2020 Statewide Home Visiting Needs Assessment Report

Updated: March 2025

SOUTH DAKOTA DEPARTMENT OF HEALTH

Division of Family and Community Health
Maternal, Infant, and Early Childhood
Home Visiting Program

Contents

Purpose of the Maternal, Infant, and Early Childhood Home Visiting Statewide Needs Assessment

South Dakota's maternal, infant, and early childhood population needs mirror many of the same challenges faced by other rural and frontier states, such as access to healthcare services as well as social needs like housing and food. Specific challenges include access to mental health and substance abuse resources and services, parenting education and support and affordable health insurance.

The Office of Child and Family Services (OCFS) completed a statewide Needs Assessment of maternal, infant, and early childhood populations across South Dakota (SD) to understand health and well-being issues that impact them. The Needs Assessment process encompassed both the Maternal Child Health Title V program and the Maternal, Infant and Early Childhood (MIECHV) Home Visiting program. This comprehensive Needs Assessment process was driven by two key frameworks: Life Course Theory and Health Equity Model. The focus was to understand the social determinants of health and health inequities that impact health outcomes throughout the life course. Utilization of these frameworks emphasized understanding the factors that shape the health and well-being of SD families.

The joint Needs Assessment was carried out between September 2018 and September 2020. Targeted planning for the Home Visiting assessment was conducted between September – December 2019 in collaboration with OCFS staff, the Needs Assessment Project Team, and an external consultant to inform the process design and implementation. Implementation of the Title V Needs Assessment occurred between January 2019 and May 2020, and the Home Visiting Needs Assessment between September 2019 and September 2020. See the Home Visiting Needs Assessment Project Timeline in **Appendix A.**

The Home Visiting Needs Assessment approach included quantitative and qualitative data collection methods to identify at-risk areas of the state. Input was elicited from service providers and individuals who represent broad perspectives through a survey, focus groups, and key informant interviews, with targeted outreach to ensure representation from diverse SD communities and underserved populations.

Implementation of a comprehensive Needs Assessment process that emphasized health equity and engaged multi-sector partners and community members for the first time is a significant success that illustrates federal-state Title V and MIECHV partnerships in action. Specifically, the process engaged new external partners throughout the process. Community members, including adolescents, tribal communities, and underserved populations were engaged to ensure the voice of populations impacted by health issues was included in the initial phase focused on Title V. Moreover, by including a focus on health equity throughout the process, has established a foundation to ensure efforts moving forward are focused on addressing health equity in the Home Visiting program.

The MIECHV Needs Assessment process will inform future home visiting program planning in collaboration with key partners.

Overview of South Dakota

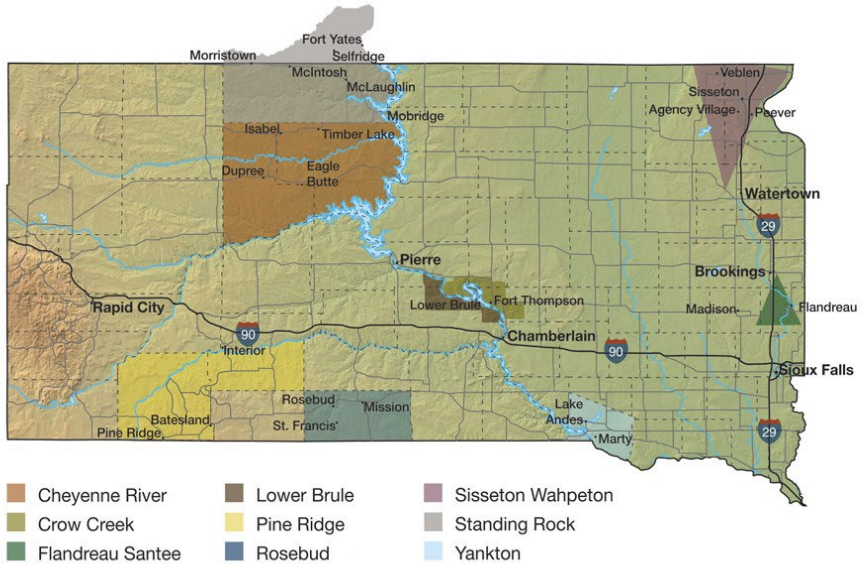
Demographics, Geography, Economy

South Dakota (SD) includes over 75,000 square miles in the upper Midwest and is one of the United States' most rural and frontier geographic areas. SD is home to diverse landscape that is divided into east and west by the Missouri River. There are 882,235 people living in SD with an average population density of 10.7 people per square mile. Of SD's 66 counties, 30 are rural and 34 are frontier (less than 6 people per sq. mile). The states' two most populated counties – Minnehaha and Pennington - are located on opposite sides of the state. There are nine federally recognized American Indian tribes within the South Dakota borders.

The state's population by race and ethnicity is 84.4% White, 9% American Indian/Alaska Native (AI/AN), 2.4% Black, 1.7% Asian, 2.4% Two or More Races and 4.1% Hispanic or Latino. The population by sex is 49.5% female and 50.5% male. Just under 25% of the state's population are persons under the age of 18, with 7% of persons under 5 years of age. Approximately 37% of the state's female population is of childbearing age, 15 through 44.

Figure 1 below illustrates South Dakota's tribal lands. It is important to note that the counties within the tribal reservations noted on this map correlate highly with the areas identified as at-risk in this Needs Assessment. South Dakota's tribal lands are rural, remote and have high rates of poverty, all of which compound the challenges associated with long-term health and well-being among the state's American Indian population.

Figure 1: South Dakota Tribal Lands



South Dakota's median household income is $56,499. Nearly 13% of SD households live below 100% of the Federal Poverty Level (FDL), with the 10 poorest counties either part of or adjacent to SD's American

Indian reservations. Reservations experience significantly higher poverty levels ranging from 22.3%-48.6%. Almost 12% of persons under 65 years of age lack health insurance. In addition, 91.7% of persons aged 25 years and older are high school graduates or higher and 28.5% have a bachelor's degree or higher. Key industries that shape SD's economy include agriculture, mining, finance, manufacturing, and tourism.

Strengths and Challenges

South Dakota possesses unique strengths and challenges that impact the health status of young families. Specifically, SD is home to a growing healthcare industry. The state's healthcare industry is projected to be among the largest growth industries from 2012-2022. This industry is projected to add 7,305 workers to SD's economy (from a level of 52,875 in 2012 to a level of 60,180 in 2022). The rate of growth is projected to be 13.8%, nearly double the 7.0% growth projected in total employment for all industries.

This growth in the healthcare industry is significant because as baby boomers retire and leave the healthcare workforce, they are subsequently aging, requiring additional healthcare services. A focus has been placed on high school graduates who can replace the retirees in the workforce and continue to provide quality healthcare services across the state. The SD Departments of Education, Health, Labor and Regulation, and the SD Board of Regents have created a program to address this critical need for healthcare workers in the state. Health Occupations for Today and Tomorrow (HOTT) focuses on health career information and opportunities for South Dakota students at all grade levels.

Despite the growth in the healthcare industry and strategies to address the healthcare workforce, SD residents are challenged by the limited access to healthcare. Approximately two-thirds of the state is designated by the federal government as a Health Professional Shortage Area (HPSA); health care provider shortages in primary care, dental health, and mental health. There are also 71 Medically Underserved Areas/Populations (MUA/P), including a shortage of primary care health services across South Dakota. As of June 4, 2019, there were 4,442 physicians and 654 physician assistants licensed in the state. In addition, there were 1,140 actively licensed nurse practitioners and 34 actively licensed nurse midwives in South Dakota.

Another challenge facing SD's population is a lack of transportation to access services and resources. This is compounded by factors such as poverty and geographic isolation. For some, this means traveling great distances (over 50 miles) to see a primary care provider and even further to see a specialist. Most healthcare specialists and the state's lone children's hospital is located on the eastern side of the state. This adds additional travel and expense for families of children in the central and western regions of the state which can be as much as 400 miles away. Access to services and resources is further complicated on American Indian reservations by the lack of a reliable transportation system.

The programs of the Office of Child and Family Services continue to identify strategies to address these challenges such as marketing program services to reach all eligible populations, recruiting and retaining adequately trained/prepared individuals to meet workforce needs (especially in remote counties and reservation communities), being responsive to populations with different cultures and beliefs, impacting social media, and improving access to dental and mental health services.

Department of Health Strategic Plan

In December 2019, the SD-DOH released its 2020-2025 Strategic Plan. The strategic plan provides a road map for the future and helps staff work together as a department to achieve meaningful outcomes. The plan is not designed to be a compilation of all DOH programs and services but instead helps identify new things to be accomplished as well as reflect key strategic initiatives the SD-DOH is doing today and will continue in the future.

The 2020-2025 Strategic Plan for the South Dakota Department of Health envisions "every South Dakotan healthy and strong", with the mission of "working together to promote, protect, and improve health". The guiding principles of the SD DOH include serve with integrity and respect, focus on evidence-based prevention and outcomes, support data-driven innovation, achieve health equity in all communities, demonstrate proactive leadership and strengthen partnerships, and exhibit transparency and accountability.

The strategic plan addresses the following goals:
Goal 1: Enhance the accessibility, quality, and effective use of health resources.
Goal 2: Provide services to improve public health.
Goal 3: Plan, prepare, and respond to public health threats.
Goal 4: Maximize partnerships to address underlying factors that determine overall health.
Goal 5: Strengthen and support a qualified workforce.

Each goal has objectives and key strategies to help guide SD-DOH activities. There are also 13 key performance indicators that will be tracked to allow the SD-DOH to monitor progress towards these goals. More information about the plan can be found at http://doh.sd.gov/strategicplan/.

The SD-DOH also remains committed to providing comprehensive public health services and programs for and with underserved populations and communities throughout the state. Much of the state is designated as a healthcare shortage area and is therefore underserved.

The SD-DOH remains committed to fostering relationships with both Indian Health Services (IHS) staff and statewide tribal government/tribal health to identify opportunities to support services on South Dakota Indian reservations. The SD-DOH has supported several tribal initiatives, such as Project LAUNCH grants and Tribal Maternal Infant and Early Childhood Home Visiting grants, by providing letters of support and community advisory board commitments. These partnerships are in place with the Sisseton Wahpeton Oyate MCH program, as well as with Great Plains Tribal Chairmen's Health Board on behalf of the Rosebud Sioux Tribe and Sisseton Wahpeton Oyate.

Identifying Communities with Concentrations of Risk

Phase 1: For purposes of this assessment, the term "community" was defined as county. To identify communities with concentrations of risk, South Dakota utilized the simplified method, which was based on nationally available data provided by HRSA and included 13 indicators of risk within five domain categories: Socioeconomic Status, Adverse Perinatal Outcomes, Substance Use Disorder, Crime, and Child Maltreatment. We expanded on the simplified method by adding two additional indicators, teen pregnancy and prenatal care initiation, to the Adverse Perinatal Outcomes domain. Teen pregnancy was

evaluated as the percentage of births to adolescents aged 15-19/1,000 births. Data from years 2014-2018 were acquired from the South Dakota Vital Statistics Department and the Annual County and Resident Population Estimates by Selected Age Groups and Sex from the United States Census Bureau. Teen pregnancy has been associated with a myriad of adverse outcomes, both maternal and perinatal. Increased risks of low birthweight, preterm delivery, small for gestational age infants, and severe neonatal conditions[1] are correlations. The increased risk of adverse perinatal outcomes relates to biological immaturity as well as maternal ethnicity and lack of prenatal care[2]. Pregnancy during adolescence puts both the mother and baby at risk for increased adverse effects. It is critical that these mothers are provided with support and education to help combat and reduce adverse perinatal effects.

Prenatal care is used to detect medical complications, provide education to pregnant woman, and ultimately increase the chances of having a healthy baby. The World Health Organization (WHO) recommends women begin prenatal care within the first 16 weeks of pregnancy while the American Academy of Pediatrics (AAP) recommends initiation of prenatal care within the first 14 weeks of pregnancy[3]. A relationship has been detected between late prenatal care initiation and poor pregnancy outcomes. By not receiving prenatal care within the first trimester, infants have a greater risk of low birth weight, neonatal death, and preterm birth[3]. In addition to the improved health of infants, early prenatal care has been shown to decrease monetary costs significantly[3]. As prenatal care decreases, risk of prematurity, stillbirth, and neonatal death increase[4]. This strong association between prenatal care and perinatal outcomes emphasizes the importance of early prenatal care. To include this indicator, data from 2019 birth records acquired from the South Dakota Vital Statistics Department were evaluated to determine month of prenatal care initiation. Initiation of prenatal care during months 1-3 of pregnancy are considered adequate entry while receiving no prenatal care or initiating prenatal care past the 3rd month of pregnancy was considered late entry. Late entry to prenatal care was considered as an indicator under adverse perinatal outcomes. To encourage good perinatal outcomes, it is crucial that early prenatal care is encouraged for all pregnant women. Identifying counties at-risk of late entry into prenatal care is important to unveil potential barriers to prenatal care entry such as issues with access to care or transportation concerns and address solutions to overcome these barriers.

To better understand county-level risk for each domain, domain-level maps were created and evaluated to build an understanding of potential issues facing each county. If at least half the indicators within the domain had z-scores greater than or equal to one standard deviation higher than the mean of all counties in the state, that domain was considered at risk for that county. A map for Socioeconomic Status (SES) risk is seen in Figure 2. For example, of the four indicators under the SES domain, Buffalo county had a z-score of 2.4 for 'poverty' and 2.3 for 'unemployment', placing the county with at least half the indicators having z-scores greater than one standard deviation higher than the mean of all counties, and thus, at-risk.

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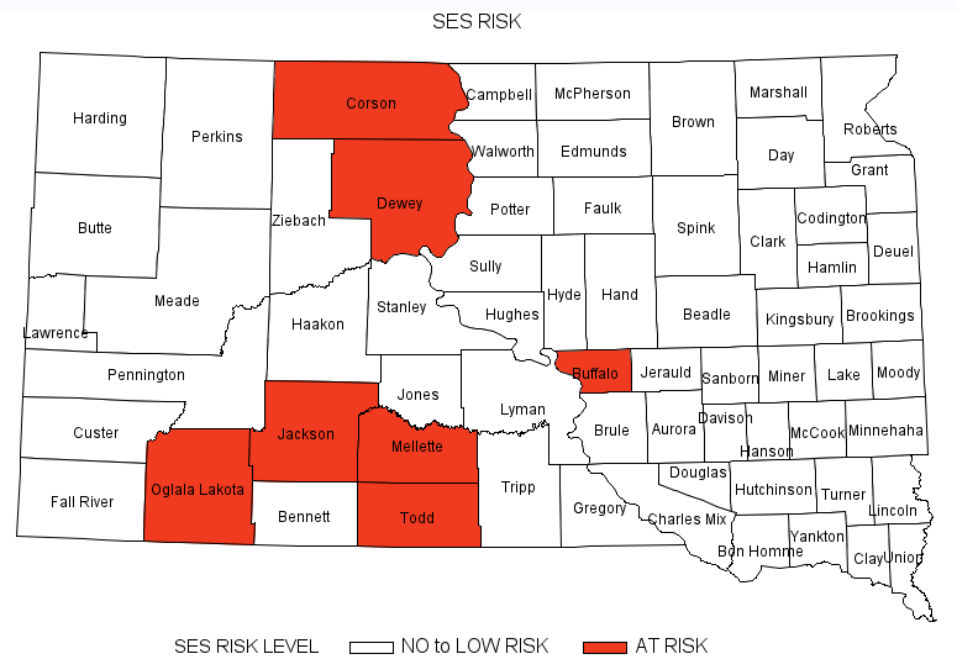
[1] L. Gortzak-Uzan, M. Hallak, F. Press, M. Katz & I. Shoham-Vardi (2001) Teenage pregnancy: risk factors for adverse perinatal outcome, Journal of Maternal-Fetal Medicine, 10:6, 393-397, DOI: 10.1080/jmf.10.6.393.397

[2] Althabe, F., Moore, J.L., Gibbons, L. *et al.* Adverse maternal and perinatal outcomes in adolescent pregnancies: The Global Network's Maternal Newborn Health Registry study. *Reprod Health* **12,** S8 (2015). https://doi.org/10.1186/1742-4755-12-S2-S8

[3] Till SR, Everetts D, Haas DM. Incentives for increasing prenatal care use by women in order to improve maternal and neonatal outcomes. Cochrane Database of Systematic Reviews 2015, Issue 12. Art. No.: CD009916. DOI: 10.1002/14651858.CD009916.pub2.

[4] Partridge S, Balayla J, Holcroft CA, Abenhaim HA. Inadequate prenatal care utilization and risks of infant mortality and poor birth outcome: a retrospective analysis of 28,729,765 U.S. deliveries over 8 years. Am J Perinatol. 2012 Nov;29(10):787-93. doi: 10.1055/s-0032-1316439. Epub 2012 Jul 26. PMID: 22836820.

Figure 2: Socioeconomic Status Risk Map



Risk maps were created for each of the remaining five domains. Figure 3 shows risk for Adverse Perinatal Outcomes, Figure 4 highlights Substance Use Disorder Risk, Figure 5 Crime Risk, and Figure 6 Child Maltreatment.

Figure 3: Adverse Perinatal Outcomes Risk Map

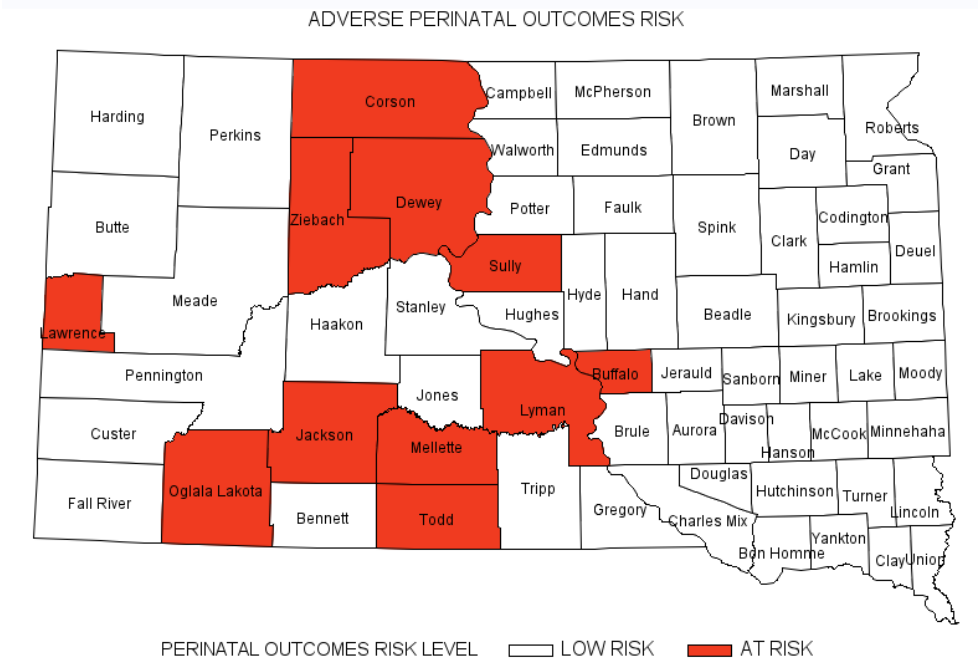
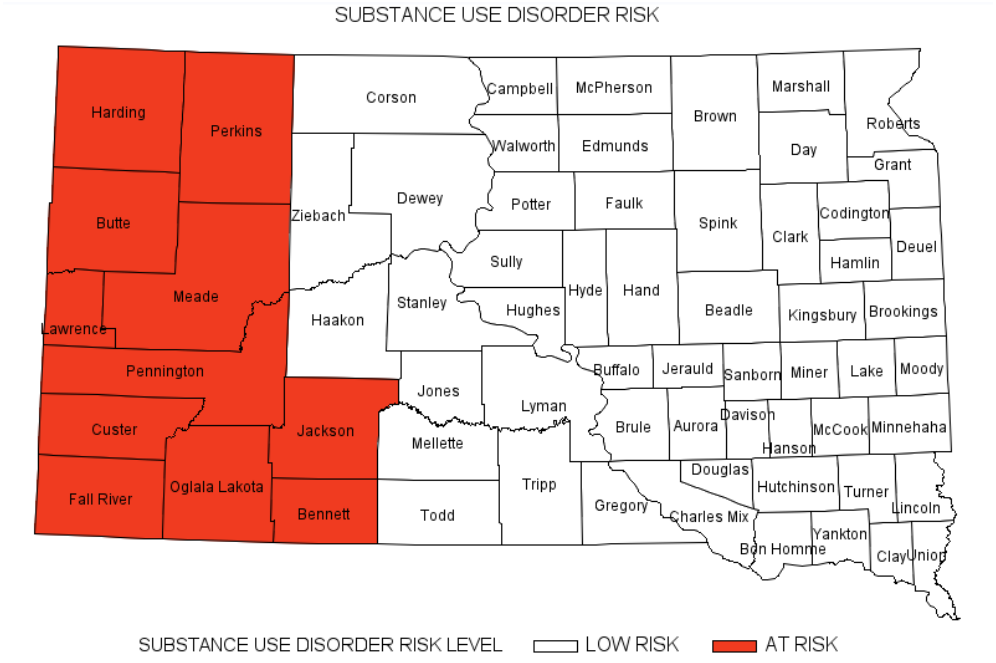


Figure 4: Substance Use Disorder Risk Map



For substance use disorder risk, data received from HRSA using SAMHSA - National Survey of Drug Use and Health was used. The western side of the state has issues that require further investigation.

Figure 5: Crime Risk Map

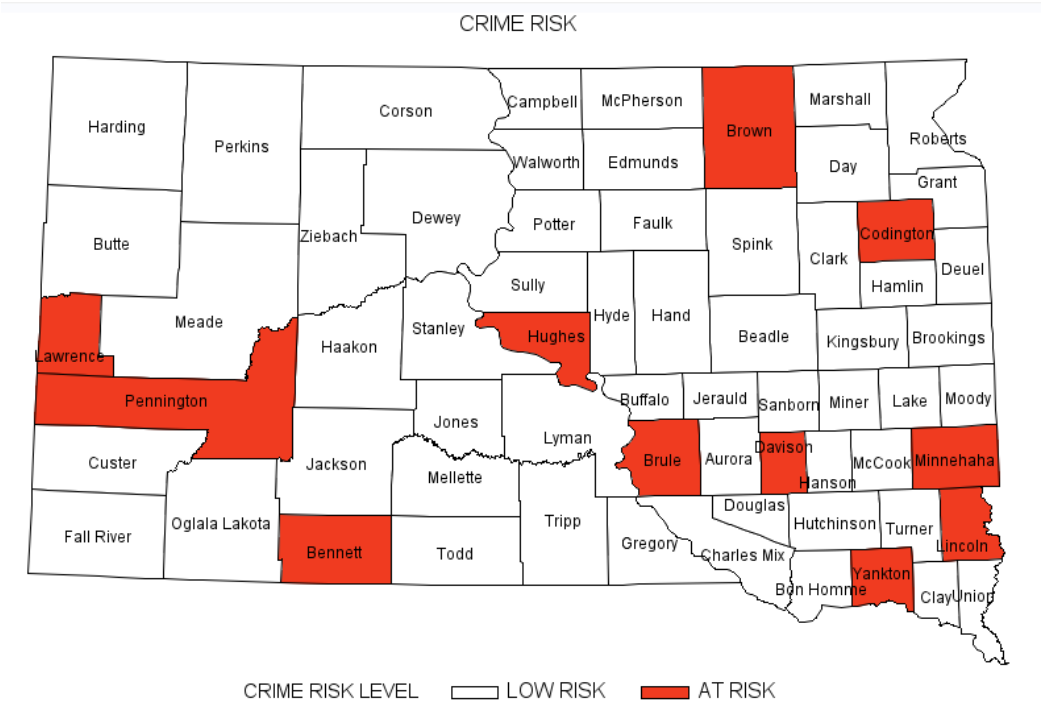
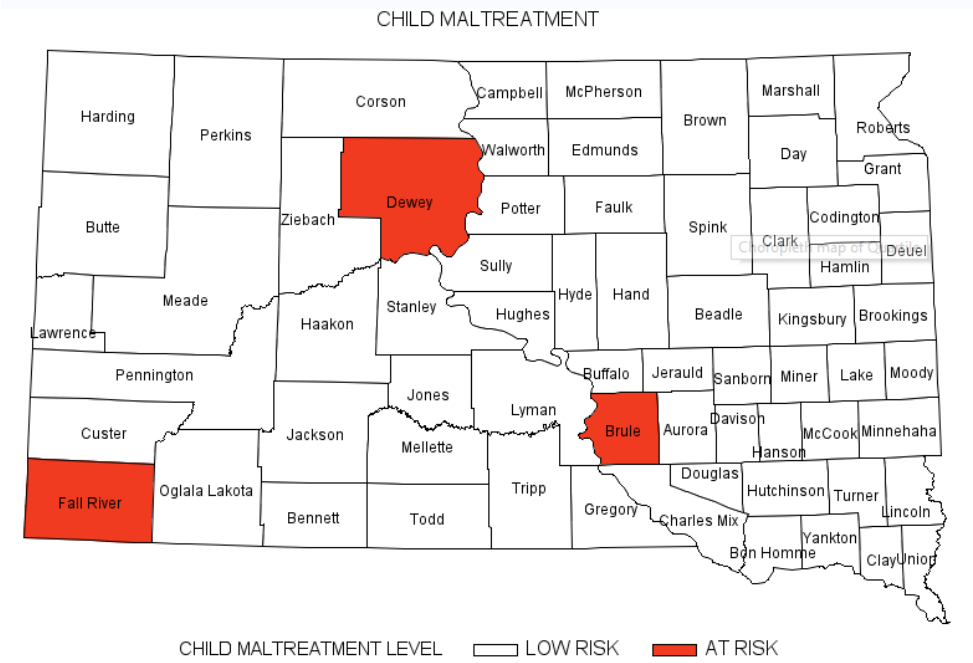
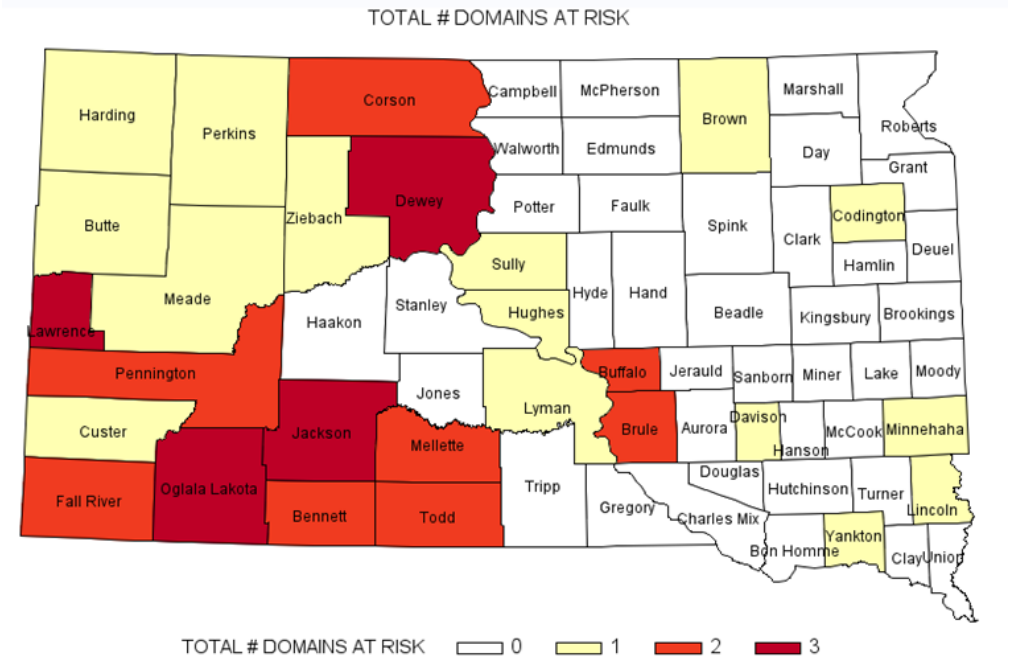


Figure 6: Child Maltreatment Map



The simplified method identifies a county as at-risk if two or more domains have at least half of the indicators with z-scores greater than or equal to one standard deviation higher than the mean of all counties in the state. Counties with two or more domains at-risk are identified as communities with concentrations of risk. The combined risk across all domains was then used to determine overall county risk across all five domains and the result is shown in Figure 7.

Figure 7. Communities with Concentrations of Risk



After considering the initial 13 indicators of risk provided by HRSA within the five domains and subsequently adding the two additional above-mentioned risk indicators, 12 counties were identified as at-risk by having two or more total domains at-risk as outlined in Table 1.

Table 1: Counties Identified as At-Risk in Phase 1

Bennett County	*Jackson County*
Brule County	Lawrence County
Buffalo County	Mellette County
Corson County	Oglala Lakota County
Dewey County	Pennington County
Fall River County	*Todd County*

Phase Two: After compiling the data provided to complete the simplified method with the additional data points of teen pregnancy and prenatal care access, South Dakota has decided to factor in additional data points that impact the maternal and early childhood populations of the state. The South Dakota Department of Health tracked Covid-19 infections by county of residence beginning in March 2020 and continuing through July 2021. Through the course of the pandemic, certain populations and counties of the state were disproportionately affected by Covid-19 infections.

According to a scoping review published in *Reproductive Health*, the Covid-19 pandemic has had an outsized impact on pregnant people and mothers, and in areas beyond the health impacts of the disease itself.

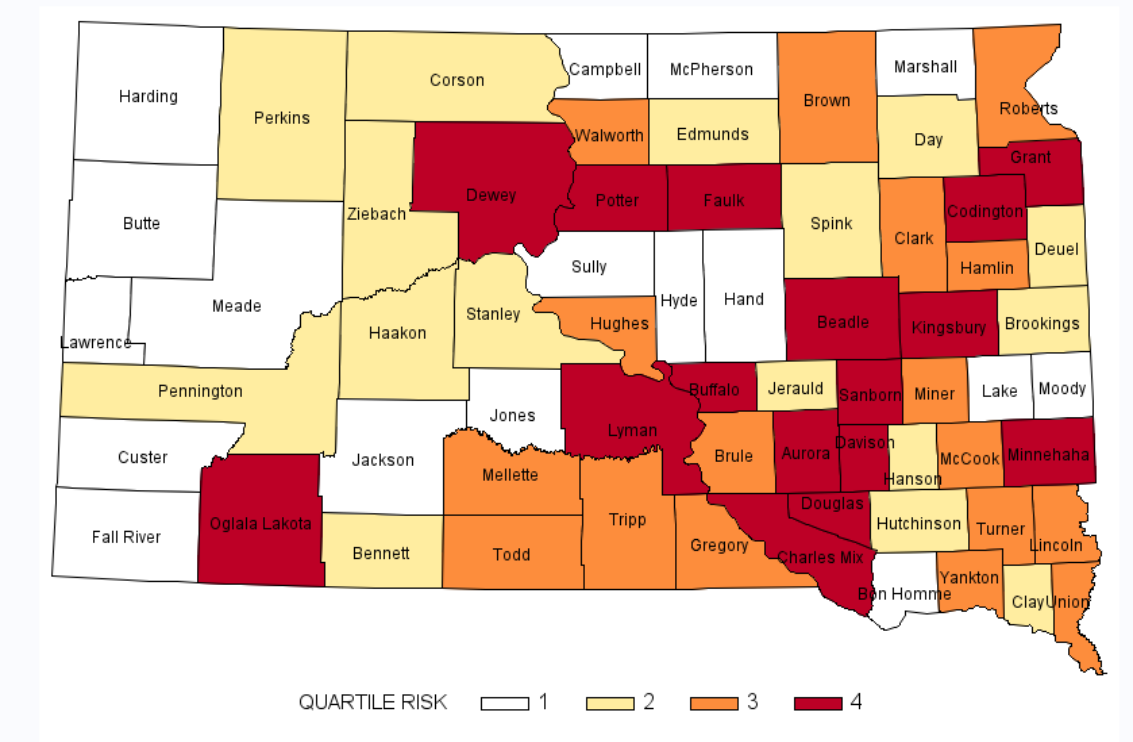
> "Severe increases in maternal mental health issues, such as clinically relevant anxiety and depression, were reported. Domestic violence appeared to spike. Prenatal care visits decreased, healthcare infrastructure was strained, and potentially harmful policies implemented with little evidence. Women were more likely to lose their income due to the pandemic than men, and working mothers struggled with increased childcare demands."[5]

These identified impacts of Covid-19 connect to the Home Visiting Benchmarks addressing Maternal and Newborn Health, Crime/Domestic Violence, and Family Economic Self Sufficiency.

Through contact tracing and community mitigation efforts, the Department of Health noted a correlation between Covid-19 spread and the number of large employers in those counties. Particularly hard hit were manufacturing and agricultural processing plants. These businesses rely heavily on lower-income and non-English speaking workers. This is a trend that the current South Dakota Department of Health Home Visiting Staff also noted in the communities they serve. The current service delivery sites in Beadle, Roberts, Brown, and Minnehaha counties serve a higher than the state average proportion of non-English speaking clients and had high levels of community spread.

[5] Kotlar, B., Gerson, E., Petrillo, S. et al. The impact of the COVID-19 pandemic on maternal and perinatal health: a scoping review. Reprod Health 18, 10 (2021). https://doi.org/10.1186/s12978-021-01070-6

Figure 8: Covid-19 Incidence:

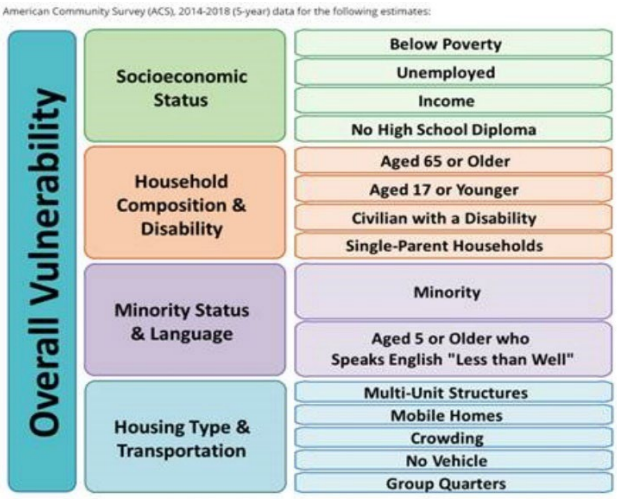


In Figure 8, counties in the top two quartiles of infection rates in the state are noted in red and orange.

The next step in Phase 2 was to further explore the overlap of counties with higher levels of Covid-19 infections and underlying community factors using the Social Vulnerability Index (SVI). The SVI is a compilation of Census data 15 variables (see Table 2) and can be used to identify communities that may need support before, during or after disasters – such as the Covid-19 pandemic.[6] Outside of the immediate preparation and response efforts needed in the time of a natural or public health disaster, the SVI can be used to identify communities that will need continued support to recover following such an event. The South Dakota Home Visiting program is using the SVI as a tool to guide community-based response to the Covid-19 pandemic.

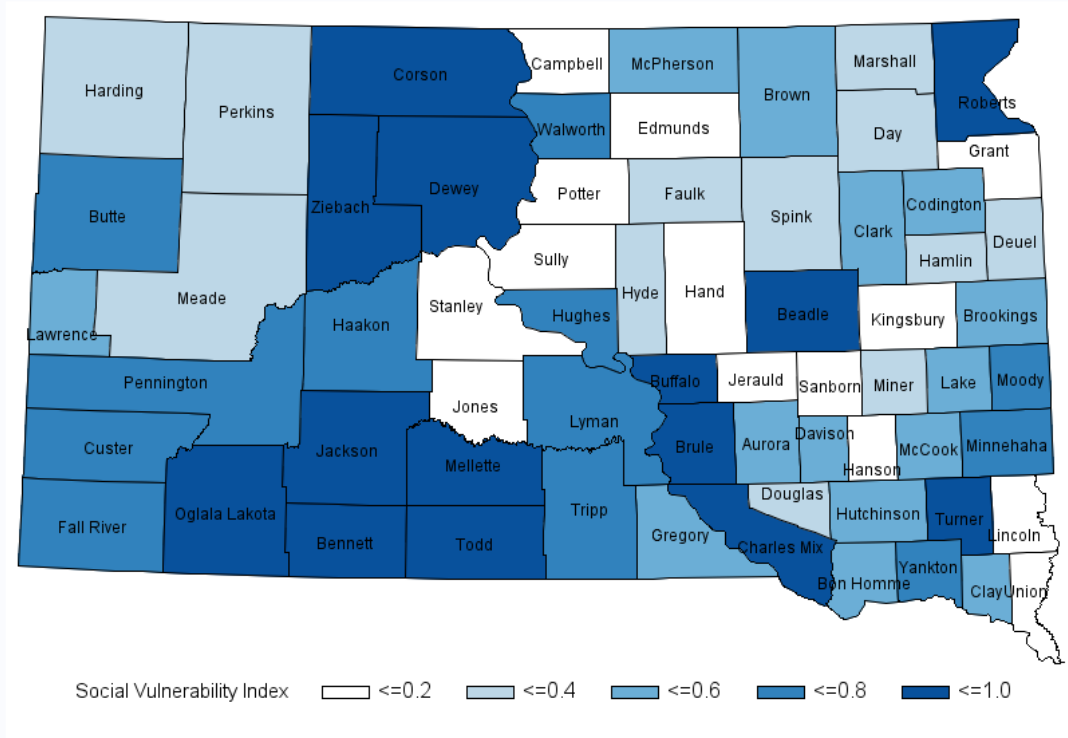
[6] ***https://www.atsdr.cdc.gov/placeandhealth/svi/index.html***

Table 2: Variables Used in Determining Social Vulnerability



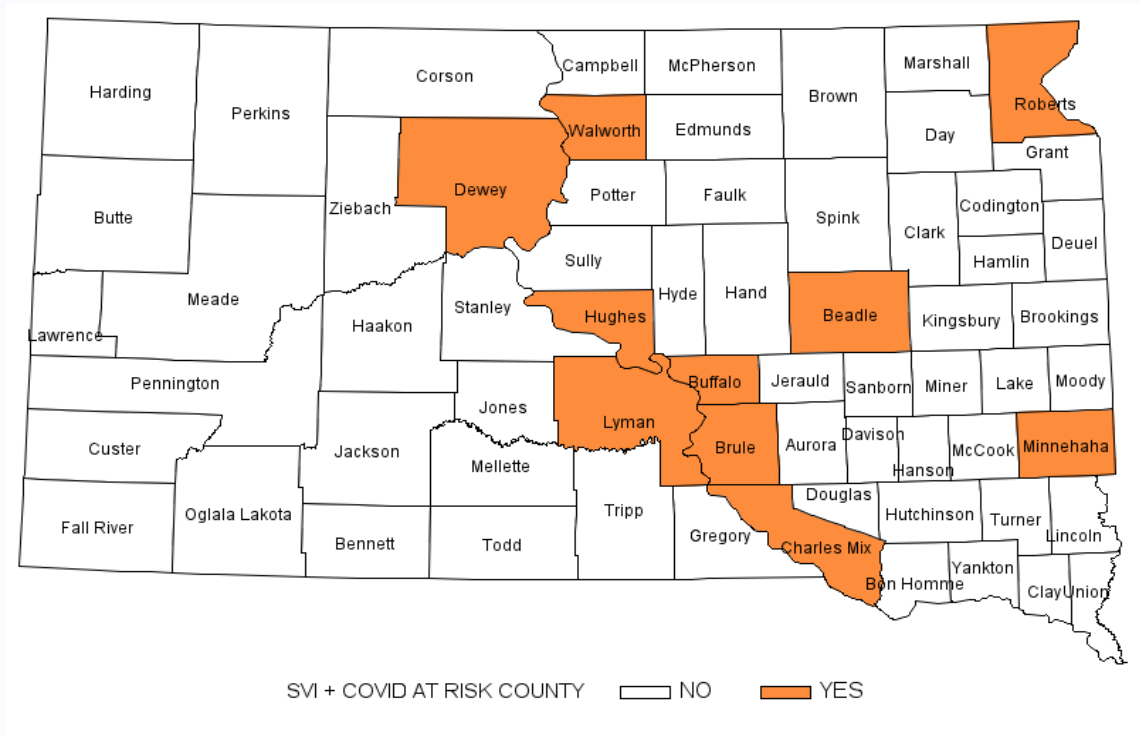
Although not all the variables in the SVI are specific to maternal child health populations, the four theme areas – Socioeconomic status, Household composition and disability, Minority status and language, and Housing and transportation – paint the picture of potential public health risk. The higher-risk counties, based on the SVI are shown in Figure 9.

Figure 9 – Social Vulnerability Index:



When the two additional data sets used in Phase 2 of the quantitative assessment of risk are combined to show counties with high rates of Covid-19 infection and high SVI scores, additional at-risk counties are identified and can be added to the Phase 1 list. Those counties are identified in Figure 10 and Table 3.

Figure 10: Counties with High Rates of Covid-19 infection and High Social Vulnerability Index Scores:



In combining the results of the Phase 1 and the Phase 2 quantitative data analysis, South Dakota Home Visiting identified nineteen counties as at-risk. As a final step to the Phase 2 process, the South Dakota Home Visiting Program will include counties that are currently served using MIECHV funding not already identified, as well as one county that comprises half of a tribal community shared with Dewey County identified in Phase 1.

There are three counties that have been served with MIECHV funding since 2012-21 that are not stand-alone service delivery areas. These counties are combined with other at-risk counties (all identified in both the 2010 and 2020 needs assessments) to form a service delivery area with an eligible population large enough to support a full home visiting caseload. **Butte county** in western South Dakota is linked with Lawrence county as the service delivery area for one nurse home visitor. Butte County was identified in in the 2010 home visiting Needs Assessment as having a high infant mortality rate. Butte county had one domain area of risk and was in the second-highest level of counties in the Social Vulnerability Index rankings. **Marshall** and **Day counties** are in the northeast part of the state and are combined with Roberts county as the service delivery area for one home visitor. Both counties are rural and overlap with part of the Sisseton Wahpeton tribal area.

Ziebach county in north central South Dakota shares the same geography as one half of the Cheyenne River reservation, also extending to Dewey county. If South Dakota proceeds with a subrecipient contract to deliver home visiting in this area, it will most likely be with a tribal partner. Potential for such a partnership will be greatly increased by the ability to serve the entire tribal community. Ziebach county was at risk in one domain area in Phase 1, was in the second quartile of Covid-19 infections and was in the highest level of the Social Vulnerability Index.

Table 3: Counties Identified as At-Risk in Phase 2, Not Previously Identified in Phase 1:

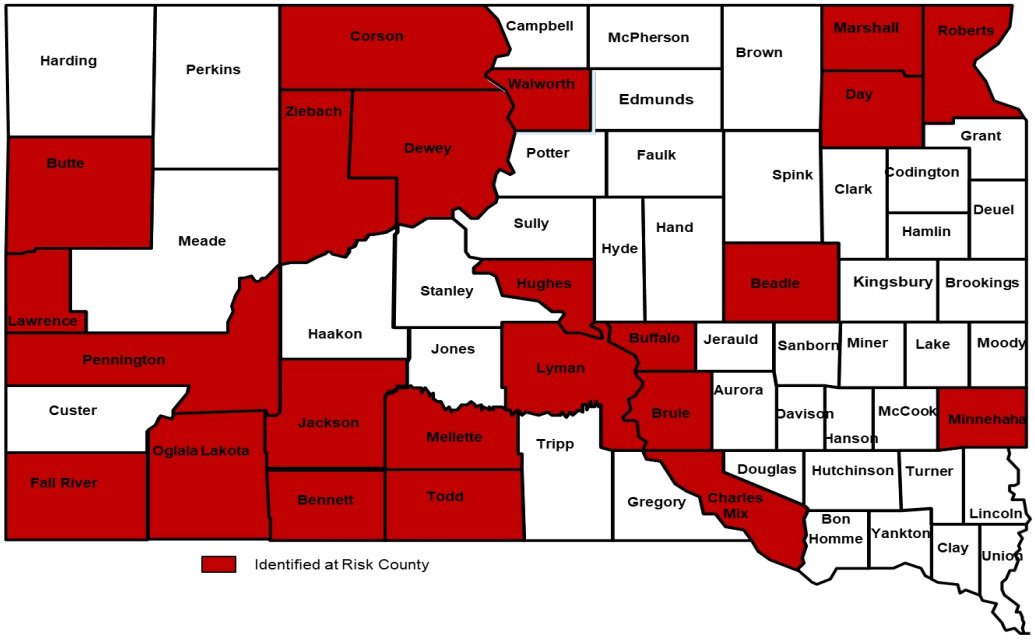
Beadle County	*Marshall County*
Butte County	*Minnehaha County*
Charles Mix County	*Roberts County*
Day County	*Walworth County*
Hughes County	*Ziebach County*
Lyman County	

Through the process of a Phase 1 review of county-level risk data, a Phase 2 addition of Covid-19 incidence rates, the CDC Social Vulnerability Index, current home visiting service delivery areas and an additional county under tribal jurisdiction, the South Dakota Department of Health Home Visiting program has established a list of twenty-three at-risk counties.

Table 4: Complete List of At-Risk Counties in South Dakota

Beadle County	*Dewey County*	*Mellette County*
Bennett County	*Fall River County*	*Oglala Lakota County*
Brule County	*Hughes County*	*Pennington County*
Buffalo County	*Jackson County*	*Roberts County*
Butte County	*Lawrence County*	*Todd County*
Charles Mix County	*Lyman County*	*Walworth County*
Corson County	*Marshall County*	*Ziebach County*
Day County	*Minnehaha County*	

Figure 11: Map of Identified At-Risk Counties in South Dakota



Phase Three: As part of the 2025 Needs Assessment Update Amendment process, South Dakota reviewed additional data sources to assess and identify communities with concentrations of risk. South Dakota reviewed HRSA data outlining Medically Underserved Areas (MUAs).[5] MUAs identify geographic areas and populations with a lack of access to primary care services within geographic areas. Given the associated risk to prenatal, maternal, newborn, and child health with lack of access to primary care services, South Dakota identified an additional 43 at-risk South Dakota counties in Phase 3. After the conclusion of the Phase 1, 2, and 3 reviews, South Dakota is identifying all 66 South Dakota counties as at-risk counties.

Table 5: Counties Identified as At-Risk in Phase 3, Not Previously Identified in Phases 1 & 2:

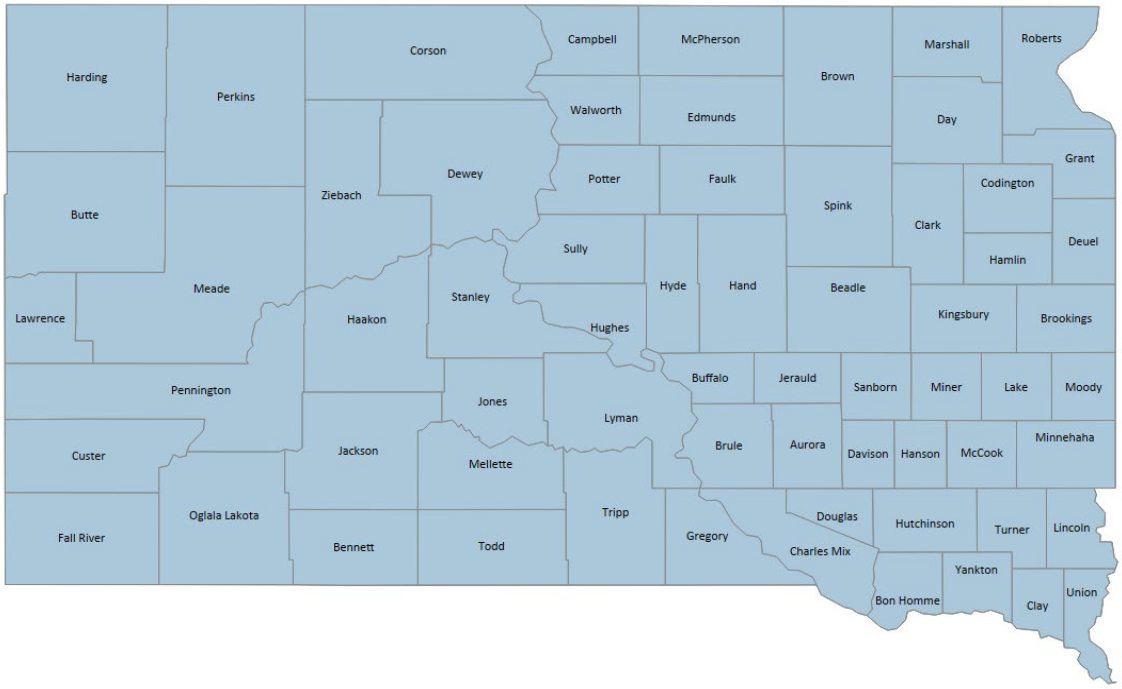
Aurora County	*Grant County*	McCook County
Bon Homme County	*Gregory County*	McPherson County
Brookings County	*Haakon County*	Meade County
Brown County	*Hamlin County*	Miner County
Campbell County	*Hand County*	Moody County
Clark County	*Hanson County*	Perkins County
Clay County	*Harding County*	Potter County
Codington County	*Hutchinson County*	Sanborn County
Custer County	Hyde County	Spink County
Davison County	Jerauld County	Stanley County
Deuel County	Jones County	Sully County
Douglas County	Kingsbury County	Tripp County
Edmunds County	Lake County	Turner County
Faulk County	Lincoln County	Union County
		Yankton County

[5] HRSA Data Warehouse: Medically Underserved Areas/Populations (MUA/P). Accessed 02/07/2025. https://data.hrsa.gov/data/download

Table 6: Complete List of At-Risk Counties in South Dakota

Aurora County	*Fall River County*	McPherson County
Beadle County	*Faulk County*	Meade County
Bennett County	*Grant County*	Mellette County
Bon Homme County	*Gregory County*	Miner County
Brookings County	*Haakon County*	Minnehaha County
Brown County	*Hamlin County*	Moody County
Brule County	*Hand County*	Oglala Lakota County
Buffalo County	*Hanson County*	Pennington County
Butte County	*Harding County*	Perkins County
Campbell County	*Hughes County*	Potter County
Charles Mix County	*Hutchinson County*	Roberts County
Clark County	Hyde County	Sanborn County
Clay County	Jackson County	Spink County
Codington County	Jerauld County	Stanley County
Corson County	Jones County	Sully County
Custer County	Kingsbury County	Todd County
Davison County	Lake County	Tripp County
Day County	Lawrence County	Turner County
Deuel County	Lincoln County	Union County
Dewey County	Lyman County	Walworth County
Douglas County	Marshall County	Yankton County
Edmunds County	McCook County	Ziebach County

Figure 12: Map of Identified At-Risk Counties in South Dakota



Identifying Quality and Capacity of Existing Programs

South Dakota Bright Start Home Visiting

South Dakota Bright Start Home Visiting is the program implemented through the SD-DOH. The program includes three different funding streams – MIECHV, state Medicaid/TANF funds, and a grant from Nurse Family Partnership. Clients are served by either Nurse Family Partnership or a state-generated curriculum for clients not eligible for NFP services (using only state funds).

The target enrollees of all Bright Start Home Visiting services are expectant mothers and fathers. Services are designed to help them improve their health to give birth to healthy babies. A component of Bright Start Home Visiting is the Nurse Family Partnership Home Visitation Program, where parents and prospective parents receive support from their own personal nurse on how to care for their family health needs, care for their child or children, stimulate their child's development, and provide a nurturing environment.

The Bright Start Home Visiting Program clients/families generally have limited or no income, lack other resources such as transportation and have risk factors that put the pregnant mother at a higher likelihood for a poor pregnancy outcome and difficulties with parenting skills. Other primary risk factors of families who are enrolled in the home visiting program include lack of a personal support system, intimate partner violence, and mental health issues.

South Dakota's Bright Start Home Visiting Program has served families in Sioux Falls and Rapid City since June of 2000. On November 1, 2008, the Children's Home Society in Sioux Falls began providing the

Bright Start Home Visiting Program through a contractual arrangement with the Department of Social Services and the Department of Health. In October of 2008, a nurse was hired to begin Bright Start Home Visiting services on the Pine Ridge reservation. In 2012-13, MIECHV funding provided for the expansion of home visiting services to rural communities in the state that were identified as high risk due to high infant mortality rates during the 2011 Needs Assessment process. The most recent expansion of services occurred in September 2018 to Aberdeen and surrounding communities because of a service-delivery expansion grant from Nurse Family Partnership, which expires in 2021. Figure 8 outlines coverage areas of the South Dakota Home Visiting Bright Start Program.

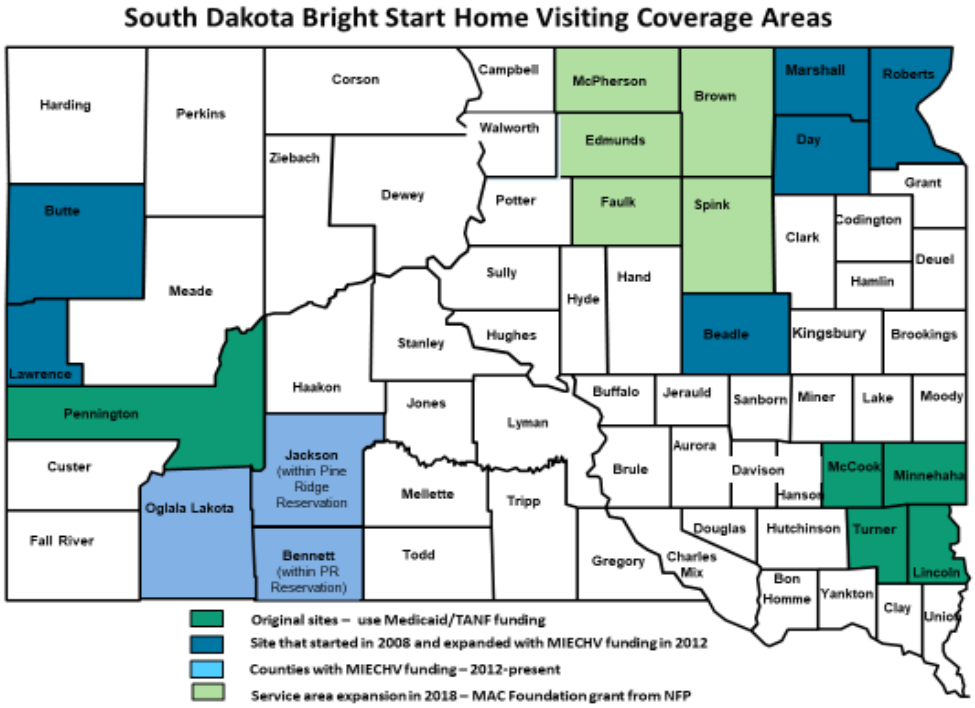
In fiscal year 2020, the Bright Start Home Visiting Program served 596 families and 1127 individual clients across all sites and funding sources.

2025 Needs Assessment Update:

Since 2020, the Bright Start Home Visiting Program has expanded to statewide service delivery in South Dakota. In 2021 the Legislature approved additional Medicaid and state general funds for Nurse Family Partnership and expanded enrollment for pregnant women and new parents. In order to expand service delivery, the Department of Health entered into subrecipient contracts with three partners: Children's Home Society of South Dakota (an existing partner), Black Hills Special Services Cooperative, and the South Dakota Foundation for Medical Care. These partners employ nurse home visitors who work alongside the SDDOH staff to support families across the state.

In fiscal year 2024, the Bright Start program served 625 families and 1110 individuals across all sites and funding sources.

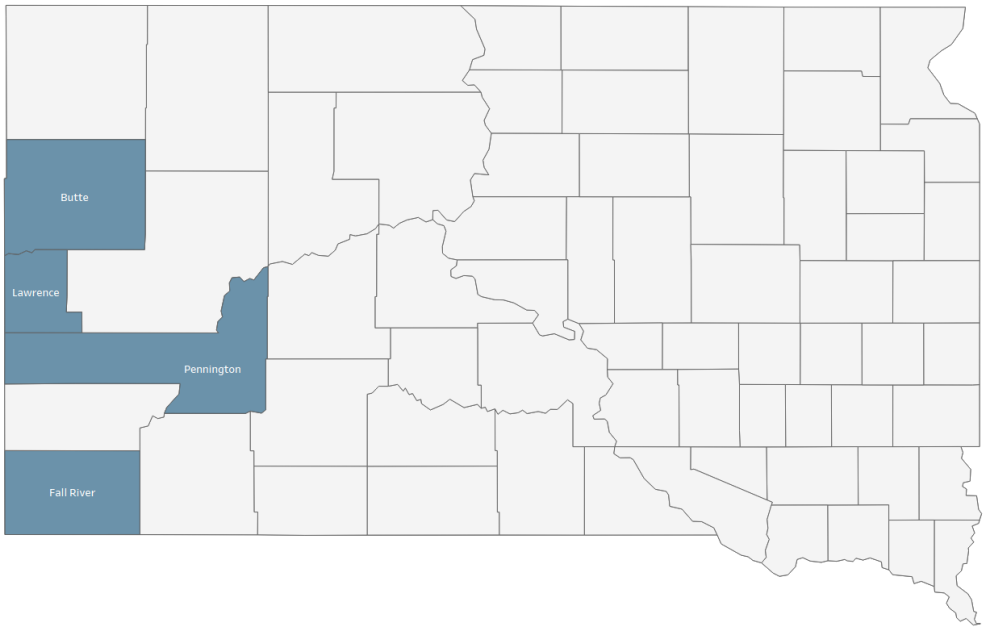
Figure 13: Bright Starting Home Visiting Coverage (outdated – from 2020)



Families First Home Visiting

In 2023, South Dakota added a new model to their home visiting service delivery offering to include the evidence-based Parents as Teachers model. PAT home visiting services are offered through a subrecipient agreement with Black Hills Special Services Cooperative and operate under the program name of Families First. Home visiting services are available for families with children from birth to kindergarten entry. Parent educators support parents in building nurturing relationships, promoting optimal development, and achieving their family goals. From October 1, 2023-September 30, 2024, Families First home visitors served 41 families, including 51 caregivers and 61 children, and completed 347 home visits. A map highlighting the service delivery area for Families First is featured below.

Figure 14: Families First Home Visiting Coverage



Tribal MIECHV Programs

South Dakota is home to nine tribes, all members of the Great Sioux Nation. Three of these tribes are served by Tribal Maternal Infant and Early Childhood Home Visiting (T-MIECHV) programs: Crow Creek, Lower Brule, and Sisseton Wahpeton. These tribal nations encompass the South Dakota counties of Buffalo, Lyman, Roberts, Marshall, and Day.

Shared Waters is the T-MIECHV program that serves Crow Creek and Lower Brule reservations in central South Dakota and implements the Parents as Teachers model. Crow Creek Tribal School is the grantee. This program began enrolling clients in 2018 and served 35 families in the most recent fiscal year, with a total capacity of 60 families.

Strengthening and Encouraging Families is the T-MIECHV program that serves the Sisseton Wahpeton Oyate of the Lake Traverse Reservation in northeast South Dakota. They are implementing the Family Spirit model, and Great Plains Tribal Chairmen's Health Board is the grantee. The program recently began enrolling clients in the Spring of 2020 and have enrolled 11 families to date, with a full capacity of 40 families. Strengthening and Encouraging Families (SEF) is a home visiting program that will serve

families, prenatal to 5 years-old, that reside within or near the boundaries of the Lake Traverse Reservation. The program is specialized to serve families affected by substance use disorders, those involved in the criminal justice system and those experiencing homelessness This program's service delivery area overlaps with Bright Start Home Visiting and the Enemy Swim Day School FACE program.

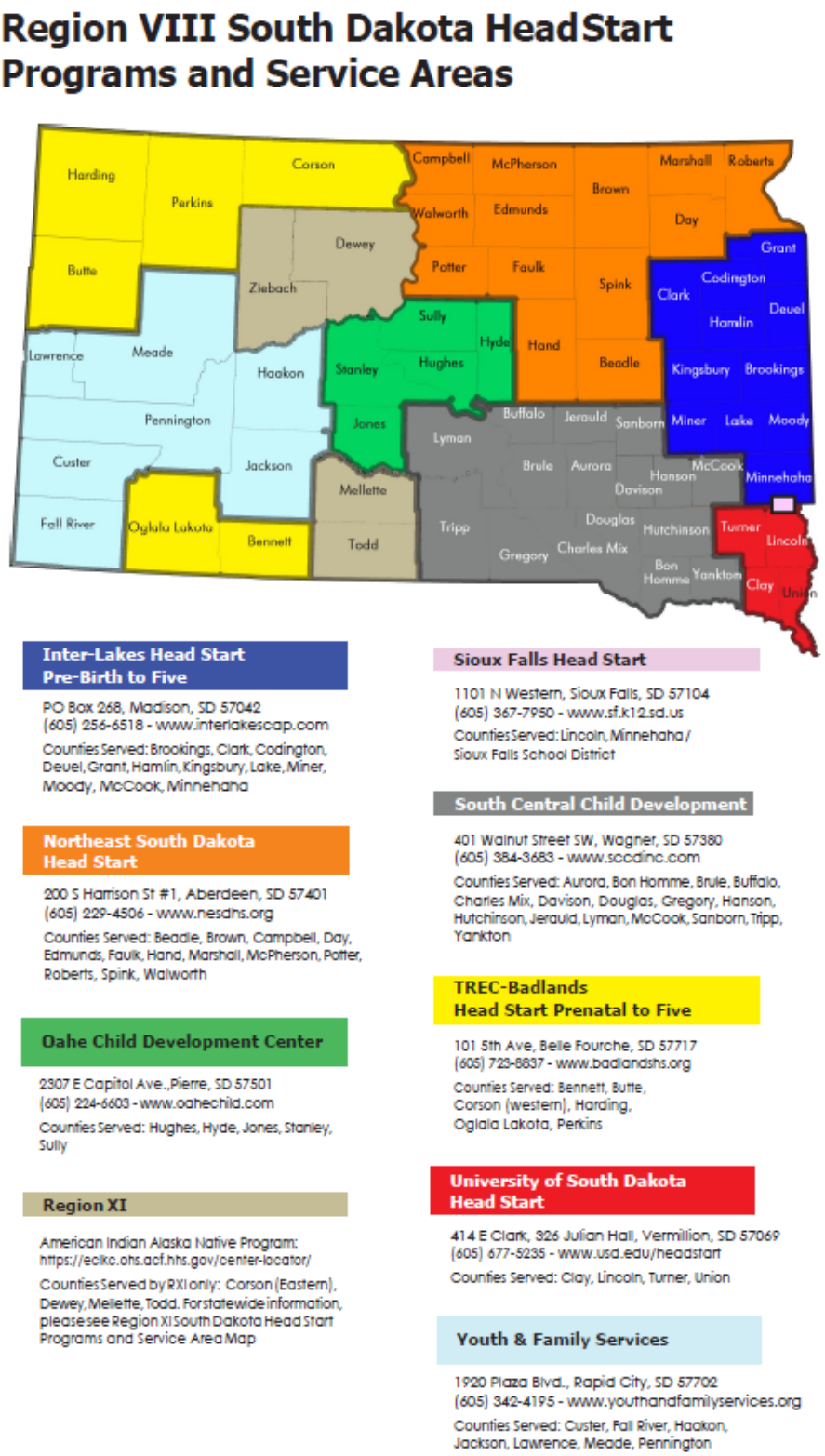
Early Head Start and Home-Based Head Start

South Dakota Head Start offers three different programs to serve low-income children and their families. The services may include learning experiences; health programs including immunizations, medical, dental, mental health, and nutrition services; parental involvement including parent education and program planning; and social services to each family as their needs are determined. Head Start services may be provided in a center or at home. The three programs operated in South Dakota include:

- **Center-Based Head Start**, provides services to children who meet in a central location and participate in classroom activities for half- or full days for 3-5 days per week. Meals and snacks are provided, and children receive a variety of learning experiences to foster intellectual, social, and physical development. Center-Based Head Start enrollment is not reflected in the Service Delivery Table.
- **Home-Based Head Start** programs provide services to families through a Home Visitor who goes into the child's home weekly and helps parents provide for their children the same kinds of developmental opportunities available in center-based programs. This program uses the Parents as Teachers evidence-based model and numbers are reflected in the Service Delivery Table.
- **Early Head Start** programs provide services for low-income families with children under three years old and for pregnant women. These services include in- and out-of- home education; home visits; parent education including parent-child activities; health services; nutrition; and ongoing support for parents through case management and peer support. This program uses the Parents as Teachers evidence-based model and numbers are reflected in the Service Delivery Table.

The South Dakota program has eight American Indian/American Indian/Alaska Native (AI/AN) and eight non-tribal programs working to provide services to children in the state. All AI/AN grants are funded through the Regional Office XI in Washington, DC, and the non-tribal programs are funded through Regional Office VIII in Denver. Head Start programs in South Dakota use federal funds to provide services and most grantees at the community level operate nine-month, half-day, four-day-a-week programs. Four grantees offer a full-day/full-year center- based option of some of their sites. Some programs are licensed childcare centers that provide comprehensive center- and home-based options. Early Head Start grantees operate year-around, with some providing full-day services for qualifying families. Five of the non-tribal programs include home visiting services, and none of the tribal Early Head Start Programs do. Figure 9 outlines the South Dakota Head Start Services Areas.

Figure 15: South Dakota Head Start Service Areas



In 2018 and 2019, South Dakota's Head Start and Early Head Start Programs provided services to 123 pregnant women, 1382 infants/toddlers ages 0-2, and 4,161 children ages 3-5.

Enemy Swim Day School FACE Program

FACE (Family and Child Education) was initiated in 1990 and currently has programs in 49 Bureau of Indian Education (BIE) funded schools across the country. It was designed as a family literacy program and an integrated model for an early childhood/parental involvement program for American Indian families in BIE-funded schools. Evaluation indicates that FACE programs are succeeding in addressing achievement gaps for American Indian children primarily located on rural reservations, and in better preparing them for school.

The FACE program is a national education model for children, prenatal through age eight and their parents or primary care givers. FACE's focus is on literacy, life-long learning, school readiness, and enhancing native language and culture.

FACE Components

- Center Based Adult/Parent Education
- Early Childhood Education
- GED Readiness/Completion
- Home based Parent Education
- Basic Computers
- Employability Skills

In SD, there is one FACE program that includes home visits in its programming. This program is in Enemy Swim Day School in Waubay, which is a Sisseton Wahpeton tribal school. This program uses the Parents as Teachers evidence-based model.

Parent Support Programs with Home Visiting as an Ancillary Service

In South Dakota, there are several programs that include home visits as a service, however those visits are not the primary intervention of the programs. Their service delivery numbers are not included in Table 2 below.

SD Birth to Three contributes to the success of children from birth to 36-months of age with developmental delays and their families by providing individualized early intervention services and supports. Birth to Three builds on family strengths through encouraging every-day routines and learning experiences. In 2019, SD Birth to Three implemented the evidence-based curriculum "Getting Ready" developed by the University of Nebraska-Lincoln (known as "Bright Beginnings" in SD), which is an approach that encourages parental engagement, particularly for families living in poverty.

SD Birth to Three Components:

- A family-focused, in-home service for children from birth to 36 months of age with developmental delays.
- A system of services and supports for families to help understand their child's development and specific training to assist the family in addressing these areas of delay.
- A process that helps the adults in a child's life learn to help the child develop.
- A collaboration with the child's parents, caregivers, childcare providers, professionals, and others – not just the child.
- A voluntary system.

In addition to the SD Birth to Three program which has statewide coverage, several of the tribal nations implement their own early intervention programs that may or may not include home visits.

Great Plains Healthy Start has been serving families of the Great Plains Region of the Indian Health Service by supporting American Indian families to ensure every child gets the chance they deserve to have a "healthy start" in life. The program goals are to 1) improve women's health before, during and after pregnancy, and 2) help families care for their infants through their first 18 months, so they are healthy and ready to learn.

Great Plains Healthy Start is a community-based program using Community Health Workers (CHW's) to deliver a variety of services to women of childbearing age, their partners, and children from birth to 18 months. CHW's are paraprofessional health educators trained in the Family Spirit curriculum. The services are available in the following South Dakota communities:

- Cheyenne River
- Crow Creek
- Rapid City
- Oglala Lakota/Pine Ridge
- Sisseton Wahpeton
- Standing Rock

Project Indigenous LAUNCH (I-LAUNCH) programs operate in two tribal locations: on the Sisseton Wahpeton of the Lake Traverse Reservation and the Rosebud Reservation. Both locations use the Family Spirit curriculum with enrolled families.

Sisseton Wahpeton Oyate Project Indigenous LAUNCH will serve American Indian families with children from 0-8 years of age who reside on the Lake Traverse Reservation. The program goal is for children to thrive in safe, supportive environments and enter school ready to learn and able to succeed. In order to achieve this goal, the project will increase the percent of mothers screening positive for depression during the first one thousand days of a new baby's life (from conception to age 2) who are successfully recruited to participate in preventive, culturally grounded, trauma-informed, practice-informed, and evidence informed services to 75% by September 29, 2022. SWO is working to expand and enhance its home visiting capacity through replication of the Family Spirit Program. The project will also implement the Infant/Early Childhood Mental Health Consultation model, another evidence-based project that teams a mental health professional with early childhood program staff and caregivers to improve the social, emotional, and behavioral health of children in early childhood programs. It promotes mental health and wellness and reduces the impacts of toxic stress and trauma, including historical trauma and adverse childhood experiences. Maternal depression is a significant risk factor affecting the well-being and school readiness of children. Disproportionately, it impacts low-income parents whose depression is embedded in their life circumstances, poverty, lack of social supports and networks, substance abuse, intimate partner violence, childhood abuse, and stress linked to a life of hardship and hopelessness. The aims of this project include increased parenting knowledge, increased parent self-efficacy, reduced parental stress, decreased maternal depression and substance abuse, and fewer behavior problems in young children.

The Great Plains Tribal Chairmen's Health Board/Rosebud Sioux Tribe (GPTCHB/RST) Project I-LAUNCH serves children ages 0-8 years old and their families living on and near the Rosebud Indian Reservation. Using the public health approach, the project will focus on a two-prong strategy that strengthens the capacity and infrastructure of MCH systems in the community and increases support to families through enhanced direct services. The project seeks to create a coordinated care environment; improve continuity of care, strengthen communications and collaborations between agencies, service provides,

families; and build on strengths to provide direct services that are evidence based, culturally appropriate, and client centered. A Collective Impact framework and approach ensure that complex issues are addressed using strengths-based methods. The project will bring wellness in the following ways:

- Strengthen referral and data collection systems among clinical and community partners;
- Multi-sectoral case management meetings;
- Expand on early child development;
- Expand the workforce by hiring mothers that have benefitted from MCH services as peer mentors or administrative support;
- Provide continuing education and professional development opportunities to MCH outreach workers in critical areas (such as Mental Health First Aid and Motivational Interviewing);
- Extend outreach services to benefit all prenatal clients (not just "medically high risk");
- Introduce life skill coaching/training for parents;
- Integrate traditional cultural ceremonies (such as the amulet/star blanket and cradleboard) as part of the work with young families; and
- Develop new/innovative ways to work with pregnant mothers.

Statewide Home Visiting Coverage

Table 7 lists all South Dakota counties and approximates statewide coverage of home visiting services. The data specific to identified at-risk counties is in Table 7 of the Needs Assessment Data Summary Excel file.. In addition to this county-level data, the National Home Visiting Resource Center compiles an annual survey of Home Visiting coverage in each state. The 2024 report can be found here: https://nhvrc.org/state_profile/south-dakota-2024/

Table 7: Home Visiting Services by County (Updated for 2025)

County	Served by Evidence Based Home Visiting	Currently Served by MIECHV-funded Home Visiting	Number of Families Served in last FY by State funded program	Estimated Need of Eligible Families in the County
Aurora	NFP	No	2	5
Beadle	NFP	Yes	58	37
Bennett	NFP	Yes	8	47
Bon Homme	NFP	No	2	14
Brookings	NFP	No	16	69
Brown	NFP	No	26	148
Brule	NFP	No	5	11
Buffalo	NFP PAT (Tribal)	Yes (State and Tribal)	1	28
Butte	NFP PAT	Yes	23	42
Campbell	NFP	No	0	5
Charles Mix	NFP	No	7	128
Clark	NFP	No	2	14
Clay	NFP	No	4	29

County	Served by Evidence Based Home Visiting	Currently Served by MIECHV-funded Home Visiting	Number of Families Served in last FY by State funded program	Estimated Need of Eligible Families in the County
Codington	NFP	No	13	106
Corson	NFP	Yes	0	57
Custer	NFP	No	4	35
Davison	NFP	No	28	40
Day	NFP PAT (Tribal)	Yes (State and Tribal)	3	21
Deuel	NFP	No	0	16
Dewey	NFP	No	0	78
Douglas	NFP	No	0	6
Edmunds	NFP	No	0	15
Fall River	NFP PAT	Yes	10	94
Faulk	NFP	No	0	9
Grant	NFP	No	4	27
Gregory	NFP	No	4	57
Haakon	NFP	No	1	26
Hamlin	NFP	No	3	23
Hand	NFP	No	2	7
Hanson	NFP	No	0	7
Harding	NFP	No	0	5
Hughes	NFP	Yes	14	239
Hutchinson	NFP	No	1	15
Hyde	NFP	No	0	18
Jackson	NFP	Yes	2	45
Jerauld	NFP	No	0	4
Jones	NFP	No	0	13
Kingsbury	NFP	No	6	10
Lake	NFP	No	3	26
Lawrence	NFP PAT	Yes	26	104
Lincoln	NFP	No	14	188

County	Served by Evidence Based Home Visiting	Currently Served by MIECHV-funded Home Visiting	Number of Families Served in last FY by State funded program	Estimated Need of Eligible Families in the County
Lyman	NFP	Yes (State and Tribal)	4	52
Marshall	NFP	Yes (State and Tribal)	2	11
McCook	NFP	No	2	9
McPherson	NFP	No	1	188
Meade	NFP	No	15	114
Mellette	NFP	No	1	28
Miner	NFP	No	2	5
Minnehaha	NFP	No	149	811
Moody	NFP	No	4	13
Oglala Lakota	NFP	Yes	31	196
Pennington	NFP PAT	Yes	124	451
Perkins	NFP	No	0	12
Potter	NFP	No	1	9
Roberts	NFP PAT (Tribal)	Yes (State and Tribal)	14	39
Sanborn	NFP	No	0	5
Spink	NFP	No	0	24
Stanley	NFP	No	1	41
Sully	NFP	No	0	20
Todd	NFP	No	1	137
Tripp	NFP	No	6	75
Turner	NFP	No	2	17
Union	NFP	No	2	31
Walworth	NFP	No	1	21
Yankton	NFP	No	13	46
Ziebach	NFP	No	1	38

Table 8: Home Visiting Services by County (Original 2020 submission)

	Home Visiting services reach <25% of estimated eligible families
	Home Visiting Services reach 25-75% of estimated eligible families
	Home Visiting services reach >75% of estimated eligible families
	Identified At-Risk Counties

County	Served by any Home Visiting Program	Served by Evidence Based Home Visiting	Served by MIECHV-funded Home Visiting	Estimated Number of Families Served in last FY	Estimated Need of Eligible Families in the County
Aurora	No	No	No	0	5
Beadle	Bright Start	NFP	Yes	50	37
Bennett	Bright Start	NFP	Yes	4 -site combined with Oglala Lakota and Jackson	47
Bon Homme	No	No	No	0	14
Brookings	Early Head Start	No**	No	29	69
Brown	Bright Start	NFP	No	36	148
Brule	No	No	No	0	11
Buffalo	Shared Waters	PAT	Yes (Tribal)	25	28
Butte	Bright Start and Early Head Start	NFP and PAT	Yes	57	42
Campbell	No	No	No	0	5
Charles Mix	No	No	No	0	128
Clark	No	No	No	0	14
Clay	Early Head Start	PAT	No	24	29
Codington	Early Head Start	No**	No	21	106
Corson	No	No	No	0	57
Custer	Home Based Head Start and Early Head Start	PAT	No	11	35
Davison	No	No	No	0	40
Day	Bright Start and FACE	NFP and PAT	Yes	6	21
Deuel	Early Head Start	No**	No	1	16
Dewey	No	No	No	0	78
Douglas	No	No	No	0	6
Edmunds	No	No	No	0	15

County	Served by any Home Visiting Program	Served by Evidence Based Home Visiting	Served by MIECHV-funded Home Visiting	Estimated Number of Families Served in last FY	Estimated Need of Eligible Families in the County
Fall River	Yes	PAT	No	12	94
Faulk	No	No	No	0	9
Grant	Early Head Start	No**	No	4	27
Gregory	No	No	No	0	57
Haakon	Home Based Head Start and Early Head Start	PAT	No	4	26
Hamlin	No	No	No	0	23
Hand	No	No	No	0	7
Hanson	No	No	No	0	7
Harding	Early Head Start	PAT	No	10	5
Hughes	Early Head Start	PAT	No*	29	239
Hutchinson	No	No	No	0	15
Hyde	Early Head Start	PAT	No	10	18
Jackson	Bright Start, Home Based Head Start and Early Head Start	NFP and PAT	Yes	10	45
Jerauld	No	No	No	0	4
Jones	Early Head Start	PAT	No	10	13
Kingsbury	Early Head Start	No**	No	1	10
Lake	Early Head Start	No**	No	22	26
Lawrence	Bright Start, Home Based Head Start and Early Head Start	NFP and PAT	Yes	72	104
Lincoln	Bright Start and Early Head Start	NFP and PAT	No	54	188
Lyman	Shared Waters	PAT	Yes - Tribal No -State*	5	52
Marshall	Bright Start	NFP	Yes	3	11
McCook	No	No	No	0	9
McPherson	No	No	No	0	188
Meade	Home Based Head Start and Early Head Start	PAT	No	24	114

County	Served by any Home Visiting Program	Served by Evidence Based Home Visiting	Served by MIECHV-funded Home Visiting	Estimated Number of Families Served in last FY	Estimated Need of Eligible Families in the County
Mellette	No	No	No	0	28
Miner	Early Head Start	No**	No	2	5
Minnehaha	Bright Start and Early Head Start	NFP and non-evidence based	No	205	811
Moody	Early Head Start	No**	No	3	13
Oglala Lakota	Bright Start	NFP	Yes	64	196
Pennington	Bright Start, Home Based Head Start, and Early Head Start	NFP and PAT	No	224	451
Perkins	Early Head Start	PAT	No	11	12
Potter	No	No	No	0	9
Roberts	Bright Start, Strengthening and Empowering Families, and FACE	NFP, Family Spirit and Parents as Teachers	Yes - State and Tribal	29 -MIECHV 11-T-MIECHV 28-non-MIECHV 68 TOTAL	39
Sanborn	No	No	No	0	5
Spink	No	No	No	0	24
Stanley	Early Head Start	PAT	No*	0 (combined with Hughes and Sully)	41
Sully	Early Head Start	PAT	No	1 (combined with Hughes and Stanley)	20
Todd	No	No	No	0	137
Tripp	No	No	No	0	75
Turner	Early Head Start	PAT	No	12	17
Union	Early Head Start	PAT	No	23	31
Walworth	No	No	No	0	21
Yankton	No	No	No	0	46
Ziebach	No	No	No	0	38

*This area had MIECHV funded services until April 2020. MIECHV client numbers not included in prior FY total

**Early Head Start program through Interlakes Community Action Program does not use PAT curriculum

Home Visiting Provider Survey Results

In the fall of 2019, home visiting staff and administrators voluntarily completed an electronic survey to gather data on program capacity, strengths and gaps as perceived by the home visiting workforce in the state. The survey was introduced at the 2019 South Dakota Home Visiting Institute, an event that is held

every two years and is convened by the South Dakota Head Start Association. Thirty-seven respondents included 18 home visitors, 11 local team leads/supervisors, five program administrators, and three clerical/program support staff. Respondents reported working for South Dakota Bright Start, various Early Head Start agencies, both Tribal MIECHV programs, FACE, Birth to Three, and Sisseton Wahpeton Oyate Indigenous LAUNCH. Findings from the survey are outlined in figures 10-14. The survey can be found in **Appendix B**.

Figure 16: Distance Traveled

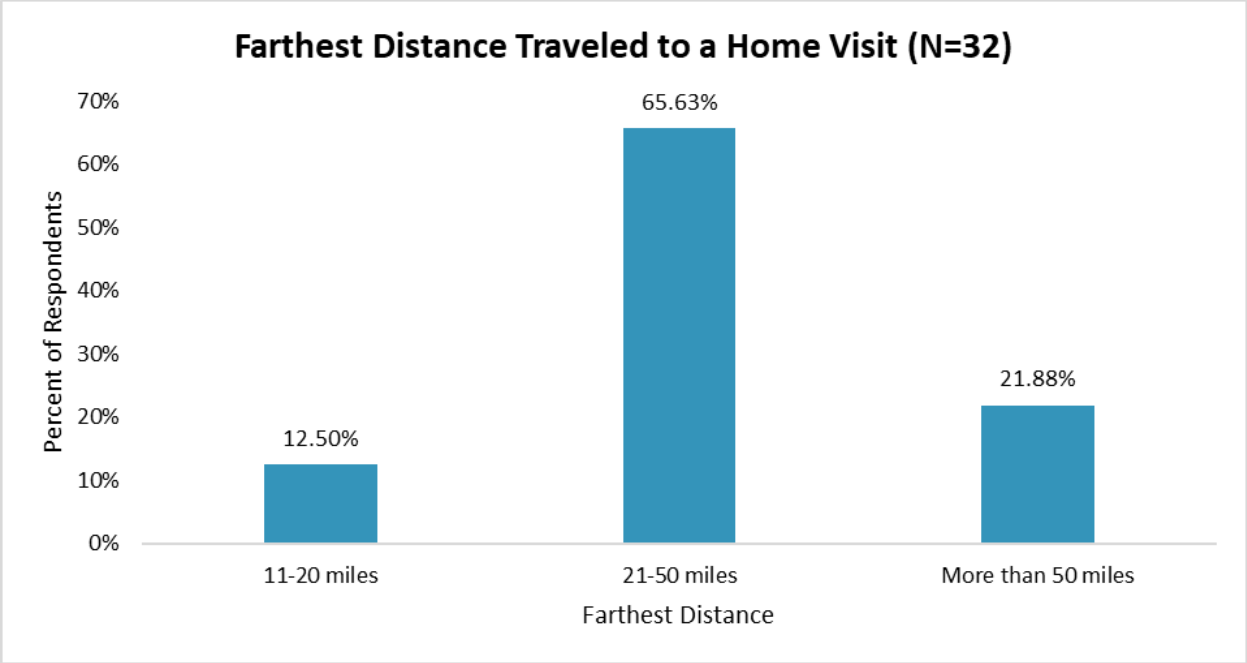


Figure 17: Strengths of HV Program

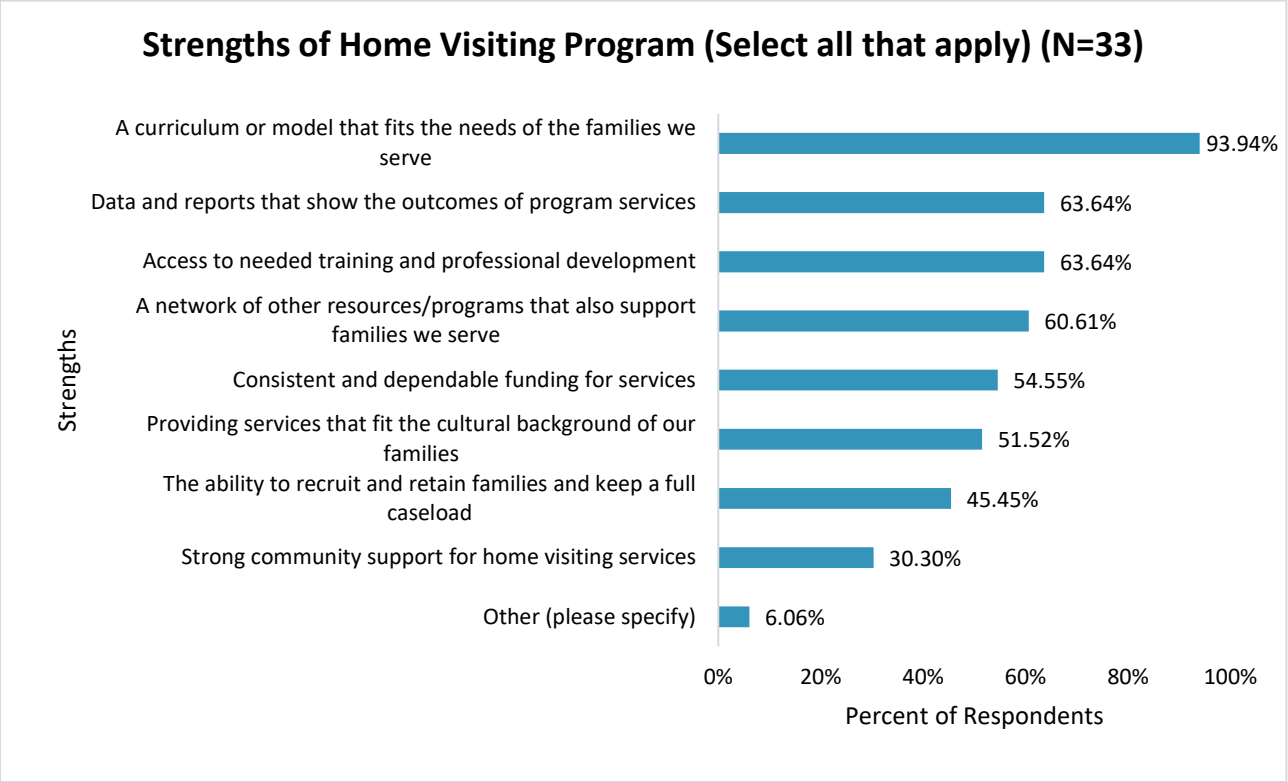


Figure 18: Challenges of Home Visiting Programs

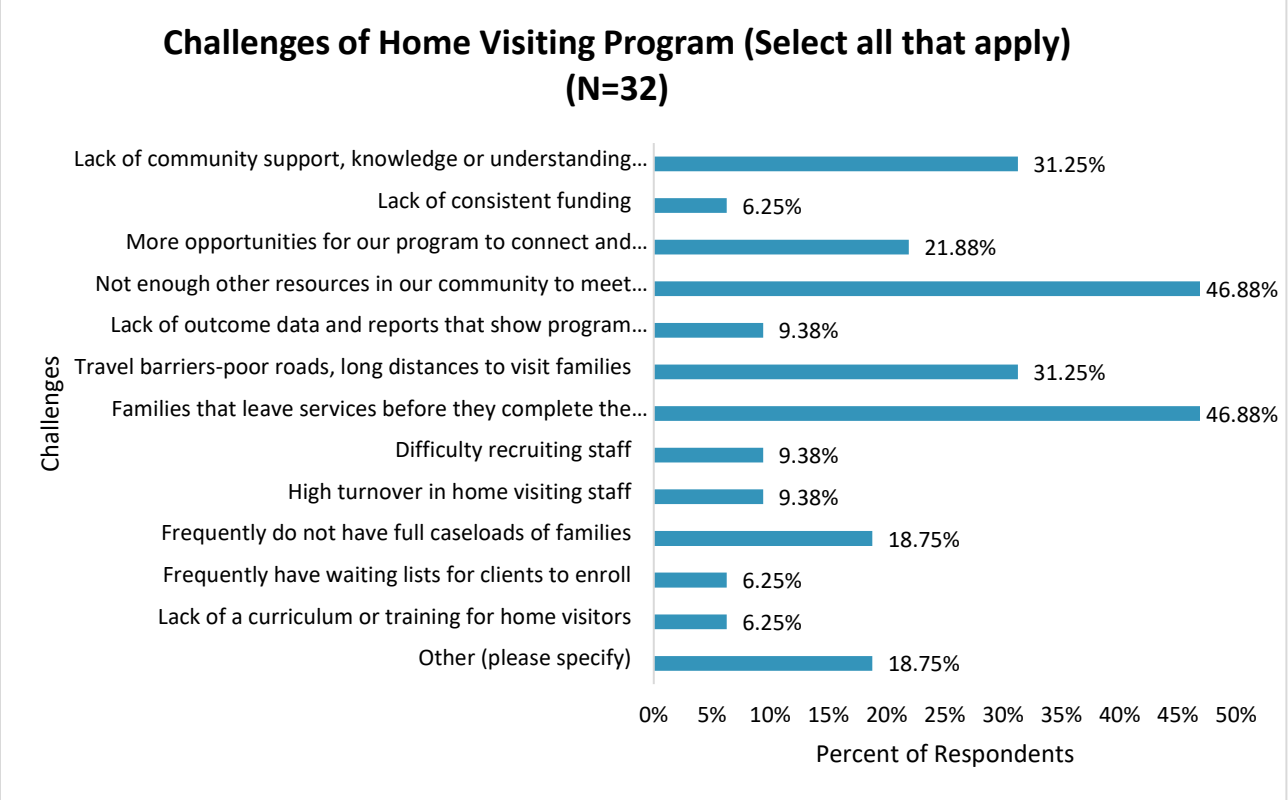


Figure 19: Challenges of Families Served

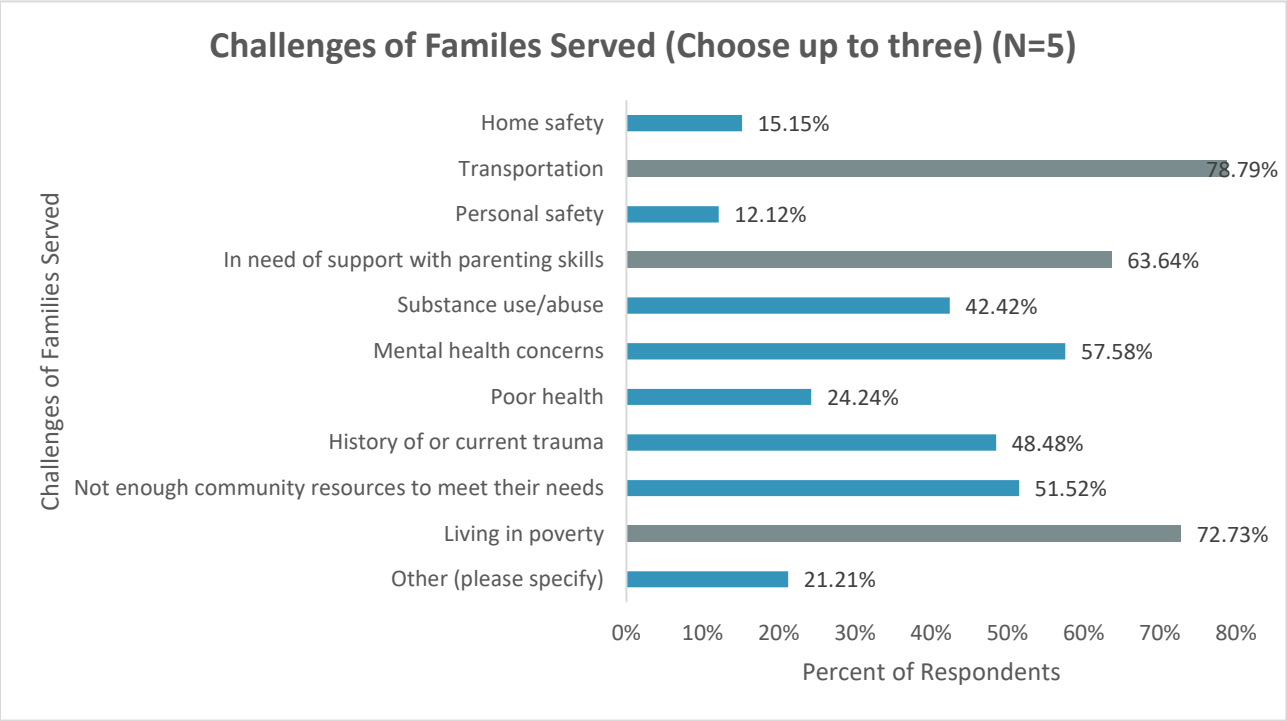
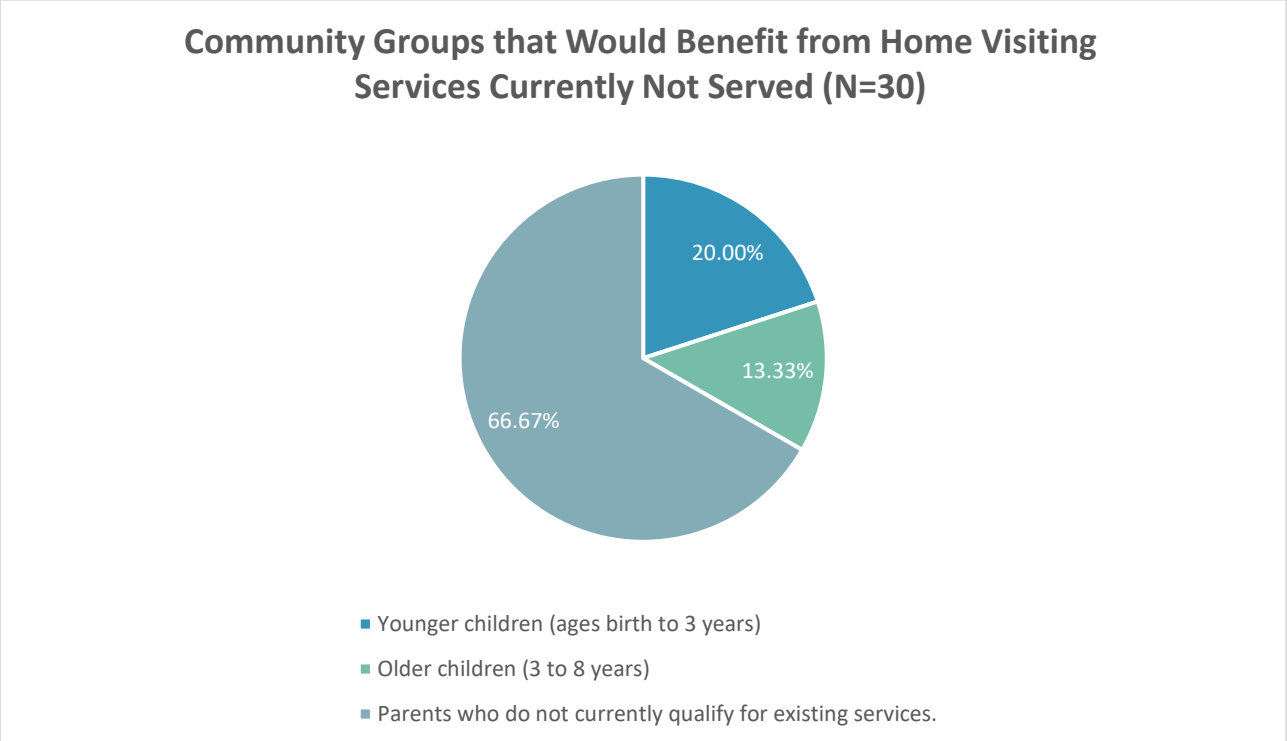


Figure 20: Underserved Groups



Additionally, home visitors and program staff were asked to share what inspires them most about working in this field. As evidenced by these comments, a small but dedicated workforce is a strength of South Dakota's home visiting programs.

- *Serving at-risk, first time moms and their families to overcome some of the most difficult obstacles.*
- *Relationships with families*
- *Being able to help families with the resources they need.*
- *The families that we help are very grateful for the program and they enjoy having the home visitors come to see them.*
- *Seeing the small changes in our clients working toward becoming better parents and reaching their goals. Seeing that they are benefiting in some way from the services we provide.*
- *Watching the small positive changes our clients make in their lives. Empowering young women.*
- *The direct and positive impact it can have on the entire family.*
- *I enjoy making a difference and seeing the progress that parents make with their children!*
- *Getting upstream to do prevention work and mitigate the toxic effects of trauma from adverse childhood experiences that is so detrimental to brain development and lifelong health.*
- *The ability to assist families and grow their confidence and competence in working with their child.*
- *Empowering parents to be the first and foremost teacher in their child's life.*
- *Being able to educate and connect with first time mothers, while instilling the knowledge and skills necessary to be a successful parent.*
- *Seeing clients make progress towards long-term goals, especially related to economic self-sufficiency*
- *Seeing clients who grew up in dysfunctional families can learn parenting/life skills and break the cycle of a dysfunctional home life. Their kids' future is much brighter when this happens. Children will learn more, have better social skills and have a better chance at being a responsible adult in the future.*
- *I am a family service worker so for me it is, helping to reach these parents and children and make a difference in any way I can. I want to make a difference.*
- *Being able to be a large piece of their support system and be able to just be there for their journey. The flexibility is amazing being able to meet them at their homes as many have a lack of transportation and it also helps build that trust and relationship by them allowing you to come into their home.*
- *My biggest inspiration/motivation for working in this field is to provide families with hope. From my own experience living and working on reservations, hope (or lack thereof) is a factor that can make or break a family. Knowing that we have the power to provide families with their own motivation to discover their own strengths to survive and thrive is truly gratifying.*

Needs of Pregnant and Parenting Families in South Dakota

Key informant interviews were conducted with professionals and pregnant and parenting families from a variety of communities around the state in the summer of 2020 to further explore the strengths and challenges identified in the Home Visiting Provider Survey. Professionals included home visitors, community leaders, and directors of family support programs. Families included past clients of home visiting programs as well as families who had not participated in home visiting. See the Key Informant Interview Guide in **Appendix C**.

The interviews of professionals and families were analyzed and five key themes specific to the needs/issues that affect pregnant and parenting families in SD were identified:

Social needs, the downstream indicators of the impact of the social determinants of health, such as housing, food security, and childcare, play a key role in shaping needs/issues that impact pregnant and parenting families in SD. Key informants identified a lack of resources and social services, poverty, food insecurity, affordable childcare, and housing availability as subthemes of social needs. Resources and social services identified as lacking to support self-sufficiency include limited access to Women, Infant and Children (WIC) and decreased eligibility for the Supplemental Nutritional Assistance Program (SNAP) due to previous or current employment status. Poverty plays a significant role in shaping needs and issues, including for pregnant and parenting families living in SD tribal communities. A lack of affordable, quality housing presents challenges to a safe place to live in communities across the state. Access to affordable childcare was indicated as an issue too, including childcare for parents to get to an appointment. Food insecurity - household-level economic and social condition of limited or uncertain access to adequate food - impacts pregnant and parenting families in SD, including underserved regions and populations of SD where many people live in one house. Also, a lack of transportation and transportation systems are a large need and issue that impacts pregnant and parenting families' ability to access resources and services and navigate the rural geography.

Access to health care and services is also identified need/issue that impacts pregnant and parenting families in SD. SD did not expand Medicaid, and eligibility for the program as is was indicated noted as an issue, including a gap between people who qualify for Medicaid and those who cannot afford insurance, as well as access to the type of services that are allowed depending on which category a person is enrolled in (pregnancy, low-income, Child Health Insurance Program, etc.). Access to oral health services and poor oral health hygiene impacts pregnant and parenting families as well as children due to a lack of community dental facilities and a lack of Medicaid coverage. Mental health services are lacking to support pregnant and parenting facilities living in tribal communities. Also, many communities across SD do not have a home visiting program, which impact pregnant and parents' family's access to needed services and support by family support providers.

Access to resources is an issue across the state in both rural and urban areas that impacts pregnant and parenting families. For example, there is a lack of access to low-cost/no-cost activities for children from low-income families. In addition, a general lack of awareness and utilization of existing resources is an issue fostered by lack of broadband internet and outreach to pregnant and parenting families, including those living in rural, underserved communities across the state.

A lack of consistent family and parenting support plays a key role in in the needs and issues that impact pregnant and parenting families across SD. Families do not have extended family nearby to provide emotional, mental, and even childcare support. Families struggle to meet the needs of their children with the lack of support. Positive role models do not exist in some of SD's tribal communities to support parents to parent appropriately, impacted by generational trauma and generation of children who lost parenting support. Emotional support is also lacking to help provide positive encouragement to parents. In addition, some family units are parented by grandparents and there is lack of a support circle to help navigate parenting challenges or concerns.

Substance misuse impacts pregnant and parenting families in communities across SD, including an increase in drug use among pregnant women. SD's current laws that criminalize addiction were indicated as playing a key role impacting pregnant women who are using drugs to not seek prenatal care. Substance misuse is at times connected to social needs, including poverty, lack of housing, and the lack of ability for parents to provide basic needs for children. It was also noted young parents struggle

and give up or lose parental rights due to drug and alcohol use in some underserved populations in SD. Substance abuse also leads to shifting parenting duties to grandparents.

Other needs and issues identified by some participants include chronic diseases and associated risk factors, such as diabetes, cancer, and poor nutrition; and health literacy impacted by cultural norms and beliefs, such as understanding the importance of immunizations, preventative screening, and dental visits. Perceived stigma from healthcare providers was also indicated as an issue for younger pregnant and parenting families, including assumptions about parenting knowledge and concerns.

Barriers to Success Identified by Programs and Families

Professionals and pregnant and parenting families identified barriers to addressing the above identified needs and issues, including:

A lack of transportation was noted as a need impacting families; however, it was also indicated as barrier to accessing resources and services as well as health care services, especially in rural communities. Some families do not have a vehicle and/or rely upon family and friends to transport them to services and appointments. In communities where there is public transportation, it is not reliable and often confusing to navigate.

Access to care and services presents barriers, including utilization of state programs and lack of health care providers. The hours of service that WIC is available, such as only being open during regular business hours, presents a barrier which impacts some employed parents' ability to access WIC. However, the shift to telephone visits due to COVID-19 has been positive and welcomed by clients. In addition, a lack of comprehensive substance abuse treatment services and facilities contributes to substance abuse issues impacting pregnant and parenting families. For example, available treatment facilities are in a neighboring community which is challenging for some families to access due to a lack of transportation. Substance abuse treatment services and facilities available present challenges to utilization due to a wait list to receive services, a lack of mental health and substance abuse professionals, as well as existing state laws that punish rather than treat substance abuse issues. Also, Medicaid services that support dental care are in a community more than 75 miles away, making it a challenge to access services due to a lack of transportation, scheduling conflicts and other pressing issues. The type of Medicaid (pregnancy coverage vs. low-income coverage) was also indicated as a barrier to access care and services.

Social needs were also identified as a barrier by professionals and families. Access to affordable childcare presents a barrier to the family unit shaped in part by a lack of nearby family support. Broadband access is also a barrier for many communities across SD, specifically rural communities. Pregnant and parenting families face barriers due to access to reliable Wi-Fi and communication services. For example, a resource guide was developed to support underserved families in a rural SD community, however, due to a lack of access broadband access, many families were unable to access it. Income and poverty also present barriers to addressing most identified needs and issues.

Other barriers noted by professionals include the lack of home visiting presence in some communities across the state. In order to effectively support pregnant and parenting families in SD and encourage utilization of services, time is needed to build trust between professionals and families, however time if often unavailable with families due to families moving in and out of communities. Having general knowledge of healthy eating behaviors was also indicated as a barrier to addressing chronic disease and

associated risk factors that impact some pregnant and parenting families in SD. Also, underutilization of existing resources such as Birth to Three early intervention or prenatal care was noted as barrier to pregnant and parenting families receiving support. Providers feel that although resources do exist, underutilization is shaped by poverty, lack of transportation, and lack of affordable childcare.

Opportunities for Home Visiting to Address Identified Needs and Barriers

> *"Without the Bright Start Home Visiting Program, I would not... We would be in a horrible place right now. They saved this family because it would have been a mess without them." -Past Bright Start client*

> *"I really think the nurse that we had was just the best one ever, and... Anything she didn't know, she would go to find out and get back to us, and... I don't know. She just took really good care of us, and we considered her a part of our family." -Past Bright Start client*

Home visiting programs provide structured visits by trained professionals and paraprofessionals to high-risk parents to fill the gap in many of the barriers identified in the survey and key informant interviews. Home visiting supports families by providing health assessments and screenings, assisting with referrals to needed resources, parenting support, and guidance with navigating other programs and services in their community. In the case of programs that implement evidence-based models, there is the requirement of data collection, reporting and evaluation to ensure that the models' expected outcomes are met in local implementation. There are several factors in SD that may support or challenge existing programs' abilities to deliver services.

Factors contributing to the quality and capacity of home visiting services:

Evidence-Based Services with Fidelity to the Model: In SD, Nurse Family Partnership, Family Spirit and Parents as Teachers are the three models broadly represented. The South Dakota Bright Start Program can demonstrate the extent to which services meet the needs of families through a robust system of data collection and reports available through the Nurse Family Partnership model. With ongoing data review, performance measurement, and continuous quality improvement, the Bright Start Program administration and local staff can identify trends and adjust services (within Program and model guidelines) to better meet the needs of families. As additions or changes to service delivery are considered based on this Needs Assessment, NFP reports will guide South Dakota Bright Start's decision making. For the purposes of this Needs Assessment, program outcomes were not requested from other home visiting models and agencies in the state.

Relationship-based Family Support: Despite what society may presume about the internet as the go-to resource for millennial parents, comments from Key Informant Interviews do not support that:

> *"I'm a person who has to learn in-person, I have to be talking to them either over the phone or in person, to fully understand or grasp the concept of what they're trying to tell me." -Parent not involved in home visiting*

> *"The internet is probably a big resource, or family from their experiences. And then I just try to ask a couple of different resources and then average out to get what I hope is the best answer. Looking things up online can be a double-edged sword, especially if you're looking up some symptom you're worried about, you can work yourself up and get*

incredibly scared and, like, "Oh, they have a runny nose, they must be dying." -Bright Start parent

"There's just so many blogs out there for support groups online for new mothers, and I think a lot of people will turn there before they actually do a physical group for whatever reason. So, I guess in that regard, it can be helpful, like the support and stuff. I just mean if you're looking up a quick question or something, you can get carried away with all the wrong answers, or the worst answers first." -Bright Start parent

"Usually I go to Google. Google can tell me some things, but there's just so many things out there now. 5,000 people ask the same question and there's 5,000 different answers from other people. Even word-of-mouth, somebody could tell me something, and somebody else would tell me something different." -Past Bright Start parent

The relationship between a home visitor and the family is built over time as the nurses or paraprofessionals work with families on goal setting, assess health and family functioning, provide parenting guidance, and assist with resource finding and navigating other support systems.

"I think sitting and talking with our Bright Start nurse about things was probably the most beneficial because you had that person who could sit there with you and talk it out and help you come to the best solution for your kid. And the fact that she also knew my child from before birth, and that's a little bit more personal, I guess, and informed on the specific situation versus just going to the doctor that you see once every few months, or trying to find something on the internet when there's so many different things that you can find on there, but it might not be specific to your situation, I guess." -Bright Start client

"And they're low-income, first-time mommies. Some didn't complete their high school because they have a lot of issues going on at home and they are high risk as far as no resources, no income, no support at home and they have some type of substance abuse or some type of violent issues going on either with their family or with their partner. And a lot of them are lonely, they feel isolated even though they have three or four families living in one home, they still feel that emptiness. When I pick them up, they don't really talk too much. Sometimes they don't answer me. But after maybe the third or fourth visit, then they start contributing to the conversation. And they tell me what's really bothering them and what they want to do. And I tell them that we're here to help them find resources and go back to school to make themselves more self-sufficient, and that they would be able to take care of themselves and their babies. A lot of them don't think they are able to go to college because they just, they're not smart enough, is what they say. But after they start their classes, then they realize that they do know, but they... Nobody really encouraged them." -Bright Start nurse in a tribal community

"Definitely (one of the most useful parenting supports) is my Bright Start nurse. She's wonderful. I love her very much. I'm sad that she's leaving. I mean, I've been with her for three years because I had her throughout my pregnancy, so it's weird that I won't see her anymore. I can just text her whenever, and she'll get back to me as soon as possible." -Bright Start client

"She (the Bright Start nurse) always made herself available, like we could call or text her.

When she visited, and just anything we needed help with, if she didn't have the answer she would say, 'Let me find out and get back to you.' And she's always really on top of everything." -Past Bright Start client

"She was pretty good at checking all aspects, making sure your emotional health was okay, and the physical health was okay, and that you had access to things like WIC and food and diapers and all those kinds of things." -Bright Start client

Geographic and Programmatic Reach: South Dakota's state public health system includes a centralized organizational structure where the state government directly governs the state's 77 local community health offices. The Office of Child and Family Services administers the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), community health nursing, Bright Start Home Visiting program, and the Maternal and Child Health block grant, among others. While OCFS has a huge service delivery and outreach presence, it is just one piece of the efforts to serve the maternal, infant, and early childhood population. Partnerships with other DOH programs, other state agencies, and local entities supplement capacity to meet the needs of South Dakota's young families through Bright Start home visiting. Examples include access to contracted interpreters to serve non-English speaking clients, inclusion in initiatives such as Cribs for Kids/Safe Sleep, a broad array of staff training and support options.

The South Dakota Department of Health is both the grantee and implementing agency for MIECHV funded services, meaning that OCFS-employed nurses and clerical staff based in the local community health offices deliver home visiting services. Bright Start Nurse Family Partnership Home Visiting is not available statewide but is targeted toward communities identified as at-risk in the 2010 MIECHV statewide home visiting Needs Assessment. The Home Visiting Program Manager is the Project Director for the MIECHV grant, and also provides direct programmatic support to the teams of nurse home visitors in the state through policy implementation and interpretation, reflective supervision with local team leads, intermediary support between the Nurse Family Partnership National Service Office and local teams, and as the representative for Home Visiting on state-level teams.

Coordination of service providers: Organizations that serve families in South Dakota have unique skill in coordination of services to maximize resources. Our small communities and limited resources have built unique partnerships and referral pathways to support both families and service providers. This is evidenced by comments from the Home Visiting Provider Survey, Key Informant Interviews, and the Title V Needs Assessment Community Partner Survey. There is always work to be done in this area, particularly with health care and policy systems, but the frequent recognition of the benefits of service coordination show the outcomes of the work that has been done to build systems of care.

"With transportation, one of our Head Start Program regulations for our program is we can only transport an enrolled child and their parents. We cannot transport any siblings. And so even if we can provide transportation to get to a doctor's appointment or a medical appointment, oftentimes, there's no one else left at the home to watch the siblings. If we can partner up with some other type of service could transport the whole family. You know, those things seem to work well, if we can meet those needs of families too." -Early Head Start Program Director

Partnerships to serve tribal communities: South Dakota's home visiting landscape includes both State and Tribal MIECHV programs, and partnerships built between programs is opening discussions on resource distribution to best serve culturally diverse communities. As T-MIECHV programs have

implemented services, first in Crow Creek and Lower Brule in 2018, then in Sisseton Wahpeton in 2020, families have greater choice and access to home visiting options that provide culturally grounded services. Noting that most at-risk counties are located on tribal lands, any consideration of changes to or addition of home visiting services to at-risk areas will involve continued partnership.

Flexibility in service delivery workforce: South Dakota Bright Start and Nurse Family Partnership model elements require that home visitors are Bachelors-prepared registered nurses. Despite this educational requirement in a rural state, nurse recruitment and retention has not been an issue of note for the program. Average time to fill a vacancy is less than two months, and there was one home visitor resignation out of eight positions in the past fiscal year. The exception to this difficulty in recruitment was in the Pine Ridge community in 2017-18, where we had two home visitor vacancies, with one position open for 12 months and one open for 18 months. The program was able to realign service delivery areas to provide coverage by nurses from Rapid City. Also, Nurse Family Partnership has granted model element variances to SD Home Visiting to be able to hire Associates-prepared nurses with additional training in public health and maternal child health. Registered nurses are particularly skilled in supporting families with high-risk pregnancies, promoting child health, and providing resources to support family functioning.

In other programs, early childhood professionals and paraprofessionals provide family support according to model and funding requirements. In 2019, a new route to delivering family support services was added when South Dakota Medicaid approved coverage of programs using a Community Health Worker (CHW). Programs are now able to apply for reimbursement of services that include supporting high risk pregnancies using models such as Family Spirit. Medicaid Community Health Worker Standards outlines the qualifications of CHW's, and this option will be something that home visiting programs explore to expand service delivery.

Factors indicating gaps in home visiting capacity:

Geographic barriers: The identified at-risk communities/counties in the data survey are also some of the most sparsely populated – and the largest in area. This presents a challenge to home visiting programs that must meet enrollment expectations, as there may be a very low number of eligible families and a large distance for home visitors to travel to see them. Per the Home Visiting Provider Survey, 89% of respondents indicated that they have travelled over 20 miles for a home visit, with 22% who have travelled over 50 miles to visit families. These factors that lead to transportation and access barriers for families living in these communities must also be considered by home visiting programs providing services making resource and staffing decisions.

Unserved populations: Both the Home Visiting Provider Survey and Key Informant Interviews identified that there are additional populations who could benefit from family support programs such as home visiting. Key Informant Interviews with past clients indicated that they would have continued with services past the child's second birthday until age five:

> "*I haven't really found much outside of Bright Start. If they could have continued that program until he turned five, that would have been probably the best situation I could think of. If they were still with up until five then they would be more aware of programs, which then I feel would have made figuring out some of this stuff easier." -Past client*

> *"So I think it could be beneficial to expand it for not just like first time mothers, because I have found it out with my second kid that each pregnancy and each child is very different*

and can be very black and white, and everything I had support with in my first pregnancy was entirely different for the second one, and it was just like learning all over again." - Past client

"I know that what I've experienced from being a parent over the past nine years, if there were somebody who could help with finding resources or if they can't, they redirect to me in a way where I could try to find help. Yeah, I'd utilize it if it was nearby, or readily nearby, I'd utilize it." -Parent in a community with no home visiting program

State and tribal jurisdictions: In the past 10 years of MIECHV implementation and the subsequent addition of Tribal MIECHV programs, there has been increased collaboration between state and tribal service providers, which is a success. This effort will need to be expanded to ensure that culturally and community-based services are an option in the identified at-risk counties that lie within tribal reservation borders. Of the 12 counties identified as at-risk, eight are wholly or partially located within one of South Dakota's nine reservations. Reservation areas are sovereign nations, some of which have their own school systems, health care infrastructures, and public health/social service delivery systems which are not integrated with State systems. South Dakota Bright Start will use a health-equity approach to assess the potential to expand home visiting to tribal communities using state MIECHV and other funding, or -preferably- encouraging and assisting tribal entities to apply for Tribal MIECHV grants.

Improved knowledge of and support for diverse communities: South Dakota's overall demographics indicate a large majority White population (84.4%). However, home visitors and community providers identified that working with families of different cultural and socioeconomic backgrounds is common. Cumulative client enrollment data for Bright Start Home Visiting Nurse Family Partnership clients indicates that 27% are AI/AN and 10.9% are Hispanic or Latina. Some areas of the state have "pockets" of ethnically diverse clients, particularly in areas where agricultural, industrial or factory work employ members of resettled refugee communities. For example, South Dakota is home to Karen (Burmese) people who were resettled in the Huron and Aberdeen areas. While 2.4% of SD NFP clients overall identify as Asian, 11.6% of the NFP clients enrolled in the Northeast part of the state identify as such. When assessing data to identify at-risk counties, overall racial demographic data did not show the same population levels, likely because census data has not caught up to the resettlement trends of the 2010's. This discrepancy will be assessed as South Dakota does the work of contextualizing Needs Assessment data. Regardless, home visiting programs self-identify the need for support in delivering culturally competent services.

"A lot of parents here seem to lack positive role models when it comes to parenting, and there's a lot of theories that relate to that. But certainly, boarding school is one of those. These are probably second and third generation parents whose ancestors were in boarding school and never had that positive parent in their life. You had a generation of children who lost that parenting support, raising the next generation where they didn't really have a model of what that should look like, and now they're grandchildren of that. There's been a lot of that basic understanding of how to be a positive parent that were lost in the generations." -Tribal Public Health advocate

"One thing that we do, and this seems like a tiny little thing, but we have a lot of Nepali clients, and you take off your shoes before you go into their house. Typically, we would not do that as a nurse home visitor, just because people's houses are really messy. But for our Nepali clients, we take off our shoes because we know that is a cultural thing." - Bright Start Home Visitor

"My wish for family support providers is to have every organization be required to be poverty-informed and trauma-informed and culturally informed in a high quality, effective, long-term way. I can't tell you how many times I've been checked off as culturally trained, I'm like, really? Each time I learned so much more. Especially in Western South Dakota. There is a large Native American population, and I know Sioux Falls has many diverse populations as well." -Community leader and funder

Opportunities for a Statewide Early Childhood System and Family Involvement: South Dakota is one of very few states that does not have a formal Statewide Early Childhood Advisory Council and has not applied for a Preschool Development Grant Birth-Five (PDG B-5). There are several state-and local-level boards and workgroups that address the comprehensive needs of young families in the state, but none are legislatively mandated or inclusive of State agencies, private service providers, and families. In addition, local community advisory boards tend to lack representation from families and community members. Home Visiting programs that participate in such boards could benefit from the broad perspectives offered by a diverse membership to guide program planning. Additionally, opportunities for policy makers, health care systems, and private industry knowledge of and support for the home visiting profession are missed. Statewide initiatives such as Early Learner South Dakota and the South Dakota Head Start Association are working to build public policy support for a formal early childhood system.

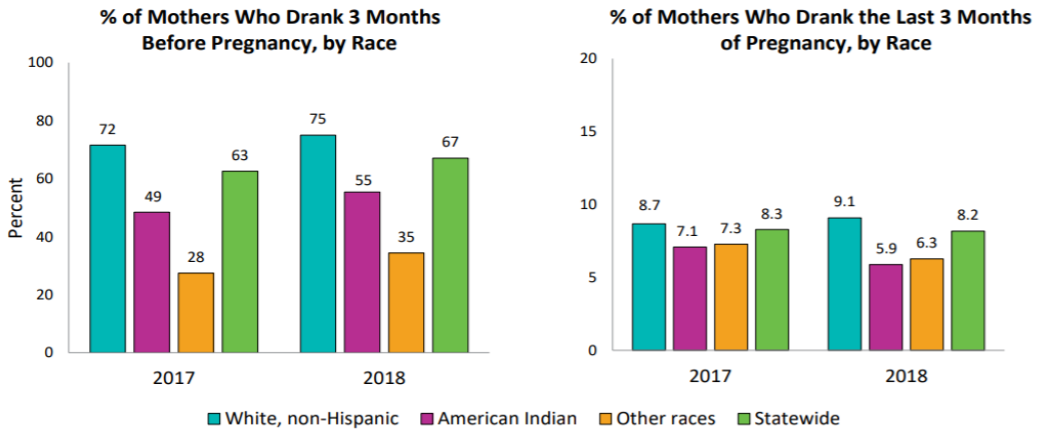
"I think in a perfect world, it would be great if all of the home visiting programs could be even more so in line. Not that we're working in separation from each other, but I think we share a lot of the same families at times, and so if we could somehow figure out how to bundle our services somehow. It could decrease overburdening the families." -Birth to Three Program Director

Capacity for Providing Substance Use Disorder Treatment and Counseling Services

"In the community I live in substance abuse, like drug and alcohol is really bad. And I see a lot of young parents struggling and giving up being a parent due to drugs and alcohol." -Parent in a community not served by home visiting

Although SD has not been affected by the high rates of Opioid Use Disorder and related mortality as some states, the rate of deaths due to drug overdose have been rising since 2012. In addition to opioids and misuse of prescription medications, methamphetamine is a drug of concern in the state – particularly in tribal areas. Alcohol continues to be the substance reported as misused by pregnant women, as evidenced by the data outlined in Figure 19 regarding alcohol use before and during pregnancy from the 2018 Pregnancy Risk Monitoring Survey.

Figure 21: Mothers Who Drank in the Last 3 Months Before and During Pregnancy



Substance Use Treatment and Counseling Services in South Dakota

The South Dakota Department of Social Services (DSS) oversees the Division of Behavioral Health and the Community Behavioral Health program. The Community Behavioral Health program is responsible for oversight of state funded mental health and addiction treatment services provided to youth, adults, and justice-involved individuals with behavioral health needs through accredited agencies. The following services are available to adults and youth and are mapped in Figure 19:

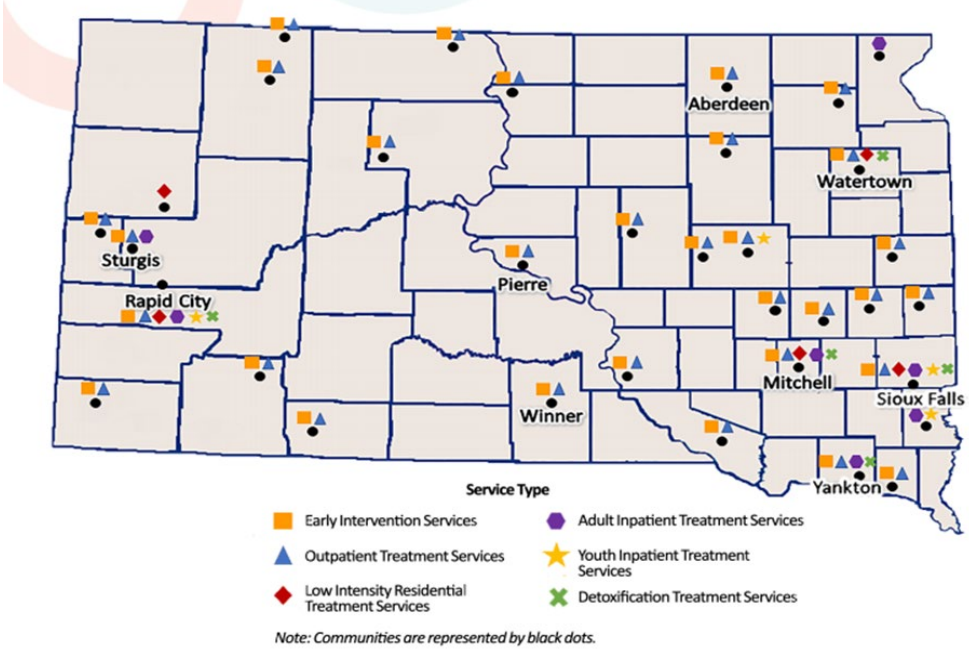
- **Early Intervention Services** offer outpatient services to individuals who may have substance use related problems but have not been diagnosed with a substance use disorder. Early Intervention Services are available for both adults and youth.
- **Outpatient Treatment Services** provide treatment services in a community setting to individuals diagnosed with substance use disorders. Outpatient Treatment Services are available for both adults and youth.
- **Day Treatment Services** provide treatment services to adults diagnosed with substance use disorders in a structured, intensive treatment program that may include a residential component.
- **Low Intensity Residential Treatment Services** provides residential, peer-orientated treatment programs for adults diagnosed with substance use disorders whose living situation or recovery environment is incompatible with recovery goals. The program provides substance use disorder counseling with case management services to prepare the client to live successfully in the community.
- **Inpatient Treatment Services** provide residential treatment with medically monitored intensive treatment for individuals with severe substance use disorders. Inpatient Treatment Services are available for both adults and youth.
- **Detoxification Treatment Services** are residential treatment services delivered by trained staff that provide 24-hour supervision, observation and support for adults who are intoxicated or experiencing withdrawal symptoms.

Through the support of two federal grants, the Department of Health, the Department of Social Services, and the South Dakota Opioid Abuse Advisory Committee have been working collaboratively for the past three years to educate and raise awareness regarding opioids misuse and abuse. More information can be found at the Avoid Opioid Website. DSS provides grant funds to support South

Dakota organizations and agencies seeking to deliver continuing education or training to professionals in combatting the opioid crisis.

Intensive Methamphetamine Treatment (IMT) services offer long-term, evidence-based programming to individuals with severe methamphetamine use disorders. Individuals receiving IMT services require extended treatment to allow for recovery of cognitive capacity as well as on-going case management. Treatment may include residential services, outpatient treatment and care coordination to support long-term recovery. Best practices for the treatment of severe methamphetamine disorders includes a combination of Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Contingency Management and community reinforcement approaches.

Figure 22: Community Based Substance Use Counseling Services



In addition to the state-funded community-based treatment options, eight of South Dakota's nine tribal nations and two Urban Indian Health providers house SUD treatment facilities. More information about the counseling and treatment options for tribal members can be found in a resource compiled by the Great Plains Tribal Leaders' Health Board. Figure 21 below outlines tribal substance use counseling services available across SD.

Figure 23: Tribal Substance Use Counseling Services

Even with the range of SUD treatment options available in the state, South Dakota is lacking in options tailored to pregnant and parenting women. According to the Guttmacher Institute 2020 review of state laws and policy, South Dakota has not created SUD programming specific to pregnant women – though private facilities have - and does not offer priority access to treatment for pregnant women. In addition, South Dakota codified law considers substance use during pregnancy child abuse and is grounds for civil commitment. Two residential treatment programs for pregnant and parenting women are available in the state's two largest cities: New Start Specialty Program for Women through Volunteers of America is in Sioux Falls, and Full Circle through Behavior Management in Rapid City.

Gaps in the Current Level of Treatment and Counseling Services

A vulnerability assessment of South Dakota communities was conducted in 2019 to identify areas at high risk for opioid overdose and injection-related to HIV and Hepatitis C. Results identified gaps in access to behavioral health providers, including substance use disorder providers and community mental health centers, with only 37.7% of the state's population in 15-minute driving service areas of any behavioral healthcare provider. This indicator was associated with county-level Hepatitis C cases. Thirteen SD counties were identified at elevated risk for opioid overdose and bloodborne infections, which includes eleven of the 23 counties identified as at-risk in this Needs Assessment. More data from the 2019 Vulnerability Assessment can be found here: South Dakota Vulnerability Assessment

Key informant interviews also identified gaps in availability for Substance Use Disorder (SUD) treatment and counseling services in tribal communities, including a lack of providers beyond the Indian Health Service, as well as a lack of nearby residential treatment facilities. This often requires residents of tribal communities to leave their local area for needed inpatient/residential treatment.

The Title V Needs Assessment found that substance use prevention and treatment was ranked a top five need for mothers of infants and children aged 1 to 9 years. Specifically, a community input survey conducted with women, families, and community members (n = 903) revealed that 30% of participants reported substance use prevention and treatment for parents and caregivers is an unmet need affecting

the health and wellbeing of infants and 32% of participants reported substance use treatment for parents and caregivers of children ages one through nine years of age is an unmet need affecting the health and wellbeing of children in their care. In addition, 24% of participants indicated substance use prevention and treatment is an unmet need affecting the health of women in SD.

There are no changes to the assessment or activities previously noted in this section related to the addition of Phase 2 data.

Barriers to Receipt of Substance Use Treatment and Counseling

Barriers to receipt of SUD treatment and counseling services identified through key informant interviews include a lack of transportation to available facilities, and SD laws that imprison versus treat pregnant and parenting families with SUD. Also, a general lack of treatment facilities and adequate treatment facilities present barriers to receipt of SUD treatment and counseling services for pregnant and parenting families.

Focus groups conducted with single mothers and co-parents in rural South Dakota communities to inform the Title V Needs Assessment also found that substance use among parents in their communities is an unmet need and is elevated due to a lack of resources to treat their addiction, including access to local SUD treatment and counseling services. In addition, participants indicated that available pamphlets specific to substance use prevention were ineffective and would rather listen to someone who experienced addiction.

The Vulnerability Assessment identified percent uninsured (β -0.089; p=0.001), percent single parent household (β -0.118; p=0.017), and percent minority (β 0.137; p<0.001) as statistically significant indicators associated with risk elevated risk for opioid overdose and bloodborne infections, which are also social and economic factors that pose barriers to receipt of SUD treatment and counseling services.

Opportunities for Collaboration with State and Local Partners

CARA - The Comprehensive Addiction and Recovery Act of 2016 - was enacted to address the opioid health crisis in the United States. It requires state child welfare systems to develop a Plan of Safe Care for infants born and identified as being affected by substance use or withdrawal symptoms or Fetal Alcohol Spectrum Disorder (FASD). The intent of this legislation is to deliver appropriate services to the entire family to ensure the safety and well-being of infants following the release from the health care provider. A Plan of Safe Care is a plan designed to ensure the safety and well-being of an infant with prenatal substance exposure. The plan can begin when the mother is pregnant or following the infants release from the care of a health care provider by addressing the health and substance use needs of the infant and affected caregiver and family.

South Dakota's Division of Child Protection Services routinely implements Plans of Safe Care for infants who are affected by substance use and/or who experience medical or physical withdraw symptoms. These plans, referred to as a Present Danger Plan, ensure the infant is receiving safe care and their needs are being met to allow for the completion of an assessment of the family, without seeking court custody. Child Protection Services only serves those families who meet criteria to require intervention in order to maintain the safety of the child.

South Dakota applied for and was selected as one of nine states to attend the 2020 Practice and Policy Academy: Developing a Comprehensive Approach to Serving Infants with Prenatal Substance Exposure

and their Families. The purpose of the academy is to enhance the capacity to meet the needs of infants who are affected by prenatal exposure of substance use and to receive technical assistance in mobilizing a comprehensive team in developing Plans of Safe Care. Currently, the State of South Dakota's data and information collection is specific and limited to children who meet criteria for investigation through Child Protection Services. South Dakota desires to collaborate and bring together cross-agency partners to develop, implement, and monitor Plans of Safe Care for all infants affected by substance use, not just those infants who meet criteria for child welfare intervention. The South Dakota Home Visiting Program manager is a partner in the cross-agency group, along with representatives from state and tribal child welfare and substance use programs, prenatal and pediatric care providers, members of the judicial system, and childcare/disability care providers. The group is currently developing the South Dakota Plan of Safe Care by focusing on scope of work, definitions, and data needs.

Coordination with Title V MCH Block Grant, Head Start and CAPTA Needs Assessments

Coordination with the Title V MCH Block Grant

South Dakota's Bright Start Home Visiting Program is operated through the same Office as the Maternal Child Health Program, so there were minimal hurdles to overcome in coordinating our respective Needs Assessments. South Dakota appreciates the effort that HRSA put into aligning the timelines for the two assessments. In the discussion below, Office of Child and Family Services programs includes Title V, WIC, the Bright Start Home Visiting Program, Family Planning and Newborn Screening.

Goal, Frameworks, & Guiding principles

The South Dakota Maternal and Child Health program is required to submit an updated MCH Title V Needs Assessment in 2025. The team kicked off the year-long needs assessment process in October 2023. Several SDDOH Family and Child Health programs, including Home Visiting, collaborated during the process to establish goals, frameworks and guiding principles of the needs assessment. During the Spring and Summer of 2024, the MCH team hosted community conversations in five rural communities, partner meetings in three urban areas, and a disseminated statewide community survey. Office of Home Visiting leadership team and service delivery staff (home visitors) supported these activities by helping to facilitate small-group discussion at the community conversation and partner meeting events, as well as distribution of the community survey to home visiting clients and resource partners. Through the Winter of 2024 and the Spring of 2025, the Title V team is creating detailed action plans based on selected domain priorities. The final 2025 Needs Assessment report will be submitted later this year.

Figure 24: Timeline of SDDOH Title V Needs Assessment Process, 2025

Prior 2020 Submission: The goal of the Title V Needs Assessment process was to inform priority setting and OCFS planning through integration of Needs Assessment findings. Two frameworks shaped the joint Needs Assessment process: The Life Course Theory and Health Equity Model. Utilization of the Life Course theory was important to first understand health issues that impact the Maternal Child Health (MCH) population at all stages of life, including health patterns and disparities. Utilization of this approach ensure inclusion and understanding of the factors that shaped the health and well-being of families and individuals across a lifespan. Secondly, the Health Equity Model was used in alignment with the Life Course Approach to conceptualize social determinants of health that impact MCH population across the life course. Specifically, understanding factors that contributed to health issues, including social, economic, and physical factors, was important to shape the Needs Assessment and identify root causes impacting health outcomes, priority needs, and action plans. The OCFS adapted the Health Equity Model of the Colorado Department of Public Health & Environment.

Guiding Principles of the joint Title V and Home Visiting Needs Assessment Process that supported the implementation of a comprehensive and inclusive process, as well as the Needs Assessment frameworks included:

- Evidence-based decision making;
- Using a health equity lens;
- Respond to emerging issues and trends that affect families and individuals in SD;
- Social determinants of health;
- Input from diverse stakeholders and partners; and
- Do not reinvent the wheel

Methodology

The Needs Assessment was shaped by a collaborative approach that engaged multi-sector partners, families, and individuals from across the state through data collection and information gathering approaches, including surveys, regional partner meetings, and focus groups. Input was sought from partner organizations, families, and individuals who represent broad perspectives, with targeted outreach to ensure representation from diverse SD geographies and underserved populations. New and existing partners were engaged throughout the process, focused on ensuring transparency regarding the process and fostering sustainable partnerships.

Needs Assessment planning was conducted between September – December 2018 in collaboration with OCFS staff, internal partner agencies, and an external consultant (contracted for both the Title V and MIECHV assessments), including a Needs Assessment Project Team, OCFS Advisory Committee, and the MCH Impact Team. Planning included identification of the process design and timeline including leadership roles, communication plan, quantitative and qualitative data collection methods, prioritization, finalization of the Needs Assessment report and implementation of 2020-2025 priorities and evidence-based strategies. Implementation of the Needs Assessment launched in January 2019, informed by the process design and timeline.

The roles that supported planning and implementation of the Needs Assessment included the following:

- Needs Assessment Project Team: This team included a core group of OCFS staff, including the Administrator, MCH Program Director, Bright Start Home Visiting Manager, MCH Epidemiologist, and SLM Consulting. This team served as the core team who helped design and facilitate the process, develop guiding principles, a communication plan, and data collection methods, as well as identified the leadership roles necessary to implement the process. This team met on a bi-weekly basis to support planning for the implementation of the Needs Assessment.
- OCFS Advisory Committee: This team included OCFS program leaders who helped inform the process design and timelines, prioritization, and served as a pipeline to partner organizations, families, and individuals. Advisory Committee members are in communities across South Dakota. The Advisory Committee was convened monthly starting in November 2018.
- MCH Impact Team: This team includes Department of Health interagency partners, including the Office of Chronic Disease Prevention and Health Promotion, Office of Health Statistics, DOH Communications, DOH Immunization Program, and the OCFS staff who helped to inform decisions on the process, data collection, and identification of priorities for the 2020-2025 Action Plan.
- Partner Organizations: Partners included organizations, agencies, and stakeholders who the OCFS Needs Assessment Project Team, Advisory Committee, and MCH Impact Team identified as integral to support a collaborative Needs Assessment process. This included giving them a voice regarding partnerships and service programs that should be supported to meet the needs of families and individuals. In addition, partner organizations who represented diverse families and individuals were identified to help understand and assess social determinants of health that affect families and individuals in South Dakota.
- Families & Individuals: These populations included men, women, children, and youth (including children and youth with special health care needs) who are served by the OCFS programs and partner organizations, providing a community perspective on health issues. These populations informed data collection and identification of priority health issues and needs necessary to shape priorities for the 2020-2025 Action Plan.

Stakeholder Engagement

A collaborative approach was the foundation of the Needs Assessment process, focused on engaging diverse partners and stakeholders to inform a comprehensive understanding of health and well-being issues that impact families and individuals across SD. Input was gathered from stakeholders who represented state agencies, community-based organizations, health care providers, tribal agencies, as well as local community members, families, and individuals disproportionately impacted by health and well-being issues. The process engaged stakeholders across the state through regional partner meetings, focus groups, and surveys that gathered input from individuals, families, and communities. Guiding principles of the Needs Assessment included:

1) Elicit input from diverse stakeholders and partners from a wide geographic distribution
2) Build sustainable partnerships with stakeholders and partners to better support families and individuals across SD through programs and services.

Partner Organizations

The OCFS Needs Assessment Project Team and Advisory Committee identified existing and new partners to participate in the Needs Assessment process for data collection, priority setting, and action planning Engaging partners in this way provides an opportunity to expand the reach of OCFS services (including Title V and Home Visiting), understand shared priorities and strengthen the foundation of coordinated health and community systems of care.

Partners whose focus included working with women, infants, and children (including children with special health care needs) as well as families and individuals impacted by health disparities were invited to participate. OCFS program leaders leveraged their existing partners to invite their community partners as well. Outreach totaled 110 partner organizations, representing 19 sectors, including but not limited to: State Government Staff, Higher Education, Community Based Organizations, Family-Led Organizations, Private Businesses, Faith Based Organizations, Health Systems, Health Professional Organizations, Community Coalitions, Tribal MCH programs including WIC, Tribal Colleges, Tribal Government.

Partner organizations were invited to participate in the January 2019 launch of the Needs Assessment process via a webinar facilitated by the OCFS Needs Assessment Project Team. Partners were also invited to complete a survey which assessed priority health issues impacting families and individuals they work with in South Dakota. Survey findings informed the design of other data collection methods utilized in the Needs Assessment including a youth survey, community input survey, and focus groups. Also, partners were engaged through regional partner meetings.

Other data collection methods partners participated in included a partner input survey to provide feedback on priority health issues impacting women, infants, children, adolescents, and children with special health care needs across the state. Partners were asked to share the survey with their own stakeholders and other relevant organizations. After completion of data collection, partners were invited to participate in a webinar to learn about the key findings to inform priority setting by domain. In-person and virtual meetings were held with partners by MCH domain to discuss key findings and identify two priorities to focus on in the 2020-2025 Title V State Action Plan. Subsequent action planning was conducted in collaboration with partners to ensure diverse, meaningful input and collaboration moving forward.

Partners were also kept informed of the Needs Assessment process through a monthly newsletter devoted to providing information about OCFS program staff and on-going activities. It was important to be transparent with partners and keep them engaged throughout the entire process. The process provided a foundation to build existing and new partnerships that will be important to coordinate OCFS programs and support the health and well-being of families and individuals served.

Families and Individuals

A key component of the Needs Assessment process was engagement of families and individuals. It was important to inform an understanding of health and well-being issues directly from the people experiencing them. Input was elicited from families and individuals supported by OCFS programs and partner organizations through a community input survey, youth survey, and focus groups. Efforts were made to engage underserved populations disproportionately affected by health and well-being issues, including American Indian, low-income, youth, and rural populations. Partner organizations were integral to support engagement of families and individuals in this process, particularly in communities where OCFS staff and programs did not have a footprint.

The community input survey was disseminated to partner organizations with the invitation to share it with families and individuals they serve. The survey was designed to elicit feedback on priority health issues impacting women, infants, children, and adolescents, including those with special healthcare needs. A youth survey was also disseminated to South Dakota youth, grades 5 -12, to elicit feedback regarding their health and well-being needs and issues. Targeted efforts to engage these populations included attending local tribal events and youth conferences to recruit individuals to complete the surveys. In addition, the community input survey was disseminated to WIC offices across the state, where OCFS staff supported engagement of families and individuals.

Families and individuals in four SD communities were engaged through focus group discussions facilitated by South Dakota State University's Population Health Evaluation Center. These groups provided the opportunity to gather in-depth feedback on health and well-being needs and issues impacting their communities. Participants were selected based on geographic variation and populations where additional feedback was sought including youth, women, co-parents, and single parents.

OCFS Partner Survey

The OCFS Partner Survey was a preliminary survey designed to elicit quantitative and qualitative input from partner organizations regarding priority health and wellbeing issues that impact families and individuals they serve. The survey was developed based on existing MCH indicator data and priority health issues. The survey gathered feedback on demographics of survey participants, issues related to women, infant, child, and adolescent health most important for public health professionals to address, as well as recommended data sources relevant to those issues. Partners were also asked to share contact information for other partners who could help inform the Needs Assessment. The survey was disseminated electronically, and information collected shaped the data collected throughout the Needs Assessment, including the youth and community input surveys, regional partner meetings, and focus groups.

Regional Partner Meetings

Partner meetings were held in five regions across the state with a total of approximately 100 partners to discuss unique health and well-being needs of women, infants, children, and adolescents, including those with special health care needs. To foster stakeholder engagement, it was integral that OCFS took

the opportunity to engage partners in their communities and gather qualitative data. The full report is available here: MCH Partner Meeting Report

Members of the OCFS Needs Assessment Team, OCFS Advisory Committee, MCH Impact Team, and Partner organizations convened for meetings in three geographically diverse SD communities, Rapid City, Pierre, and Sioux Falls to discuss the health and well-being needs of women, children, and youth, including CYSHCN and their families unique to regional areas.

Meetings were also held in two tribal communities, Pine Ridge and Sisseton, at the regular meetings of the Home Visiting community advisory boards in each area. The meeting in Pine Ridge was held with Raising Healthy Families Together, an informal network of social service organizations providing services to the residents of the Oglala Lakota Nation on the Pine Ridge Reservation. This group meets quarterly on the first Thursday of the month.

The meeting in Sisseton was held with the Sisseton Wahpeton Oyate (SWO) First 1000 Days Initiative Interagency Forum, whose mission is creating collective impact in the first 1,000 days for healthy, resilient families on the Lake Traverse Reservation. The Forum is comprised of service providers from tribal programs, non-tribal programs, and Indian Health Service. They meet on the third Thursday of each month.

Meetings included an overview of the Needs Assessment process, including frameworks, guiding principles and goals. An overview of findings from the Partner Survey, as well as data relevant to MCH programs, indicators, and performance measures was provided. Data briefs were also developed to provide an overview of data relevant to the health of SD women, infants, children, and adolescents. This overview was important to help inform participation and discussion.

Partners in Rapid City, Pierre, and Sioux Falls participated in small group discussions by domain (women, infants, children, and adolescents) throughout the meeting. They participated in a storytelling activity and shared successes their organizations have had to address/improve the health and well-being of domain populations. Participants completed a 5 R's assessment to inventory the local system as it relates to the domain populations, including the roles (actors involved in the local system shaping the issues under study), relationships (what are the important relationships between actors), rules (rules, policies, laws governing what happens in local system), resources (inputs such as budget, personnel, time, data, trust available to local system), and results (what are the actual and desired bigger picture results that help understand how the system is functioning).

Participants used the inventory to complete an Asset/Gap activity, where they identified local assets available to support the health and well-being of domain populations, as well as gaps that hinder the health and well-being of domain populations in their region. Based on the assets and gaps identified each domain group identified the top five priorities that participants felt should be addressed in their region. Information from these meetings was used to inform development of the Community Input Survey.

Community Input Survey

A Community Input Survey was a key quantitative/qualitative data collection method used in the Needs Assessment process to seek input from community members and partners important to the process. The survey was developed by the OCFS Needs Assessment Team and SDSU E.A. Martin group to elicit feedback about unmet needs affecting the health of infants, children, adolescents, and women, as well

as community services utilized. The survey elicited input from 1,020 SD families and individuals served by OCFS programs, partner organizations, as well as concerned parents, parent/guardians of children with special health care needs, community service providers, educators, health care providers, policy makers, tribal government, and government employees who support these populations.

The survey was disseminated electronically to the OCFS Advisory Committee, MCH Impact Team, and OCFS partner organizations, who were asked to disseminate to other partners as well as families and individuals they serve. The survey was also available on the SD-DOH website for public access.
The survey was also disseminated via paper-copy to all SD DOH community health clients (including home visiting clients) and at local events sponsored by partner organizations, including health fairs hosted by tribal partners. Specifically, OCFS Needs Assessment Project Team and Advisory Committee members attended local events as a SD DOH vendor to share resources and invite participants to complete the survey. Dissemination was targeted at underserved populations served by OCFS programs and partner organizations to understand opportunities to address health equity in future program planning. SDSU EAM managed and analyzed the survey data and developed the final report. OCFS staff and contractors worked with Master of Public Health student interns to analyze and code the qualitative data. The full report is available here: MCH Community Survey Report

Focus Groups

Focus groups were held in four SD communities with unique populations, including women living on an American Indian Reservation, co-parenting adults in rural community in northwestern South Dakota, single parents in eastern South Dakota, and youth in southeastern South Dakota. The focus groups were held to capture in-depth feedback on the health and wellbeing issues that impact families and individuals in rural and underserved communities. The focus groups were facilitated by South Dakota State University's Population Health Evaluation Center and informed by a focus group discussion guide. Questions that guided focus group discussion were developed with collaboration from the OCFS Needs Assessment Project Team. The full report is available here: MCH Focus Group Findings

Findings on MCH Population Health Status

Women/Maternal Health

Strengths and Needs

Findings from the Needs Assessment revealed many notable strengths and needs in women/maternal health. Feedback elicited from partners at the regional partner meetings recognized strengths including: workforce development programs, available data (e.g. Pregnancy Risk Assessment Monitoring System (PRAMS), access to healthcare services (e.g. Federally Qualified Health Centers and Indian Health Services), the 211 Helpline, community programs (e.g. Family Planning, counseling services, the South Dakota QuitLine), and existing partnerships and collaboration between agencies that promote health. Needs identified specific to women/maternal health largely center on social needs, mental health, and substance abuse, as well as access to healthcare services.

Successes, Challenges, & Gaps

Social needs, including lack of transportation, joblessness or having a job that does not meet the family's needs, lack of education, and poor housing conditions were noted gaps in women/maternal health outcomes. Data also revealed gaps in access to healthcare services and providers, lack of sexual health

education, lack of cultural awareness and the need for improved advocacy around women's health issues (SDDOH, 2019).

Women's mental health and substance abuse was a common theme across the state. Focus group participants were concerned about gaps in counseling services and underutilization of available services due to a lack of awareness and confidentiality. Participants also identified concerns around substance use, especially methamphetamine. Findings from the community input survey indicated that access to mental health services and substance abuse prevention and treatment were ranked among the top six priorities. Specifically, access to mental health services was more likely to be an unmet need among women who were married, who had a higher income, and were white or a race other than American Indian. While the MCH program has had limited success in increasing the number of women ages 18-44 who receive a well-woman, preventative medical visit each year, SD did report a higher rate of visits, 77%, compared to the United States, 73.6%, in 2018. Needs Assessment findings indicate the importance of such a visit as a care coordination and referral starting point for women.

Maternal attitude and behaviors of SD mothers also reflects challenges and gaps in morbidity and health risks outlined in 2018 PRAMS data, including:

- 67% of mothers statewide reported drinking alcohol 3 months before pregnancy, and 8% reported drinking alcohol the last 3 months of pregnancy.
- 25% of mothers statewide reported smoking the 3 months before pregnancy and 10% smoked the last 3 months of pregnancy.
- 16% of women reported depression 3 months before pregnancy, 17% reported it during pregnancy, and of those that had a postpartum visit, 13% reported postpartum depression.
- Women that are enrolled in the South Dakota Women, Infants, and Children (WIC) program are more likely than those not enrolled in WIC to have depression during pregnancy (26% vs. 13%) and score high on an indicator for postpartum depression (21% vs. 10%) (SD PRAMS, 2018).

Child Health

Strengths and Needs

Strengths identified within the child domain include statewide programs and partnerships, data sharing between programs and partnerships, healthcare and dental services, cultural diversity and tribal sovereignty, resources such as food pantries and homeless shelters, mental health services, and telehealth. The community input survey noted needs including safe and affordable housing, parenting education and support, affordable health insurance, substance use prevention and treatment, and access to healthy foods. Affordable housing was a greater need among individuals who were not married and among those who earned a low income. Parenting education and support was a greater unmet need among respondents who were white and reported a higher income. However, parenting education and support was a recurring theme with all demographics throughout the Needs Assessment. Qualitative feedback identified that parents want more education on topics ranging from growth and development of children to nutrition and cooking healthy meals. Lack of knowledge of available resources was commonly stressed as a barrier to achieving wellness. One respondent stated that "resources for single fathers" would be an asset (SDDOH, 2019).

Successes, Challenges, & Gaps

Specific gaps identified regarding child health include: limited healthcare and dental workforce capacity, access to services (especially in rural areas), lack of policy and regulation for seat belt use, daycares, and preschool standards, lack of resources for parents or lack of knowledge how to access these,

transportation; parenting skills/education, cultural competency, and mental health and substance abuse resources and services.

Infant/Perinatal Health

Strengths and Needs

Strengths identified within the infant domain included programs such as Birth to 3, Cribs for Kids, Women, Infants and Children Supplemental Nutrition Program (WIC), and partnerships between statewide agencies that serve this population. SD's percent of low birth weight infants and percent of preterm deliveries continues to remain lower than the national average. In 2017, the percent of low birth weight deliveries was 6.9% compared to 8.3% nationally, and the percent of preterm births was 9.3% in South Dakota compared to 9.9% nationally (SDDOH Vital Statistics). However, priorities that still need to be addressed regarding infant/perinatal health include social needs, access to health care services, mental health and substance abuse, culture, and childcare.

Successes, Challenges, & Gaps

South Dakota's successes in Infant/Perinatal Health have been shown with the percentage of infants placed to sleep on their backs, 87%, and on a separate approved sleep surface, 41.6%, a ranking of number four out of 30 states and number one of 31 states respectively (SD PRAMS, 2018). Some of the gaps that were identified through the Needs Assessment process include: social needs, such as transportation and affordable housing; policies that hinder data sharing; lack of Medicaid Expansion; a need for more parent education and life skills training; mental health and substance abuse treatment for mothers; access to health care services and care (specifically specialty care); affordable and accessible childcare; and cultural stigma. Another notable gap identified for the infant domain is continuing education and programming around infant sleep. Although South Dakota's infant mortality rate has been steadily declining, the post neonatal and SUID mortality rates remain high. Data on infant mortality and sleep addresses a gap in care and the need for continued interventions:

- In 2017, the post neonatal mortality rate for infants was 2.2 deaths per 1,000 live births, compared to the national rate of 1.9.
- In 2017, the sleep-related sudden infant death (SUID) rate was 115.4 deaths per 100,000 live births, compared to the national rate of 93.0.
- In 2017, the infant mortality rate was 7.7 per 1,000 births, compared to the national rate of 5.8 (SDDOH Vital Statistics, 2017).
- Based on data from SD's Infant Death Review (2014-2018), 70% of infant deaths (post hospitalization) occurred in an unsafe sleep environment (SDDOH, 2018).

Identifying Priority Needs

A structured and inclusive priority-setting process was shaped by collaboration with the MCH Impact Team and OCFS partner organizations. The Needs Assessment Project Team analyzed findings from quantitative and qualitative data and developed a priority setting tool to help select preliminary priority needs by domain (women, infant, children, adolescent, and children and youth with special healthcare needs). Each tool was first disseminated to the MCH Impact Team to assist with narrowing down the priority needs prior to engaging partner organizations. Additional priority setting methods were utilized with partner organizations to help further narrow down priorities and ensure a collaborative and inclusive priority-setting process. Partner organizations, the MCH Impact Team, and the OCFS Advisory Committee were engaged in fall partner meetings to support the priority setting process.

The OCFS Needs Assessment Project Team organized partner meetings to support engagement and identification of priorities based on the Needs Assessment data findings. A webinar was held with partner organizations, the OCFS Advisory Committee, and the MCH Impact Team to provide an overview of the Needs Assessment process and data findings.

Additional in-person/virtual meetings were held by domain (women, infants, children/CYSHCN, and adolescents) with partner organizations, OCFS Advisory Committee members, and members of the MCH Impact Team to identify two key priorities to focus on in the five-year action plans. Domain leaders (MCH staff) led the meetings and provided an overview of current strategies being implemented by the OCFS to address specific priority areas. Meeting participants were also invited to share the activities they were currently working on within each population domain. This discussion helped participants to understand what is currently happening across the state and identify opportunities for future programming.

Priority needs identified previously were shared with meeting participants to review. The dot method was utilized to support priority setting during each domain meeting. Criteria utilized was modeled after the priority tool used with the MCH Impact Team outlined before; including significance to public health (seriousness of the issues, health equities, available data), ability to impact the issue (evidence-based strategies and momentum for change), and capacity to address the issues (leadership and current resources). Priority areas not selected were moved to a parking lot, understanding some of them could still be addressed and/or integrated into strategies within the identified priority areas.

Following the fall partner meetings, the MCH team and other key OCFS program staff met in-person to discuss the priorities identified and narrow down the focus to one priority per domain. The seven priority needs and their corresponding NPMs and SPMs are listed in the table below.

Table 9: Title V Block Grant Needs Assessment Priority Needs by Domain

Priority	**MCH Population Domain**	**NPM or SPM**
Mental health and substance abuse	Women/Maternal Health	NPM 1 Well-Woman Visit
Infant safe sleep	Perinatal/Infant Health	NPM 5 Safe Sleep
Parenting education and support	Child Health	NPM 6 Developmental Screening
Mental health/suicide prevention	Adolescent Health	NPM 7 Injury Hospitalization
Access to care and services	CSHCN	NPM 11 Medical Home
Healthy relationships/Sexual health	Adolescent Health	SPM 1
Data sharing and collaboration	Cross-Cutting	SPM 2

Other common needs noted across domains included social determinants of health such as employment, housing, and transportation. These did not rank as high as other priorities in the process because the MCH program has limited resources to address these issues. Specifically, OCFS felt that the MCH program should not be the lead on addressing these needs. The OCFS does recognize their importance in the overall health of individuals and will continue to engage partners who can better address these issues. It was also discussed that at some point in the future strategies could be

developed around these needs. Childcare, parenting education, and mental health/substance abuse were other common themes across domains. Lack of affordable and accessible childcare was noted in the infant and child domains. In South Dakota, childcare falls under the authority of the Department of Social Services. A representative from this group routinely participated in Needs Assessment activities and the priority setting process. OCFS collaborated with this representative to share data for their own Needs Assessment that was being conducted. Parenting education, mental health, and substance abuse were also frequently cited across population domains. The MCH team chose to link each of these priority needs to the NPM/SPM with the best potential to move the needle.

Coordination with South Dakota Head Start Needs Assessment

Home Visiting Participation in the Head Start Needs Assessment

The South Dakota Head Start Collaboration Office (SD-HSCO) performed a survey of Head Start Grantees and Stakeholders in early 2020 to inform their Needs Assessment of program collaboration, knowledge of community resources, and educational needs. The Needs Assessment survey included both Early Head Start/Head Start Grantee staff as well as external stakeholders. The Home Visiting Program manager participated in the Stakeholder survey in February 2020. The results of that Needs Assessment survey can be found here: 2020 South Dakota Head Start Needs Assessment

Per the survey results, Head Start Grantees expressed a strong desire for collaboration and support in emerging areas such as children having behavioral challenges and families with members dealing with substance use disorders. The most-often cited professional development need of Head Start Grantee respondents is education on mental health needs of families, followed by understanding how to best support children with challenging behaviors. The South Dakota Bright Start Home Visiting Program serves a similar demographic of families and may use these findings as a proxy for needs of families eligible for, enrolled in, or graduated from home visiting services.

The SD-HSCO reports that the Stakeholder (partner) version of the survey reflects very similar findings. The most-commonly cited level of engagement by stakeholders representing various service providers with Head Start/Early Head Start is “limited engagement”, and respondents overwhelming report that they want to be more engaged with Head Start Grantees and the SD-HSCO. Stakeholders reported that they are interested in coordinating with Head Start Grantees to build resiliency in families through efforts such as parent and family engagement, coordinating community and family resources, and early language and literacy. Regarding opportunities to collaborate with the SD-HSCO, stakeholders responded with a desire to advance the access to quality early childhood education. Data sharing opportunities and support in building a quality workforce are also important.

The results of the survey will be used to develop the SD-HDCO strategic plan, which is currently underway. In August 2020, the Bright Start Home Visiting Program manager provided input for the HSCO strategic plan via a key informant interview.

Head Start Participation on the Home Visiting Needs Assessment

Head Start staff and families participated in the Title V and Home Visiting joint Needs Assessment process as stakeholders in local communities as well as at the state level. As described in the Title V collaborative process above, the OCFS Project Team and Advisory Committee were very intentional in recruiting partners from organizations that serve and support similar populations as well as families who use such services. The Head Start Collaboration Office director is a member of the Child and Family Services Interagency workgroup, the advisory council for the Home Visiting Needs Assessment process.

The SD-HSCO director was a key partner to assist in recruiting and encouraging local agency Head Start directors and staff from around the state to participate in the Regional Partner Meetings and the Stakeholder survey. There were Head Start/Early Head Start local agency staff in attendance at each of the three Regional Partner Meetings, and Head Start staff also took part in the Fall Priority Setting meetings. Similarly, Head Start program directors and staff were key in disseminating and encouraging the families in their programs to complete the Community Input survey utilized in the Title V Needs Assessment.

OCFS staff (including the Bright Start Home Visiting Program manager) participated as vendors at the South Dakota Early Childhood Education Conference in the Spring of 2019 to disseminate the partner survey and to encourage attendees to distribute the Community Input survey to families in their Head Start, Early Head Start, other preschool and daycare programs. Additionally, the Home Visiting Program Manager attended the SD Home Visiting Conference – sponsored and organized by the South Dakota Head Start Association – to present information about the Statewide Home Visiting Needs Assessment process and to encourage attendees to complete the Home Visitor survey in the Fall of 2019. The Home Visiting Needs Assessment advisory committee chose a director of the Early Head Start program in a community that is not currently served by MIECHV services as a Key Informant for the interviews that were completed in July 2020.

Ongoing coordination between South Dakota Home Visiting and Head Start/Early Head Start

The South Dakota Bright Start Home Visiting Program encourages local team members to coordinate services and referrals with the Head Start/Early Head Start programs in their communities, using memorandums of understanding when possible.

At the state level, the Bright Start Home Visiting Program Manager and the Head Start Collaboration Director are both members of the above-mentioned Child and Family Services Interagency Workgroup, which meets quarterly to share information update on projects carried out by the State agencies leading family-support, health and education programs. Additionally, the Bright Start Home Visiting Program manager is a member of the State Team that is supporting efforts of the SD-HSCO to address substance misuse in Head Start families. She attended a Region VIII kickoff meeting in February 2020 at the request of the SD-HSCO and has been participating in State Team activities since then. Families that are affected by substance misuse face similar issues no matter which services they receive (or do not receive). The State Team has developed the following strategic goals:

- Continue to expand collaboration between Head Start/Early Head Start, childcare providers, and other early childhood agencies.
- Both Head Start grantees and state-wide early childhood programs will be more aware of each other's services to help strengthen the desired outcomes for young children and their families.
- Through community collaboration, raise awareness about substance misuse in SD focusing on Head Start/EHS programs.

In local communities, Bright Start Home Visiting Program staff and Head Start/Early Head Start staff are encouraged to participate in shared or agency-specific advisory boards as appropriate. Several home visiting nurses are members of Head Start Health Advisory Councils, which focus on the health, dental and behavioral policies, and projects of local Head Start/Early Head Start agencies.

Coordination with CAPTA Needs Assessment

Home Visiting's participation in the CAPTA/CBCAP Needs Assessment

Home Visiting's coordination with the CAPTA Needs Assessment process has not been as formalized as the most recent Title V and Head Start assessments due to the timelines of each project. The Office of Child Protective Services (CPS) is housed within the Department of Social Services. Per the CPS 2020 Federal Progress Update, they will collaborate with the Division of Behavioral Health and the Department of Health to explore further opportunities to enhance safe care plans, including linking infants affected by substance abuse to the Bright Start Home Visiting program. The 2020 updated Needs Assessment report can be found here: South Dakota CAPTA Annual Report

Aside from the CAPTA Needs Assessment, the Home Visiting program and the Office of Child Protection did have increased collaboration around the Community Based Child Abuse Prevention (CBCAP) Needs Assessment. The Community Based Child Abuse Prevention Assessment was submitted in May of 2020 and developed criteria for the utilization of the CBCAP funds to select programs to implement parenting education and child abuse prevention activities in South Dakota. A critical factor in the selection process is the ability of the program to expand or enhance community-based efforts in parenting education and support services that prevent child abuse and strengthen families. Programs participate in local efforts increasing awareness and focusing on the prevention of child abuse and neglect.

The Parenting Education Program continues to assess unmet needs in the state in the following ways:

- Providing peer review with each Parenting Education Partner every other year. The review process is a valuable way to provide input to the program and determine unmet needs. Parenting Education Partners conduct a brief phone survey or send a survey to past parenting participants. Information from the survey is analyzed, shared during the peer review process, and unmet needs are discussed.
- Feedback from the Parenting Advisory Education Board is an avenue for enhancing the partnership shared between the parents, Parenting Education Partners, and professions providing information on a variety of topics of interest to the board. The information presented provides the board members information, resources, and contacts that otherwise may not be known.
- Feedback from the Parent Outcome Survey is used to measure the effectiveness of the program and determine unmet needs.
- Participants of CSP complete the Parent Outcome Survey during the last CSP class. Questions on the survey ask for suggestions to help parents attend CSP classes, ask what additional information would be helpful to the parent and for recommendations to inform other parents about CSP. Data gathered from the surveys are incorporated into the program when appropriate and when possible.
- Parents are asked during the first CSP session what they want from the class; comments are recorded and reflected on during the CSP sessions to show parents how CSP skills will help them address these needs and wants. CSP instructors strive to make sure parents are receiving what they came for and are getting what they need. Ongoing evaluation and feedback from parents are essential and are a factor in the success of the CSP program.
- The Parent Education Program collaborates with Head Start to provide a comprehensive Family Assessment in South Dakota.

The Parenting Education Program recognizes the contributions made by parents to enhance and improve its programs. Many parents need assistance to build confidence in their ability to parent their

child and develop leadership knowledge and skills appropriately and effectively. The Parenting Education Program's network of partners and its collaborative relationship with other programs and services maximizes opportunities for parents to gain and practice leadership skills from the CSP Program.
Parenting Education Partners are encouraged to develop strategies to promote parenting skills with fathers participating in classes. Father-friendly methods of outreach and classes are integrated into statewide efforts to support parents through education and to decrease child abuse and neglect.

The training model used in CSP focuses on experiential learning. The five training components: instruction, modeling, practice, feedback, and review, give parents an opportunity to learn, and use parenting skills in a neutral class setting before putting the skills to use at home with their children. After viewing taped examples of parenting techniques, parents practice how to use the skills they have learned with their children.

Positive Indian Parenting draws on the strengths of traditional Indian child-rearing practices using storytelling, cradleboards, harmony, lessons of nature, behavior management, and the use of praise. It also addresses the historic impact of boarding schools, intergenerational trauma, and grief, and forced assimilation of parenting; it empowers Indian families to reclaim their right to their heritage to be positive parents. Positive Indian Parenting is strengths-based, conveying the message that our ancestors' wisdom is a birthright for American Indian/Alaska Native parents. The curriculum examines how many AI/AN families were deprived of the right to learn traditional practices, invites participants to reclaim values that may have been lost by earlier generations, and validates existing traditional knowledge and values. There have been no formal evaluations of Positive Indian Parenting; however, the curriculum is grounded in extensive child welfare practice experience. Moreover, the program has been deemed an effective practice by the First Nations Behavioral Health Association.

Early Childhood Enrichment (ECE) system promotes the health, safety, and development of young children in early childhood programs through training and technical assistance. Services offered are designed to assist caregivers, teachers and others involved in the day-to-day care of children as well as communities in the development of quality childcare programs and services. Consumer education services for families on choosing and locating childcare are also offered. The ECE programs are in five communities: Aberdeen, Brookings, Pierre, Sioux Falls and Rapid City. The EC system offers a continuum of face to face and e-learning training opportunities from entry level training to specialized certificate and credential programs for childcare providers. They also provide technical assistance and coaching to state registered and licensed childcare providers in a variety of topic areas that includes infant and toddler care. In addition, programs such as Pathways to Professional Development are offered to promote education, training, and professional growth of childcare providers.

Responsive Parenting Training sessions are available to parents of children birth to age three. The goal of the training sessions is to help parents learn how their child is growing and developing so they can be more responsive to their child and how to choose childcare that meets their needs. Coordinated by the five ECE sites, training is provided across the state by trainers who have been trained in the use the Responsive Parenting curriculum. Trainers who conduct training for childcare providers in alignment with the Program for Infants and Toddler Caregivers (PITC) are available to conduct the Responsive Parenting classes and have received special instructions on how to work with parents vs. childcare providers.

South Dakota's Bright Start Home Visiting Program manager is a representative on the Community Based Child Abuse Prevention Advisory Board which meets twice each year for training, information sharing, and to review the CBCAP grant and Needs Assessment submissions.

Child Protective Services involvement in the Home Visiting Needs Assessment

The CPS Program Director has been a participant in the comprehensive Title V and Home Visiting Needs Assessment as a member of the project advisory board, the Child and Family Interagency Workgroup.

Ongoing Collaboration between the Home Visiting Program and Child Protective Services

The South Dakota Bright Start Home Visiting program has had a Memorandum of Understanding for data sharing with the Office of Child Protection since the inception of MIECHV-funded services. The MOU provides for data sharing to support the child maltreatment performance reporting measure. Each program leads from CPS and the Bright Start Home Visiting Program participate in the Child and Family Services Interagency workgroup and provide training and technical assistance to each other's program staff.

Building on this partnership, the Office of Child Protection requested the Bright Start Home Visiting Program Manager participate in the multidisciplinary Plans of Safe Care team in the Spring of 2020. The team has been meeting throughout the summer and continuing forward following a virtual Practice and Policy Academy in August to develop a statewide plan to define how partners will support pregnant women and families with substance use disorders. The Plans of Safe Care initiative is a requirement of the CAPTA grant under the Comprehensive Addiction and Recovery Act (CARA). See the Substance Use Treatment section of this Assessment for further background.

Efforts to Review and Contextualize Needs Assessment Results through Ongoing Communication

As previously indicated, lead program staff from Title V, Head Start and the Child Protection programs participate in the Child and Family Interagency Workgroup, which functions as the advisory board for all programs' Needs Assessments and provides the forum to share results. The group meets quarterly, so ongoing communication and the ability to solicit programmatic feedback is ensured. In addition to the Child and Family Interagency Workgroup, other venues for sharing the Home Visiting Needs Assessment include:

- Presenting findings at the February 2021 Community Based Child Abuse Prevention advisory committee meeting (CBCAP).
- Presenting findings to home visiting Community Advisory Boards in the communities South Dakota Home Visiting currently serves.
- Presenting findings to the Office of Child and Family Services Central Office and Regional Managers team. This group includes the Title V staff, other Maternal Child Health programs, the WIC program staff, and the managers (personnel leads) for the seven community health regions in the state.

There are no changes to the program coordination or planned activities in this section due to the addition of Phase 2 data.

Conclusion

This Needs Assessment documents the current landscape of home visiting services and related gaps, barriers, and opportunities. It establishes an objective means by which county-level risk can be determined and maps those risks to the existing services provided across the state. It should – with additional data and input from stakeholders – provide a strong foundation upon which program planning can be based.

The assessment suggests several needs that might be fulfilled through increases in or refined targeting of home visiting programs and services. SD will use an integrated approach to assess those needs that builds on existing policy infrastructure and partner input to plan for future programming. The South Dakota Bright Start Home Visiting Statewide Needs Assessment work team will continue discussion of findings through the communication channels identified previously and share opportunities for inclusion of new home visiting communities, models, and service delivery strategies. Any planning will take into account that the counties identified are rural and remote, and several are located within tribal nations. It is important to note that any plans will be coordinated with tribal programs and communities.

Acknowledgments

The South Dakota Bright Start Home Visiting Program would like to thank the following partners for their input to this Statewide Needs Assessment:

- Department of Health Office of Child and Family Services, including the Title V Needs Assessment core team and workgroup
- Sandra Melstad, SLM Consulting, LLC
- Tianna Beare, Ethel Austin Martin Group, South Dakota State University
- Department of Social Services, Division of Child Protection and Division of Behavioral Health
- Department of Education, Head Start Collaboration Office and Birth to Three Program
- Early Head Start and Home-Based Head Start Program Directors
- Great Plains Tribal Chairmen's Health Board Maternal Child Health Programs
- Shared Waters Home Visiting
- Enemy Swim Day School FACE Program
- South Dakota Head Start Association
- The home visitors, program leads and staff who participated in the Home Visitor Survey
- The clients, community members and program staff who participated in Key Informant Interviews

Bright Start
Home Visiting Program

Appendix A: Statewide Needs Assessment Project Plan

South Dakota Home Visiting Needs Assessment Project Timeline

2018-2020

Project Goal: To guide South Dakota's MIECHV Program in identifying and understanding how to meet the diverse needs of eligible families living in at-risk communities

Planning	Lead Person(s)	Timeline	Deliverable
☐ Identify list of key stakeholders and partners to support the Needs Assessment process (concurrent with OCFS Needs Assessment process)	Linda, Scarlett, Carrie, Kaitlyn	Sep-Dec 2019	Completed – See OCFS Partners list
☐ Convene Planning Committee (concurrent with OCFS Needs Assessment process) ○ Linda Ahrendt, DOH, Administrator ○ Scarlett Bierne, DOH, Project Lead (left, February 2020) ○ Jennifer Folliard, DOH, Assistant Administrator as of May 2020 ○ Katelyn Strasser DOH, Data/Epi ○ Carrie Churchill DOH, Home Visiting ○ Bonnie Specker, SDSU, Data ○ Tianna Beare, SDSU, Data ○ Sandra Melstad, SLM Consulting, Facilitator	Linda, Katelyn, Carrie, Sandi	February 2019 to December 2019	
☐ Review data, simplified method, available datasets, and progress from prior Needs Assessment specific to home visiting	Tianna and Carrie	June - December 2019	HRSA Simplified Method, PRAMS, sub-county areas of interest (local data)
☐ Participate in technical assistance opportunities to support understanding of the needs of pregnant women and infants ○ HV-ImpACT monthly webinars ○ DOHVE State-Tribal LIA Community of Practice	Carrie Tianna & Sandi as needed	June – December 2019	Completed
Implementation of Process	**Lead Person(s)**	**Timeline**	
☐ Convene Core Committee for Initial Review of Steps ○ Review current efforts and if align with current priorities ○ Collaboration on programs/initiatives ○ Assets/Gaps in services, capacity, community resources ○ Barriers to home visiting programs, including geography, availability and accessibility of services and family supports ○ Review state/strategic plan ○ Resource Inventory of available services	Carrie, Tianna, Sandi	Jan/Feb 2020	• Identify current efforts • Identify assets/gaps • Identify additional stakeholders missing from the "table" • Inventory of available services **DONE, January 2020**

☐ Determine data collection methods to meet project requirement and determine definition of "at-risk communities"	Tianna and Carrie	March/April 2020 **Delayed to May/June due to redirection of efforts to coronavirus**	Phase 1: Counties identified using HRSA simplified method Phase 2: Adding counties known to be at risk by incorporating other datasets and qualitative data
☐ Identify the quality and capacity of current home visiting programs (Quantitative and Qualitative focus) o NFP data reports (Outcomes, Fidelity, Caseload, etc.) o Survey Monkey done in October 2019 – do we need to redo or update? o Identify gaps in service areas and staff capacity	Carrie, Tianna, and Sandi	June/July 2020	Analysis of Survey Monkey conducted in October 2019 Inventory of existing programs including funders, capacity, service area and # of families who received services
☐ Assess Community Readiness (Qualitative focus) o Focus group reports from Title V Needs Assessment o Key Informant Interviews ▪ Develop KII Plan ▪ Develop interviewee list ▪ Synthesize interviews o Survey of community resources, possible barriers	Carrie and Sandi	July and August 2020	Completed
☐ Assess Substance Use Disorder Treatment and Counseling Resources o Meet with DSS to make sure we have available data on the Substance Abuse Prevention and Treatment Block Grant o Meet with Child Protection Services to assess resources and gaps in accessing SA resources for families o Describe coordination between state agencies to respond to SUD among pregnant women and young families	Carrie	June and July 2020	Completed, September 2020
☐ Gather relevant data and/or coordinate with other Needs Assessments o Title V o State Health Assessment o United Way of the Black Hills o Tribal MIECHV o Hospitals/Health Systems o Head Start o CAPTA (Child Abuse Prevention and Treatment)	Carrie and Sandi	June and July 2020	Completed, and limited to Title V, Head Start, Vulnerability assessment and CAPTA due to space

Synthesize Findings and Compile Report	Lead Person(s)	Timeline	
☐ Convene Core Committee to review and contextualize results of the relevant Needs Assessment to better assess risk, unmet needs, and gaps in care	Carrie, Jennifer, Sandi, and Tianna	Early August 2020	Completed
☐ Develop NA Summary Reports for Review by Steering Committee and Submit to HRSA by October 1st	Sandi and Carrie	August and September	Completed
☐ Develop Data tables or maps to include in report	Tianna	August	Completed
☐ Write final report for submission	Carrie and Sandi, with assistance from Jenn F and Jen Baker as needed	August and September First Draft finished: Sept 18	Completed
☐ **Submit report to HRSA**	Carrie	**October 1, 2020**	**COMPLETED**
☐ Disseminate final reports to partners and key stakeholders o Child and Family Interagency Council o Title V MCH team o Home Visiting program staff o Potential new partners	Carrie, Linda, Jennifer	After final approval from HRSA until FY21 Grant Submission	

Appendix B: Home Visiting Provider Survey

Survey of Home Visiting Programs in South Dakota

The South Dakota Department of Health is conducting a statewide Needs Assessment to assess current home visiting programs and plan for future service delivery. Your input will help us in describing the strengths and needs of services for young families in our state.

1. I am a:
   - ☐ Home Visitor
   - ☐ Local team lead/supervisor
   - ☐ Program Administrator
   - ☐ Clerical or other program support

2. Name of program: _____

   Model used (may check more than one):

   - ☐ Attachment and Biobehavioral Catch-Up (ABC) Intervention
   - ☐ Child FIRST
   - ☐ Healthy Families America
   - ☐ Home Instruction for Parents of Preschool Youngsters (HIPPY)
   - ☐ Early Head Start – Home based option
   - ☐ Head Start-Home based option
   - ☐ Nurse Family Partnership
   - ☐ Parents as Teachers
   - ☐ Family Spirit
   - ☐ SafeCare Augmented
   - ☐ Healthy Beginnings
   - ☐ Bright Beginnings (Getting Ready)
   - ☐ Partners for a Healthy Baby
   - ☐ Other: _____
   - ☐ No specific model used: _____

3. Which groups do you serve?
   - ☐ Pregnant women
   - ☐ Parents of infants/young children
   - ☐ Infants (1-12 months)
   - ☐ Toddlers (1-3 years)
   - ☐ Preschoolers (3-5 years)
   - ☐ Other: _____

4. Is your program's service delivery area limited to a specific community(ies), county(ies), or tribal area? Yes/No
   Where? _____

5. What is the farthest distance you've traveled to a home visit?
    - ☐ 1-10 miles
    - ☐ 10-20 miles
    - ☐ 20-50 miles
    - ☐ more than 50 miles

6. Maximum and Current Caseloads

Role	Maximum Caseload	Current Caseload
Home Visitor (personal caseload)		
Local agency Lead (agency caseload)		
Administrator (program caseload)		

7. What would you say are some STRENGTHS of your home visiting program? (select all that apply)
    - ☐ A curriculum or model that fits the needs of the families we serve
    - ☐ Access to needed training and professional development
    - ☐ A network of other resources/programs that also support families we serve
    - ☐ Data and reports that show the outcomes of program services
    - ☐ The ability to recruit and retain families and keep a full caseload
    - ☐ Providing services that fit the cultural background of our families
    - ☐ Consistent and dependable funding for services
    - ☐ Strong community support for home visiting services
    - ☐ Other: _____

8. What would you say are some NEEDS of your home visiting program? (select all that apply)
    - ☐ Lack of a curriculum or training for home visitors
    - ☐ Frequently have waiting lists for clients to enroll
    - ☐ Frequently do not have full caseloads of families
    - ☐ High turnover in home visiting staff
    - ☐ Difficulty recruiting staff
    - ☐ Families that leave services before they complete the program
    - ☐ Travel barriers – poor roads, long distances to visit families
    - ☐ Lack of outcome data and reports that show program effectiveness
    - ☐ Not enough other resources in our community to meet families' needs
    - ☐ More opportunities for our program to connect and communicate with other service providers
    - ☐ Lack of consistent funding
    - ☐ Lack of community support, knowledge or understanding of home visiting services

    Other_____

9. What are some of the greatest needs of the families you serve? (choose up to three)
    - ☐ Living in poverty
    - ☐ Not enough community resources to meet their needs
    - ☐ History of or current trauma
    - ☐ Poor health
    - ☐ Transportation
    - ☐ Mental health concerns
    - ☐ Substance use/abuse
    - ☐ In need of support with parenting skills
    - ☐ Personal safety
    - ☐ Home safety
    - ☐ Other_____

10. What inspires you most about being a home visitor or working in a home visiting program?
    _____

11. Besides your service delivery area, are there other communities in South Dakota that you think would benefit from home visiting services?
    _____

12. Besides your home visiting program, what other home visiting programs or models have you heard about that serve families in South Dakota?
    _____
    _____

13. Are there certain groups in your community that would benefit from home visiting services that your program or other programs in your community do not currently serve?
    - ☐ Younger children (ages birth to 3 years)
    - ☐ Older children (three to eight years)
    - ☐ Parents who do not currently qualify for existing services. Who? _____

Optional: Would you be interested in providing more information about your program services for the Needs Assessment process, or in finding out the results of this survey? Yes OR No

If so, name and email:

KEY INFORMANT GUIDE

SOUTH DAKOTA DEPARTMENT OF HEALTH

MATERNAL INFANT AND EARLY CHILDHOOD HOME VISITING

STATEWIDE NEEDS ASSESSMENT: 2020

Sandra Melstad
SLM CONSULTING, LLC | SOUTH DAKOTA |

KEY INFORMANTS

Population	Organization	Contact Name & Phone	Contact Email
Home Visitor	SD Dept of Health		
Home Visitor	Children's Home Society of South Dakota		
Home Visitor	USD Early Head Start Program		
Early Childhood Partner	Birth to 3, Department of Education		
Early Childhood Partner	Cheyenne River Sioux Tribe, Missouri Breaks		
Community Leader	John T. Vurcurevich Foundation and Early Learner Rapid City		
Client/Family Member/parent	Current client		
Client/Family Member/parent	Past client		
Client/Family Member/parent	Past client		
Client/Family Member/parent	Parent from unserved community		

RECRUITMENT LETTER/E-MAIL

Dear [Name],

The South Dakota Department of Health (SD-DOH) is conducting a statewide Maternal, Infant and Early Childhood Home Visiting statewide Needs Assessment to understand the strengths and needs of young families across the state. The assessment captures county-level data indicators that reflect the health and well-being of pregnant and parenting families, infants, and young children so that the state and its partners can carry out strategic decision-making regarding home visiting services in the state. Since data only tells part of the story, we need help to fill in the gaps.

We are seeking key individuals to help us understand the experiences of young families across the state and the resources that are available to them. You were recommended because of your knowledge, insight, and familiarity with the population that you serve.

I hope you will consider participating in a phone, in-person or virtual interview that will help inform our understanding. I have attached a list of the questions that will be asked. As you review the questions, if there is someone within your organization that would be better able to respond, please reply all to this message.

Sandra Melstad, Public Health Consultant with SLM Consulting, will follow up with you and facilitate the interview if you choose to participate. The interview should take no longer than 60 minutes. The themes that emerge from these interviews will be summarized and made available to the public, but individual interviews will be kept strictly confidential.

Thank you in advance for your help and your commitment to the health of South Dakotans.

Best,

Thank you,

Carrie Churchill, RN

Home Visiting Program Manager

RECRUITMENT STEPS

July	**1. Carrie Churchill will e-mail Key Informants to request their participation → Refer to Key Informants Contact, Recruitment Letter/E-Mail, and interview questions**
Within one week of first contact	**2. Sandra contacts Key Informant to discuss the following:** **a. Agree to Participate →** i. Schedule a date/time/location for interview ii. Provide information on interview structure, details, and questions iii. Provide and Obtain Informed Consent → **Refer to Consent Form** *1. Must be obtained before interview can begin* iv. Answer any other questions **b. Did not agree to participate** i. Thank person for their time and invite to participate in Needs Assessment process by contacting Carrie Churchill ii. Identify another Key Informant
July/August	**3. Sandra conducts the interview → Refer to Key Informant Guide and Documentation**
Within one week of interview	4. **Key Informant is sent a follow-up letter/e-mail → Refer to Follow-Up Letter**
August	**5. Data is analyzed and coded to inform Needs Assessment finding and priority setting → Refer to Analysis**

CONSENT FORM

Project: South Dakota Department of Health Key Informant Interview

The purpose of this interview is to understand health and social issues that impact pregnant and parenting families, infants, and young children. Information gathered in this interview will help with priority setting and long-term planning for the South Dakota Department of Health Home Visiting Program.

I agree to participate in this project, whose conditions are as follows:

- The purpose of this project is to understand the health and social issues impacting pregnant and parenting families, infants, and young children. For this purpose, semi-structured interviews will be conducted with key informants from key organizations.
- Each interview will last for about 45 minutes and questions will deal with understanding the health issues, barriers to good health, strategies working to address health issues, and identify opportunities to better support and engage families.
- The interview I give and the information it contains will be used solely for the purposes defined by the project.
- At any time, I can refuse to answer certain questions, discuss certain topics, or cease to participate in the interview without prejudice to myself.
- The interview will be recorded to make the interviewer's job easier. However, the recording will be destroyed as soon as it has been transcribed.
- All interview data will be handled to protect the confidentiality of sources. Therefore, no names will be mentioned, and the information will be coded.
- All data will be kept confidential and destroyed at the end of the project.
- For information on the project, I can contact Carrie Churchill, SD Department of Health at carrie.churchill@state.sd.us or 605-394-2495.

Respondent's signature: _____
Date: _____
Interviewer's signature: _____
Date: _____

INTERVIEW GUIDE

Purpose

Thank you for taking the time to talk with me and share important feedback about health of young families in South Dakota. The purpose of this interview is to understand health and social issues that impact pregnant and parenting families. The South Dakota Department of Health program seeks to identify barriers to good health, strategies working to address needs, and opportunities to better support and engage families. The information gathered in this interview will help with priority setting and long-term planning for the Home Visiting program to support South Dakotan families.

Consent

Refer to Consent Form

1. Would you like to participate in this interview?
2. Do I have your consent to record this interview?
3. Do you have any questions before we begin?

QUESTIONS FOR PROVIDERS

Introduction

1. Tell me a little about your role in your organization. How long have you been in this position?
2. What do you enjoy most about this role?

Key Questions

3. Please tell me a little bit about the population that you serve.
4. Please identify one to two pressing issues affecting pregnant and parenting families that you serve as well what factors (e.g., personal considerations, institutional/religious/community context) contribute to those issues.
5. What are barriers to addressing those issues? (*Transportation? Flexible hours for work or childcare? Geography)*
6. What efforts are working well to address those issues, including who (e.g., community leader, organization, etc.) is involved?
7. Please tell me about how you have adapted your services to support the language and cultural needs of families.

    If No, why? Not needed? Do not how?
8. What are some unique strengths that your target population has when working to become healthier, self-sufficient families? (*Examples, including positive or negative, resources, healthy behaviors)*
9. Thinking about your current program and resources you currently have available to support your role. What is your "wish list" of resources or supports (e.g. programs, services) that would provide more opportunities for your population support their ability to parent?
    a. *What resources or support would make your job easier to support parents?*

i. *Collaboration?*
ii. *Programs?*
iii. *Funding?*

Closing Question

10. Is there anything else that we should know about the strengths and needs of the population that you did not yet share?

QUESTIONS FOR CLIENTS/FAMILIES

Introduction

1. Tell me a little about your family.
2. What do you enjoy most about being a parent or the idea of becoming a parent?

Key Questions

3. What are one to two needs that families with young children like yourself may be facing in your community. *(No family nearby? Substance use? Questions about how to be a parent?)*
4. What makes it difficult to get those needs met? *(No services available? Transportation? Cost? Childcare?)*
    a. *Describe any language and cultural needs not being met?*
    b. *Describe programs and resources that have made it difficult to get your needs met?*
5. What is working well to help to address those needs?
    a. *Describe any supportive family or resource people/home visitor to address those needs?* (Provider, etc.)
    b. *Describe programs and resources that help address those needs?* (WIC, SNAP etc.)
6. How do you or young families like yours seek/access help regarding taking care of your baby/child? *(Using technology to get answers? Word of mouth from friends or family members do or encourage you to do? Healthcare provider?*
    a. *What is most effective? Why?*
    b. *What is least effective? Why?*
7. What would be on a "wish list" of things that would support your role as a parent? (*More resources nearby? A person who could help you find out about any resource you need? Culturally appropriate? (rural, age, race/ethnicity)*

Closing Question

8. Is there anything else that we should know that you did not share regarding your role as parent?

FOLLOW-UP W/ KEY INFORMANT

Greetings *[Name]*

Thank you for participating in a Key Informant Interview on *[date]*.

We appreciate you sharing your time and insights. Moving forward, we are going to pull together what we are hearing and learning from different conversations and share a summary of all interviews with you.

Thank you again for taking time to participate in the conversation.

If you have any questions about the conversation or our work, do not hesitate to call *[person]* at *[phone]*.

Sincerely,

[Name]

[Organization]

DOCUMENTATION

Method	The interview will occur in-person, on the telephone, or via Zoom platform. The method used will depend on the key informant's location and preference.
Note-taking	Interviewer will take notes of the discussion and document in Microsoft Word by key informant interview.
Audio/Video	The interview will be recorded via telephone or Zoom, depending on method used. Recording will be stored on SLM Consulting, LLC's laptop and a secure file.
Transcription	Notes and recordings will be transcribed and organized into an appropriate qualitative data software, e.g. Excel, NVivo
Confidentiality	Notes and recording's will be stored on SLM Consulting, LLC's laptop and a secure file.

ANALYSIS

Method	Interviews will be analyzed for key themes and sub-themes to inform the larger statewide Needs Assessment, priority setting, and statewide health improvement planning.