SOUTH DAKOTA DEPARTMENT OF HEALTH

Title V Maternal and Child Health State Action Plan Table

FY2026 Infant Domain	Implementation Timeline: October 1, 2026 - September 30, 2027
NPM: **Safe Sleep**	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. D) Percent of infants room-sharing with an adult during sleep.
Objective(s):	A) Increase the percent of infants placed to sleep on their backs from 78.4% in 2026 to 84.4% in 2030 (FAD). B) Increase the percent of infants placed to sleep on a separate approved sleep surface from 28.7% in 2026 to 34.7% in 2030 (FAD). C) Increase the percentage of infants placed to sleep without soft objects or loose bedding from 78.7% in 2026 to 84.7% in 2030 (FAD). D) Increase the percent of infants room-sharing with an adult from 80.3% in 2026 to 86.3% in 2030 (FAD).
Strategy 1.	**Activities**
Community-Based Crib Distribution and Safe Sleep Education Strengthen statewide safe sleep practices by supporting crib distribution and consistent education through MCH programs and partner organizations.	• Use SD Infant and Child Death Review data to identify priority areas, guide targeted initiatives, and provide focused support to communities experiencing higher infant mortality. • Promote safe sleep and infant health best practices, materials, and resources via social media, print outlets, professional journals, newsletters, and at events. • Support and expand statewide crib distribution efforts to increase access for families and strengthen the overall effectiveness of the program through partnerships and consistent data-informed decision-making.

FY2026 Infant Domain	Implementation Timeline: October 1, 2026 - September 30, 2027
Strategy 2.	**Activities**

Health Care and Social Service Provider Education
 	
Increase consistency and alignment of safe sleep messaging and education across health, human service, community providers, and agencies statewide.
	• Partner with Cribs for Kids and all SD hospitals that see infants under the age of 1 to promote safe sleep certification within their system.
	• Support and recognize committed partners for their ongoing efforts to reduce infant mortality and promote safe sleep practices in South Dakota.
	• Promote C4K Safe Sleep Ambassador Training to SD healthcare professionals, service providers, community members, and parents.
	  ○ **ESM 1.** Percent of requested healthcare/social service professionals who received the Safe Sleep Ambassador certificate after passing the training quiz with at least 90%.
	  ○ **ESM 2.** Number of SD residents who received Safe Sleep Ambassador certification after passing the training quiz with 90% or better.
	• Expand Infant Health Committee membership to strengthen statewide safe sleep and infant health initiatives.

Strategy 3.	**Activities**
Caregiver/Parent Education Empower parents and caregivers with the knowledge, skills, and confidence to practice safe sleep and make informed decisions about how to keep infants safe.	• Leverage trusted local partners, cultural traditions, and caregiver support networks to create new opportunities for educating parents and caregivers about safe sleep and other key infant health practices. • Use state infant mortality data to underscore why safe sleep practices matter and why they are important for SD's infants. • Develop and tailor community-informed safe sleep materials that close knowledge gaps and strengthen understanding of safe infant care practices.

SOUTH DAKOTA DEPARTMENT OF HEALTH

Title V Maternal and Child Health State Action Plan Table

FY2026 Child Domain	Implementation Timeline: October 1, 2026 – September 30, 2027
NPM: Food Sufficiency	Percent of children, ages 0 through 11, whose households were food sufficient in the past year
Objective(s):	Increase the percentage of children (0-11) living in food-sufficient households from 71.4% in 2026 to 73.5% in 2030.
Strategy 1.	**Activities**
Build and align state capacity to advance child food sufficiency through cross-sector coordination, workforce development, systems thinking, and data-driven action	• Expand effective nutrition programs and community supports with the Office of Family Nutrition Services • Boost enrollment in WIC and SNAP through targeted outreach • Advance Food is Medicine pilots and funding with nutrition partners
Strategy 2.	**Activities**
Increase access to affordable and nutritious foods by increasing the availability of fresh fruits and vegetables in areas experiencing food insecurity and limited access to healthy options	• Partner with schools and daycares to increase participation in the CACFP program • Partner to establish Head Start BMI referral pathways for children above the 85th and 95th percentile ○ **ESM:** Percentage of state and local partners who participate in Title V-supported training or planning sessions to improve coordination around child food sufficiency. • Use South Dakota Healthy Nutrition Collaborative Landscape Assessment findings to communicate rural pricing and access barriers

FY2026 Child Domain	Implementation Timeline: October 1, 2026 – September 30, 2027
Strategy 3.	**Activities**
Strengthen family-centered nutrition education and resource navigation programs that empower caregivers to make informed, culturally relevant food and health decisions.	• Deliver culturally relevant nutrition education for programs serving non-English-speaking families • Increase community understanding of nutrition and breastfeeding through promotional campaigns and materials • Collaborate with nutrition experts to promote marketing strategies for food programs through schools, events, and social media

FY2026 Child Domain	Implementation Timeline: October 1, 2026 - September 30, 2027
NPM: Medical Home	Percent of children, aged 0 through 17, who have a medical home
Objective(s):	Increase the percentage of children with and without special healthcare needs (0-17) who have a medical home from 52.5% in 2026 to 58.5% in 2030.
Strategy 1.	**Activities**
Strengthening statewide clinical partnerships to advance coordinated pediatric care and Medical Home implementation	• Conduct a statewide assessment of Child Medical Home capacity by identifying data gaps across survey and quality metrics • Identify primary care family physicians and pediatricians across the state to champion the medical home model • Provide financial and technical assistance for Federally Qualified Health Centers to adapt and strengthen pediatric Medical Home components within existing patient-centered medical home designation efforts

FY2026 Child Domain	Implementation Timeline: October 1, 2026 - September 30, 2027
Strategy 2.	**Activities**
Support new families in developing early connections to a medical home model through care coordination and collaboration with home visiting	• Support Continuous Quality Improvement with Home Visiting to implement medical home coordination and well-visit support ○ **ESM:** Percentage of home visiting staff trained in child medical home tools • Equip home visitors with structured tools to help families prepare for well-child visits and engage in shared decision-making
Strategy 3.	**Activities**
Integrate Oral Health into the Pediatric Medical Home Model through community, school, and Medicaid partnerships	• Conduct a statewide assessment of pediatric oral health needs by analyzing available data and administering the Basic Screening Survey for Children to identify key challenges, gaps, and opportunities for improving access and care coordination • Create parent education materials on the importance of integrating dental care into children's health care plans • Expand medical-dental integration efforts across the state through collaboration with the South Dakota Oral Health Coalition

FY2026 Children & Youth with Special Healthcare Needs (CYSHN) Domain	Implementation Timeline: October 1, 2026 - September 30, 2027
NPM: **CYSHN Medical Home**	Percent of children, ages 0 through 17, with and without special healthcare needs who have a medical home
Objective(s):	Increase the percentage of children with and without special healthcare needs (0-17) who have a medical home from 52.5% in 2026 to 58.5% in 2030.
Strategy 1.	**Activities**
Use electronic health data solutions to standardize communication	• Develop newborn screening surveillance system IT platform & configure role-based access • Work with audiology stakeholders to revise and automate follow-up reports to pediatricians and other PCPs. • Evaluate the feasibility of integrating via ETOR and other EHR technology to support electronic connectivity with Epic or the HIE
Strategy 2.	**Activities**
Enhance provider education and communication	• Define Medical Home communication templates in SD Bloom • Promote pediatrician registration in relevant IT systems related to newborn screening and related referral processes ○ **ESM:** Percent of primary care providers with at least one registered user in the newborn screening IT system • Expand educational offerings for providers, including webinars, an NBS Channel in SD Learn, and a web-based resource page

FY2026 Children & Youth with Special Healthcare Needs (CYSHCN) Domain	Implementation Timeline: October 1, 2026 - September 30, 2027
NPM: CYSHCN Medical Home Referrals	Percent of CYSHCN who receive needed referrals
Objective(s):	Increase the percentage of children with special healthcare needs (0-17) who received needed referrals from 74.3% in 2026 to 80.3% in 2030.
Strategy 1.	**Activities**
Identify and implement strategies to advance referrals	• Integrate audiologist and follow-up staff into newborn hearing screening workflow, including oversight of tele-audiology. ○ **ESM:** Percent of infants identified with hearing loss or deafness who were connected with intervention by 6 months of age • Work with Child & Adolescent Domains and Public Health Nursing to survey schools regarding school health needs • Collaborate with partners to provide continuing education opportunities for school-based staff
Strategy 2.	**Activities**
Coordinate state newborn screening infrastructure with a focus on long-term outcomes and a lifespan perspective	• Build a long-term follow-up module in the SD Bloom IT system, and establish data-sharing mechanisms to allow for the sharing of data to increase referrals beyond infancy • Evaluate sustainable funding strategies for the maintenance of core newborn screening infrastructure • Evaluate the needs of families identified via newborn screening through surveys and focus groups. • Continue support for families, including respite and medical car seats

Strategy 3.	Activities
Strengthen Transition to Adult Care and Embed Lifespan Perspective	• Work with the vendor to build SD Bloom provider registry fields & document relevant schema (telehealth, referral acceptance, etc.) • Collaborate with partners, including Medicaid, to develop health/transition tools into the existing IEP/transition workflow at schools. • Partner with the Adolescent Health Domain to integrate Transition to Adult Care into Family Messaging regarding Adolescent Well Visits

FY2026 Adolescent Domain	Implementation Timeline: October 1, 2025 – September 30, 2026
NPM: **Adolescent Well Visit**	Number of adolescents, ages 12 through 17, with a preventive medical visit in the past year
Objective(s):	A. Increase the percentage of adolescents ages 12-17 years with a preventative medical visit in the past year from 72.4% in 2026 to 78.4% by 2030 (NSCH) B. Increase the percentage of adolescents aged 10-19 years old who believe it is important to see a doctor for a checkup at least once per year from 80.6% to 85.6%. (Healthy Relationships Surveys, supplemental questions - PREP, TOP, & RPE)
Strategy 1.	**Activities**
Quality Improvement (QI) Initiatives to Increase Adolescent Well-Visits	• Implement a Quality Improvement (QI) initiative in collaboration with Title X to increase the number of adolescents receiving an annual preventive well visit. ○ **ESM:** Number of Title X clinics that have integrated evidence-based practices/quality improvement strategies to optimize the delivery of adolescent well-visit services. • Strengthen collaboration between Title V and key community stakeholders to improve coordination, increase awareness, and enhance referral pathways for adolescent preventive visits.
Strategy 2.	**Activities**
Data Systems to support Adolescent Health, including utilization of Adolescent Well Visits	• Align Title V Maternal Child Health (MCH) efforts with South Dakota Family Planning Program (SD PLAN), Rape Prevention Education (RPE), Sexual Risk Avoidance Education (SRAE), and Personal Responsibility Education Program (PREP) grants to strengthen coordinated programming and support data-informed adolescent health initiatives, including Adolescent Well Visits. • Utilize Common Measures Survey data to assess adolescent awareness, attitudes, and perceived importance of annual preventive well visits.

FY2026 Adolescent Domain	Implementation Timeline: October 1, 2025 – September 30, 2026
Strategy 3.	**Activities**
Positive Youth Development (PYD) Approach to Promote Adolescent Well Visits	• Develop and disseminate Adolescent Well Visit messaging for parents, adolescents, and young adults through Cor Health social media platforms and partner communication channels. • Implement a targeted awareness campaign to promote Adolescent Well Visits, including education on preventive care and clarification of the difference between an Adolescent Well Visit and a sports physical. • Establish a Youth Advisory Council to guide adolescent health promotion efforts, ensuring meaningful youth engagement is integrated into program design, messaging, and activities. • Plan and implement PYD-focused webinars, conferences, and training opportunities for organizations serving youth, with emphasis on integrating Adolescent Well Visit promotion into practice.

SOUTH DAKOTA DEPARTMENT OF HEALTH

Title V Maternal and Child Health State Action Plan Table

FY2026 Women's Domain	Implementation Timeline: October 1, 2025 – September 30, 2026
NPM: Postpartum Visit (PPV)	A. Percent of women who attended a postpartum checkup within 12 weeks after giving birth. B. Percent of women who attended a postpartum checkup and received recommended care components (health care provider talked to them about birth control methods and what to do if they felt depressed or anxious).
Objective(s):	A. Increase the percentage of women with a postpartum checkup within 12 weeks after giving birth from 90.8% in 2026 to >95% in 2030. B. Increase the percentage of women with a postpartum checkup and recommended care components from 79.9% in 2026 to 85.9% in 2030.
Strategy 1.	**Activities**
Improve the quality and consistency of postpartum education, screening, and care supports	• Identify and promote the use of individualized postpartum care plans and other tools that support comprehensive postpartum visits. ○ **ESM:** Percent of women in the SD DOH Pregnancy Care Program who were risk assessed and had a postpartum visit. • Promote consistent messaging on women's health and postpartum topics. • Support integration of maternal mental health resources and referrals into postpartum care pathways, including digital mental health supports.
Strategy 2.	**Activities**
Reduce barriers and improve connection to postpartum care and support.	• Develop and promote postpartum visit reminders and referral pathways to support postpartum follow-up and continuity of care. • Support BabyReady Medicaid program, which emphasizes the importance of prenatal and postpartum visits. • Support community-based and family-centered approaches to postpartum care, including postpartum support groups, peer support, and efforts that bring services closer to families. • Develop and promote resource directories and tools that connect families to locally available postpartum supports and services.

FY2026 Women's Domain	Implementation Timeline: October 1, 2025 – September 30, 2026
Strategy 3.	**Activities**
Strengthen partnerships and systems efforts that support maternal health and postpartum outcomes.	• Collaborate with healthcare systems, public health programs, and community organizations to identify gaps, respond to recommendations, and improve maternal health and postpartum outcomes. • Strengthen alignment of maternal health initiatives and expand partnerships focused on improving postpartum care engagement and support. • Support efforts that strengthen and expand the maternal health workforce, including community-based supports such as doulas, particularly in rural communities with fewer resources.