Ages and Stages Developmental Screen tool to clients.				
	Encourage Community 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 community health offices have adequate hard copy resources such as trifold developmental screening cards, books, and milestone tracking handouts to distribute to families			
	Develop and implement policy to determine whether ASQ and ASQ SE		6.1 Percentage of children enrolled in Bright Start Home Visiting that	

	screenings or LTSAE milestone checklists should be used in Community Health Offices to reduce duplication of screenings.		receive a developmental screen by 18 months of age.	
	Provide training to community health staff on early identification			
Strategy	**Activities**	**Status**	**ESM**	**Responsible person(s)**
6.2 Create new and promote existing parenting resources to support healthy children and families	NPM 6 workgroup will identify parenting resources across the state and collaborate on promotion and dissemination to families			
	Connect with medical providers, social workers, tribal communities, and community workers to identify additional parenting resources and ways to equitably promote them			
Strategy	**Activities**	**Status**	**ESM**	**Responsible person(s)**
6.3 Collaborate with partners to identify gaps in	Meet quarterly with Medicaid, Social Services, and Department of Education to coordinate			

parenting education and support and reduce duplication of efforts	services and prevent duplication of efforts			
	Collaborate with the DOH Home Visiting program and Community 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.			

Maternal Child Health – Adolescent Domain
NPM 7.2

SOUTH DAKOTA DEPARTMENT OF HEALTH

State Action Plan	**Implementation Timeframe:** October 1st, 2023 through September 30th, 2024
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 15 through 19-year-olds from 34.4 per 100,000 (2018-2020) to 26.3 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 Youth Mental Health First Aid Training		Number trained in youth Mental Health First Aid	
	Provide informational training on the 211 and 988 suicide prevention and mental health resource in South Dakota			
	Partner with the OCFS Southeast Region to enhance their suicide prevention and mental health support and resources			

	Activities	**Status**	**ESM**	**Responsible person(s)**

Maternal Child Health – Adolescent Domain
NPM 7.2

SOUTH DAKOTA DEPARTMENT OF HEALTH

Strategy 7.2.2: Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens	Develop and promote PYD Conference for organizations working with diverse youth on suicide prevention/mental health.			
	Collaborate with Youth Advisory Council to focus on adolescent priorities and provides activities that emphasize health equity and integrate youth voice throughout.			
Strategy 7.2.3: Develop and disseminate equitable and accessible Suicide Prevention education material, resources, and messaging	Promote suicide prevention and mental health 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 19 years old including vulnerable/underserved youth.			
	Activities	**Status**	**ESM**	**Responsible person(s)**
Strategy 7.2.4: Develop partnerships with diverse, multi-sector local and state agencies to address youth mental health and suicide prevention among all South Dakota youth	Continue to partner with organizations that were involved with the Title V Needs Assessment and build rapport with new organizations working with diverse youth in mental health and suicide prevention.			

Maternal Child Health – CYSHCN Domain

SOUTH DAKOTA DEPARTMENT OF HEALTH

State Action Plan	**Implementation Timeframe:** October 1st, 2023 through September 30th, 2024
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 21.45% by 2025. (NSCH)	
Facilitator: Whitney Brunner (MCH Assistant Program Director; 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		Percentage of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services	
	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 addition of social worker to Complex			

	Medical Care Program to provide long-term follow up for complex cases identified through metabolic newborn screening.			
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, and a follow up nurse to address equitable and appropriate testing, treatment, and follow up for presumptive positive			
	Convene NBS Advisory Committee Annually. Form subcommittee to review proposals to add new conditions to the panel.			

Maternal Child Health – Adolescent Domain
SPM 1

SOUTH DAKOTA DEPARTMENT OF HEALTH

State Action Plan	**Implementation Timeframe:** October 1st, 2023 through September 30th, 2024

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	Provide and promote STI guidelines training to providers serving young people 10 to 24, including vulnerable/underserved youth.			
	Collaborate with South Dakota Family Planning Program, Rape Prevention Education, Title V Sexual Risk Avoidance Education, General Department Sexual Risk Avoidance and Personal Responsibility Program Grants serving diverse populations			

Maternal Child Health – Adolescent Domain
SPM 1

SOUTH DAKOTA DEPARTMENT OF HEALTH

	Update and conduct 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 suicide prevention/mental health.			
	Collaborate with Youth Advisory Council on adolescent priorities and provide activities that emphasize health equity to integrate youth voice throughout Adolescent Activities.			
	Promote and expand PYD assessment tool for youth Agencies.			
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:	Continue to partner with organizations that were involved with			

Maternal Child Health – Adolescent Domain

SPM 1

SOUTH DAKOTA DEPARTMENT OF HEALTH

Develop partnerships with diverse, multi-sector local and state agencies to address youth healthy relationships, STI prevention and pregnancy prevention among all SD youth	the Title V Needs Assessment and build rapport with new organizations working with diverse youth on healthy relationship, STI prevention and pregnancy prevention.			

Maternal Child Health – Cross-Cutting Domain

SOUTH DAKOTA DEPARTMENT OF HEALTH

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.			