Maternal Child Health – Women Domain
NPM 1

State Action Plan	Implementation Timeframe: October 1st, 2021 through September 30th, 2022
NPM #1 Percent of women, ages 18-44 with a preventive medical visit in the past year	
State Priority Need: Mental Health/Substance Misuse	
Objective(s): Increase the percent of women, ages 18 through 44, with a preventative medical visit in the past year from 77.3% (2020) to 81.3% in 2025.	
Facilitator: Christine Catts (MCH Women's Domain Coordinator/MMR Abstractor)	

	Activities	Status	ESM	Responsible person(s)
Strategy 1.1: Develop partnerships with diverse, multisector stakeholders to promote preventative care for women of childbearing age.	Utilize social media to promote the importance of yearly well women visits.	Increased the volume of posts to social media and added Instagram and snapchat	# of messages posted promoting well women care.	
	Expand the NPM #1 workgroup to include partners and community members who are committed to this work.	New members from Community Health nursing in SD, Sanford Health, and Postpartum support international		

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

Strategy 1.3: Increase depression screening and referrals to PCP among low-income women on the SD WIC program	Develop policy within the OCFS to refer women with positive depression screen to their Primary Care Provider		% of women with positive depression screen who are referred to their PCP within OCFS field offices	
Strategy 1.4 Develop a policy recommendation with Department of Social Services to create Maternal Medical Homes				

Maternal Child Health – Perinatal/Infant Domain
NPM 5

State Action Plan	Implementation Timeframe: October 1st, 2021 through September 30th, 2022
NPM 5 A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	
State Priority Need: Safe Sleep	
Objectives: 1) Reduce the number of SUID deaths related to unsafe sleep environment from 139.8/100,000 in 2019 to 120.2/100,000 by 2025 (NVSS). 2) Increase the percent of infants placed to sleep without soft objects or loose bedding from 55.8% in 2020 to 56.5% by 2025 (PRAMS).	
Facilitator: Jill Munger (DOH – MCH Infant Domain Coordinator/CDR Coordinator)	

	Activities	Status	ESM	Responsible person(s)
Strategy 5.1: Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media and print.	Continue to post safe sleep messages on For Baby's Sake and DOH Facebook pages.			
	Continue to place ads in parenting magazines and professional journals.			
	Continue to disperse safe sleep infographic (with data from CDR) to providers and partners across the state.			

	Activities	Status	ESM	Responsible person(s)

Strategy 5.2: Collaborate with diverse community partners to provide Child Death Review and disseminate findings to all South Dakotans.	Work with team from Johns Hopkins to translate CDR findings into actionable, evidence-informed recommendations			
	Work with Medical Examiners and law enforcement to provide infant death investigation and SUIDI form training to those that conduct the investigations.			
Strategy 5.3: Collaborate with diverse, multi-sector organizations/ agencies to promote safe sleep	**Activities**	**Status**	**ESM**	**Responsible person(s)**
	Explore new opportunity *Today's Baby* with SD WIC program			
	Partner with Cribs for Kids and all SD birthing hospitals to promote bronze safe sleep certification within their system.		% of birthing hospitals that receive information on certification process that become safe sleep certified.	

Updated: 6/2/22

Maternal Child Health –Child Domain

State Action Plan	**Implementation Timeframe:** October 1st, 2022 through September 30th, 2023
NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
State Priority Need: Parenting education and support	
Objective(s): Increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year from 22.3% (2019-2020) to 29.4% by 2025 (NSCH)	

Strategy :	Activities	Status	ESM	Responsible person(s)
6.1 Utilize Community Health offices and Bright Start Home Visiting Program to provide Ages and Stages Developmental Screen tool to clients.				
	Encourage Community Health staff to connect English and Spanish speaking families with needed technology to apps including CDC Milestone Tracker app, Bright by Text app, Text4Baby			
	Ensure community health offices have adequate hard copy resources such as trifold developmental screening cards and milestone tracking handouts to distribute to families			
	Develop ASQ and ASQ SE screening processes in Community Health Offices and identify opportunities for quality improvement		6.1 Percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age.	

	Provide training to community health staff on early identification			
Strategy	**Activities**	**Status**	**ESM**	**Responsible person(s)**
6.2 Create new and promote existing parenting resources to support healthy children and families	NPM 6 workgroup will identify parenting resources across the state and collaborate on promotion and dissemination to families			
	Connect with medical providers, social workers, tribal communities, and community workers to identify additional parenting resources and ways to equitably promote them			
Strategy	**Activities**	**Status**	**ESM**	**Responsible person(s)**
6.3 Collaborate with partners to identify gaps in parenting education and support and reduce duplication of efforts	Meet quarterly with Medicaid, Social Services, and Department of Education to coordinate services and prevent duplication of efforts			
	Collaborate with the DOH Home Visiting program and Community Health Offices to reduce duplication of and/or gaps in			

	developmental screenings and referrals for evaluation between home visiting and other OCFS programs			
	Title V Child Health Coordinator will serve on the SD Developmental Disabilities Council, State Community of Practice Team, and additional workgroups as requested to boost collaboration with other entities and identify gaps in parenting education and support			

Maternal Child Health – Adolescent Domain
NPM 7.2

State Action Plan	**Implementation Timeframe:** October 1st, 2020 through September 30th, 2021
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	
State Priority Need: Suicide Prevention/Mental Health	
Objective(s): Decrease the adolescent suicide rate among 15 through 19-year olds from 29.2 per 100,000 (2016-2018) to 26.3 in 2025 (NVSS). Decrease the percentage of 9th-12th graders who attempted suicide in the past 12 months from 12.3% in 2019 to 9.0% in 2025 (YRBS).	
Facilitator: Sarah Barclay (DOH- MCH Child/Adolescent Coordinator)	

	Activities	**Status**	**ESM**	**Responsible person(s)**
Strategy 7.2.1: Promote evidence-based programs and practices that increase protection from suicide risk	Provide Youth Mental Health First Aid Training			
	Provide Question Persuade Refer (QPR) trainings for high school staff			
	Provide teen Mental Health First Aid Training		Number of students trained in teen Mental Health First Aid	
	Provide and promote Text4Hope - Teen Crisis Texting Support			

Maternal Child Health – Adolescent Domain
NPM 7.2

	Activities	Status	ESM	Responsible person(s)
Strategy 7.2.2: Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens	Develop and promote PYD training for organizations working with diverse youth on suicide prevention/mental health.			
	Collaborate with Youth Advisory Council that focuses on adolescent priorities and provide activities that emphasize health equity and integrating youth voice throughout.			
	Develop an assessment tool for Positive Youth Development activities.			
Strategy 7.2.3: Develop and disseminate equitable and accessible Suicide Prevention education material, resources, and messaging	**Activities**	**Status**	**ESM**	**Responsible person(s)**
	Promote suicide prevention and mental health messaging for Cor Health social media			
	Develop and promote Suicide Prevention training for parents of young people 10 to 19 years old, including vulnerable/underserved youth			
	Utilize communication platforms to disseminate trainings and materials accessible to diverse parents and organizations working young people 10 to 19 years old including vulnerable/underserved youth.			
Strategy 7.2.4: Develop partnerships with diverse, multi-sector local and state	**Activities**	**Status**	**ESM**	**Responsible person(s)**
	Continue to partner with organizations that were involved with the Title V Needs Assessment and build rapport with new			

agencies to address youth mental health and suicide prevention among all South Dakota youth	organizations working with diverse youth in mental health and suicide prevention.			

Maternal Child Health – CYSHCN Domain

State Action Plan	**Implementation Timeframe:** October 1st, 2022 through September 30th, 2023
NPM 11- Percent of children with and without special healthcare needs, ages 0 through 17, who have a medical home.	
State Priority Need: Access to care and services	
Objective(s): Increase the percentage of CYSHCN who report receiving care in a well-functioning system from 20.9% (2019-20) to 21.2% by 2025 (NSCH)	
Facilitator: Whitney Brunner (MCH Assistant Program Director; CYSHCN Director)	

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

	Partner with DSS to support equitable provision of special needs carseats			
	Explore additional opportunities to link families to needed resources in our state			
	Provide financial support to low income families of CYSHCN through Health KiCC program while continuing to phase the program and explore alternative resources for remaining participants			
Strategy	**Activities**	**Status**	**ESM**	**Responsible person(s)**
11.2 Identify and implement strategies to equitably advance medical home components for families of CYSHCN through access to family centered care coordination	Partner with Sanford Health to provide care coordination services for families of children with complex medical conditions at Sanford Children's Hospital		Percentage of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services	
	Collect and review data from Sanford Children's care coordination pilot to identify needs and health disparities to inform program planning			
	Explore new opportunities for expansion of care coordination services in the state, including opportunities for linking families of newborns and infants with special health			

	care needs to medical homes			
Strategy	**Activities**	**Status**	**ESM**	**Responsible person(s)**
11.3 Coordinate the state newborn screening infrastructure focused on equitable testing and access to follow up services	Contract laboratory for newborn screening of all South Dakota births			
	Partner with Sanford Health to contract medical consultants, genetics counselors, and a follow up nurse to address equitable and appropriate testing, treatment, and follow up for presumptive positive			

Maternal Child Health – Adolescent Domain
SPM 1

State Action Plan	**Implementation Timeframe:** October 1st, 2020 through September 30th, 2021

SPM 1 – Improve young people' (10-24 years) relationship by Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 45.6% in 2020 to 50.2% by 2026.

Overall Goal - Improve young peoples' (10 to 24 years) relationships by increasing education and support, STI prevention, and pregnancy prevention.

State Priority Need: Healthy Relationships

Objective(s):

- Decrease the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics from 14.2% to 12.8% by 2025 (EHR NetSmart)
- Decrease the South Dakota teen birth rate, ages 15 through 19, from 20.4/1000 in 2018 to 18.4/1000 in 2025 (NVSS)

Facilitator: Sarah Barclay (DOH)- MCH Child/Adolescent Coordinator)

Strategy 1.1:	**Activities**	**Status**	**ESM**	**Responsible person(s)**
Promote evidence-based programs and practices that increase healthy relationship skills, STI prevention and pregnancy prevention	Provide and promote STI guidelines training to providers serving young people 10 to 24, including vulnerable/underserved youth			
	Collaborate with South Dakota Family Planning Program, Rape Prevention Education, Title V Sexual Risk Avoidance Education, General Department Sexual Risk Avoidance and Personal Responsibility Program Grants serving diverse populations			

Maternal Child Health – Adolescent Domain
SPM 1

SOUTH DAKOTA DEPARTMENT OF HEALTH

	Develop a youth evaluation plan for MCH programs and partners working on healthy relationship grants and activities.			
Strategy 1.2: Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens	**Activities**	**Status**	**ESM**	**Responsible person(s)**
	Develop and promote PYD trainings for those working with diverse youth on healthy relationships			
	Collaborate with Youth Advisory Council that focuses on adolescent priorities and provide activities that emphasize health equity and integrating youth voice throughout.			
	Develop an assessment tool for Positive Youth Development activities.			
Strategy 1.3: Develop and disseminate equitable and accessible healthy relationship, STI prevention and pregnancy prevention materials, resources and messaging	Develop and promote messaging for Cor Health Social Media.			
	Utilize communication platforms to disseminate trainings and materials accessible to diverse parents and organizations working with young people 10 to 24 including vulnerable/underserved youth.			
	Develop youth-friendly services materials for agencies and clinics servicing young people 10 to 24 years old.			

Maternal Child Health – Adolescent Domain
SPM 1

Strategy 1.4: Develop partnerships with diverse, multi-sector local and state agencies to address youth healthy relationships, STI prevention and pregnancy prevention among all SD youth	Continue to partner with organizations that were involved with the Title V Needs Assessment and build rapport with new organizations working with diverse youth on healthy relationship, STI prevention and pregnancy prevention.			

Maternal Child Health – Cross-Cutting Domain

State Action Plan	**Implementation Timeframe:** October 1st, 2020 through September 30th, 2025
NPM or SPM **SPM #2 The extent to which data equity principles have been implemented in SD MCH data projects**	
State Priority Need: Data sharing and collaboration	
Objective(s): 1. Increase the number of new data sharing projects accomplished from three to seven by September 30, 2025. **2. Increase the number of new partners that we collaborate with on data projects from two to five by September 30th, 2025.**	
Facilitator: Katelyn Strasser (MCH Epidemiologist)	

Strategy :	Activities	Status	ESM	Responsible person(s)
2.1 Provide access to timely, reliable data so that partners and communities can use it in their own efforts to advance equity	Continue to update the existing OCFS internal dashboard and understand how this might be shared with partners or used to create an external dashboard			
	Highlight MCH data on inequities in a quarterly MCH newsletter, SD Public			

	Health Bulletin, and other publications.			
Strategy	**Activities**	**Status**	**ESM**	**Responsible person(s)**
2.2 Develop reports that highlight health inequities across programs and issue areas	Create a new maternal mortality report. Highlight disaggregated data, contributing factors, and prevention recommendations to share with partners.			
	Update MCH data briefs by domain to reflect new NPMs and health inequities within these domains.			
	Create a South Dakota Women's Health Report Card			
Strategy	**Activities**	**Status**	**ESM**	**Responsible person(s)**
2.3 Analyze de-identified data to assess social determinants of health and other underlying factors	Analyze social determinant of health data from infant/child death review and maternal mortality review to understand contributing factors,			

that play a role in morbidity and mortality.	disparities, and how this data can be translated to stakeholders and policy makers for multi-system collaboration.			
	Analyze social determinant of health information from the pregnancy care risk assessments in the OCFS electronic health record to understand the main factors affecting OCFS clients.			
	Link PRAMS to Medicaid claims data through the ASTHO project to understand more about women's access to care and quality of care			
2.4 Increase collaboration around American Indian data between state	Engage with tribal leaders and learn their preferred method of sharing county level data from Tribal land (i.e. PRAMS tribal reports)			

and tribal partners				
	Understand what tools the Tribes need to put data into action			