SOUTH DAKOTA DEPARTMENT OF HEALTH

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Maternal and Infant Health Task Force Strategic Plan

The Health Resources and Services Administration (HRSA) Department of Health and Human Services (HHS) provided financial support for this report through the State Maternal Health Innovation Program. The contents are those of the author. They may not reflect the policies of HRSA, HHS, or the U.S. Government.

Last Update: August 2026

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Introduction

The Maternal and Infant Health Task Force (MIH Task Force), established in 2024, was developed by the South Dakota Department of Health to advance maternal and infant health across South Dakota. The MIH Task Force comprises multidisciplinary members and individuals with personal experience committed to advancing a shared vision for maternal and infant health in the state. The MIH Task Force was created through the State Maternal Health Innovation Program awarded by the Health Resources and Services Administration.

The purpose of the MIH Task Force is to bring together maternal and infant health stakeholders and serve as the central coordinating body for advancing maternal and infant health within the state. Strategies to advance these efforts focus on addressing priority areas identified by the MIH Task Force. To inform action on priority areas, a strategic plan was developed to guide the implementation of activities that align with the grant's purpose and achieve its deliverables. Broad data informs the strategic plan, including data relevant to maternal and infant health outcomes, such as a prior Title V Needs Assessment, maternal and infant mortality data, state maternal morbidity reports, and an examination of current statewide efforts.

Maternal and Infant Health in South Dakota

Overview of Maternal and Infant Health in South Dakota

Maternal Health Outcomes

South Dakota is a Midwest rural state with a population of over 900,000 and over 11,000 annual births. The average pregnancy-associated mortality rate over the last 10 years (2015-2024) was 65.7 deaths per 100,000 live births.[1]

South Dakota's maternal and infant health indicators reveal a mixed picture when compared to national benchmarks, as seen in Table 1. SD maternal mortality (21.1 per 100,000) was slightly higher than the U.S. average (19.6 per 100,000 for maternal mortality), underscoring continued concern for maternal health in the state.[2, 3-5] At the same time, South Dakota performed better than the nation on several key perinatal indicators: rates of low birth weight (7.2% vs. 8.6%), cesarean delivery (24.4% vs. 32.3%), and primary cesarean delivery (14.5% vs. 19.2%) were all substantially lower. Preterm birth rates were similar between South Dakota (11.3%) and the United States overall (10.4%).[2, 6-7] Together, these findings highlight both the elevated burden of maternal mortality in South Dakota and areas of relative strength in perinatal outcomes.

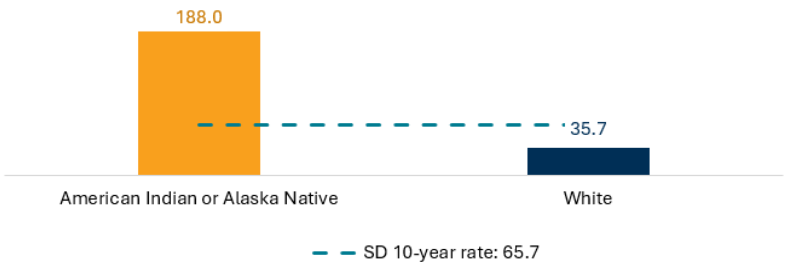
Table 1. Perinatal Health Indicators – South Dakota *versus* United States, 2022-24 (combined).

	South Dakota[2]	U.S.[3-7]
Pregnancy-Associated Mortality	72.2 per 100,000 live births	--
Maternal Mortality*	21.1 per 100,000 live births	19.6 per 100,000 live births
Low Birth Weight	7.20%	8.56%
Preterm Birth Rate	11.34%	10.39%
Cesarean Birth	24.35%	32.25%
Primary Cesarean Birth	14.45%	19.19%

*The South Dakota rate is unreliable due to a small number of cases and should be considered with caution.

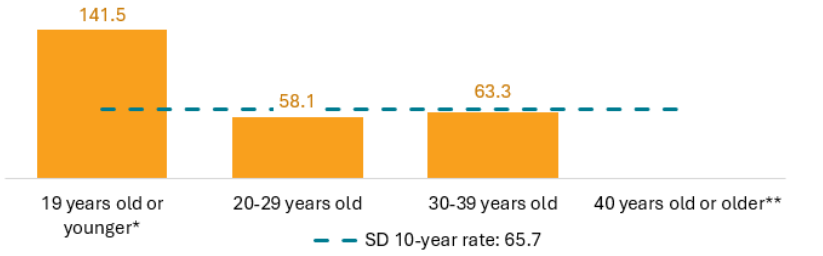
In addition to the poor maternal health outcomes in South Dakota, there are also disparities among populations impacted. During 2015-2024, American Indians accounted for **19.5%** of all live births and **49.3%** of all pregnancy-associated deaths.[1] Rates of pregnancy-associated death among American Indians were **5 times higher** than among White women (Figure 1).[1]

Figure 1. 2015-2024 SD Pregnancy-Associated Death Rates (per 100,000 live births) by Race and Ethnicity[1]



In South Dakota, the pregnancy-associated death rate was higher among younger women, whereas the national rate was higher among older women[1] (Figure 2).

Figure 2. 2015-2024 SD Pregnancy-Associated Deaths (per 100,000 live births) by Age Group[1]

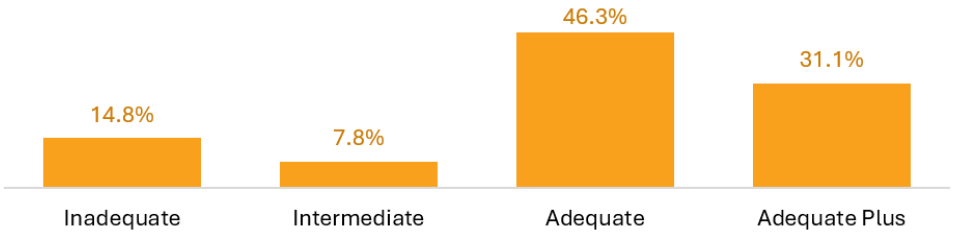


*Rate is unreliable due to the small number of cases and should be considered with caution.
**Suppressed due to very small numbers of cases that made the rate extremely unreliable.

Prenatal Care and Postpartum Checkup

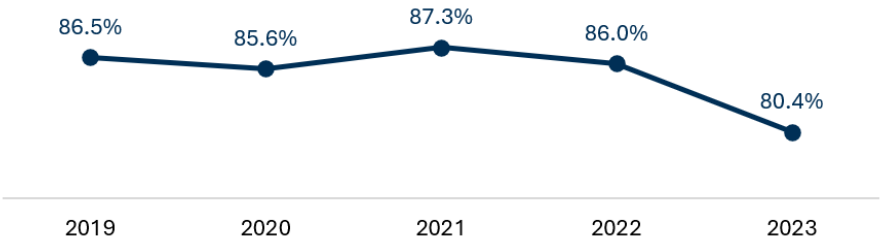
Early and regular prenatal care is important to ensuring positive maternal health outcomes. It can prevent complications and inform mothers on the steps to take for a healthy pregnancy.[8] However, the utilization of prenatal care varies across the state. South Dakota's Pregnancy Risk Assessment Monitoring System (SD PRAMS) data shows **15%** of South Dakota mothers were classified as receiving inadequate prenatal care in 2023 (Figure 3).

Figure 3. 2023 SD Adequacy of Prenatal Care Use – Koltechuck's Index[9]



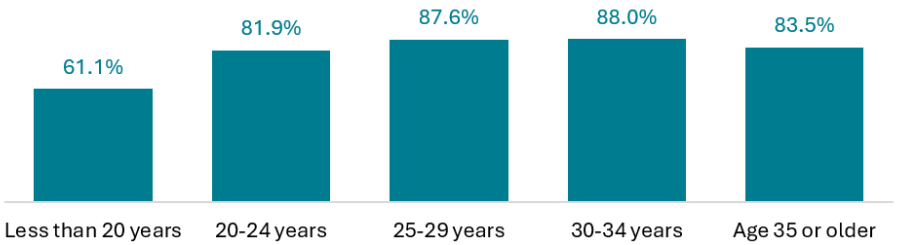
From 2019 to 2023, the percentage of South Dakota mothers who began prenatal care in the first trimester decreased with an average rate of **80.4%** (Figure 4).[10]

Figure 4. 2019-2023 SD Mothers who began Prenatal Care in First Trimester[10]



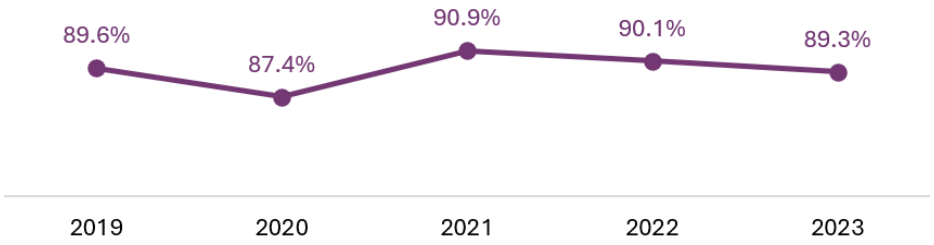
However, mothers less than 20 years old were less likely to attend more than 80% of prenatal care visits (Figure 5).[9]

Figure 5. 2023 SD Percentage of Women who Attended 80% or more of Recommended Prenatal Visits by Age[9]



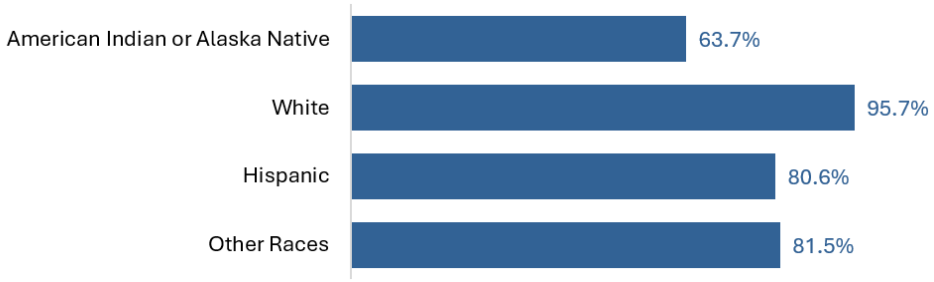
The percentage of South Dakota mothers who had a postpartum care visit remained consistent, averaging **89.3%** (Figure 6). [10]

Figure 6. 2019-2023 SD Mothers who had a Postpartum Visit[10]



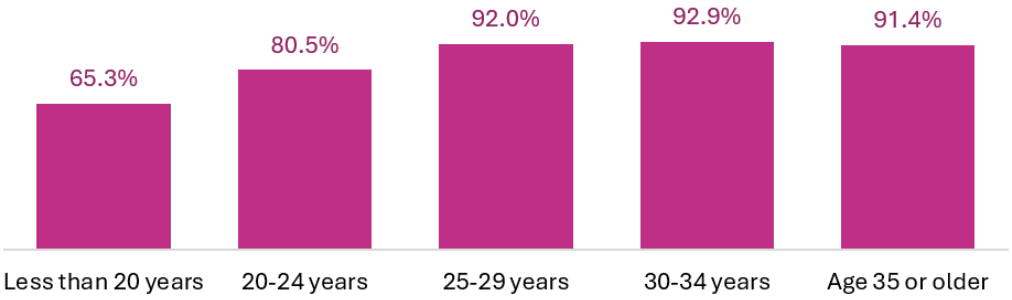
However, postpartum visit rates by race show clear gaps in care. Far fewer American Indian or Hispanic mothers had a postpartum care visit, when compared to their White counterparts (Figure 7).[9]

Figure 7. 2023 SD Postpartum Visits by Race and Ethnicity[9]



Additionally, mothers less than 20 years old are less likely to attend a postpartum care visit. South Dakota has clear opportunities to close the gap in racial disparities and to provide extra support to younger mothers (Figure 8).[9]

Figure 8. 2023 SD Postpartum Visits by Age[9]

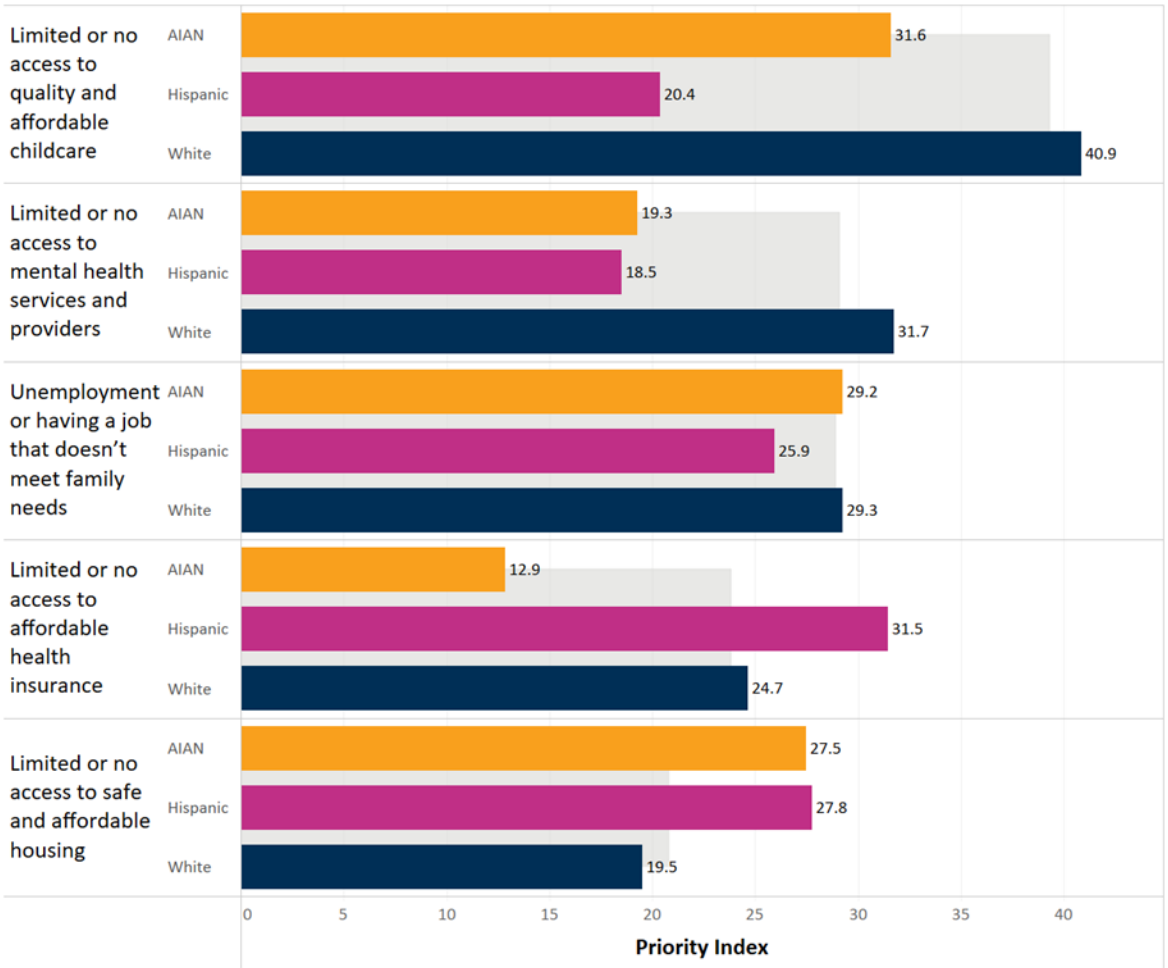


Maternal Health Needs

The 2025 Maternal Child Health Title V needs assessment data also identified maternal health needs for women across South Dakota. As part of the assessment, 629 South Dakotans participated in a community survey. Results, shown in Figure 9, indicated that the top 5 health needs for women include the following:

- Access to quality and affordable childcare
- Access to mental health services and providers
- Having a job that meets family needs
- Access to affordable health insurance
- Access to safe and affordable housing

Figure 9. Factors Affecting Women's Health-Priority Index



Other key health needs shared include access to prenatal care, lactation support, pediatricians – especially OBGYNs in rural areas – and support services like transportation, housing, food, and childcare. Additional needs include mental health care, substance use treatment, oral health,

parenting education, and peer support. In addition, open-ended needs assessment survey responses emphasized five **core priorities** for women's health, as follows:

- Affordable reproductive care
- Person-centered, continuous healthcare systems
- Trauma-informed mental health services
- Reliable access to healthy, affordable food
- Trusted, supportive care navigation

Integrating Infants into the Maternal Health Innovation Grant

Although the South Dakota Maternal Health Innovation Program focuses on interventions to decrease maternal morbidity and mortality, data from the state's death review committees indicated that addressing maternal health in isolation would not adequately meet the needs of families or reduce preventable deaths in the state. Both qualitative reviews of maternal and infant death cases and quantitative surveillance data from 2015–2024 demonstrated that the risk factors, populations affected, and gaps are deeply interconnected between mothers and infants.

Qualitative analysis revealed striking overlaps: lack of prenatal and postpartum care, untreated mental health conditions, substance use, poverty, housing instability, and unsafe environments were consistently present in both maternal and infant deaths. Equally concerning, these factors were most pronounced among the same populations, particularly American Indian/Alaska Native (AI/AN) families, rural residents, and families experiencing poverty or low educational attainment.[11,12]

The quantitative data confirmed these shared patterns. Among pregnancy-associated deaths, most occurred between 43 days and one year postpartum, often linked to overdoses, suicides, and unsafe living environments. Among infants, nearly half of all deaths occurred after the neonatal period, when social instability and unsafe sleep environments were key drivers. The populations most affected were the same: AI/AN mothers and infants had the highest mortality rates, families in the western side of the state faced disproportionately higher risks, and maternal education strongly correlated with outcomes for both mothers and babies.[1]

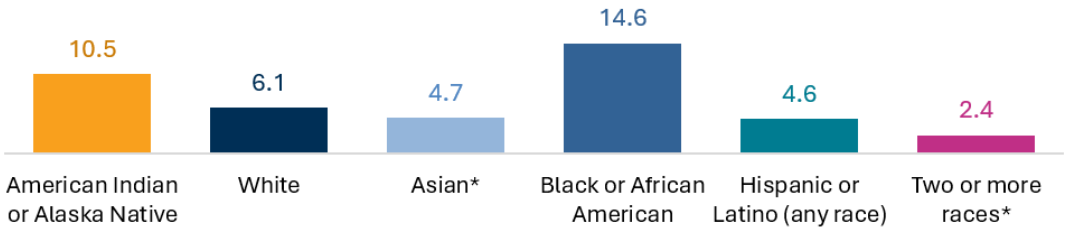
By including infants in the scope of the Maternal Health Innovation Grant, South Dakota is taking a family-centered, systems-level approach. This alignment ensures that interventions such as care coordination, universal screening, telehealth expansion, housing stability, and culturally appropriate peer support directly benefit both mothers and infants. In doing so, we maximize the impact of every intervention and prevent parallel tragedies.\

Infant Health Indicators

Infant mortality in South Dakota continues to reveal stark inequities by race and ethnicity. Between 2015 and 2024, American Indian/Alaska Native infants experienced a mortality rate of 10.5 per 1,000 live births – nearly double the rate observed among White infants (6.1) (Figure

10).[1] Black/African American infants were at even higher risk, with a mortality rate of 14.6 per 1,000 live births.[1] These findings underscore the disproportionate burden of infant deaths among American Indian and Black families, pointing to persistent inequities in maternal and child health outcomes across South Dakota.

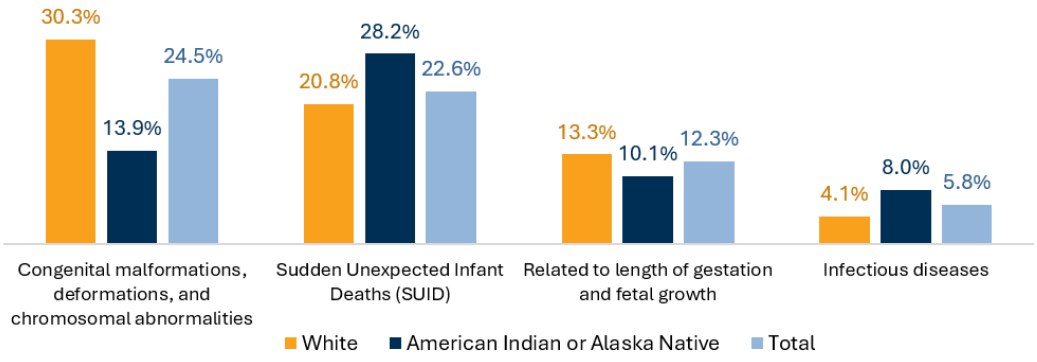
Figure 10. 2015-2024 SD Infant Death Rates (per 1,000 live births) by Race and Ethnicity[1]



* Rates of deaths for Asian infants and infants of two or more races are unreliable due to a small number of cases and should be considered with caution. Race information was not available for two infants.

The leading causes of infant death in South Dakota between 2015 and 2024 were congenital malformations (24.5%) and Sudden Unexpected Infant Deaths (SUID) (22.6%), accounting for nearly half of all deaths (Figure 11). Prematurity and fetal growth issues contributed to another 12.3%, with infectious diseases around 6%. Among White infants, congenital malformations were the predominant cause (30.3%), while among American Indian infants, SUID stood out as the leading contributor (28.2%).[1] These patterns point to important differences in the drivers of infant mortality, emphasizing the ongoing burden of SUID in American Indian communities and the continued prominence of congenital malformations among White families.

Figure 11. 2015-2024 SD Most Common Causes of Infant Deaths by Racial Group and Total[1]



Maternal Health Workforce and Access to Care

Labor and Delivery Services

South Dakota has experienced OB unit closures in rural hospitals, increasing reliance on EMS for obstetric emergencies. Women in some areas travel 60–120 minutes for delivery, and cross-state travel into neighboring states is common.

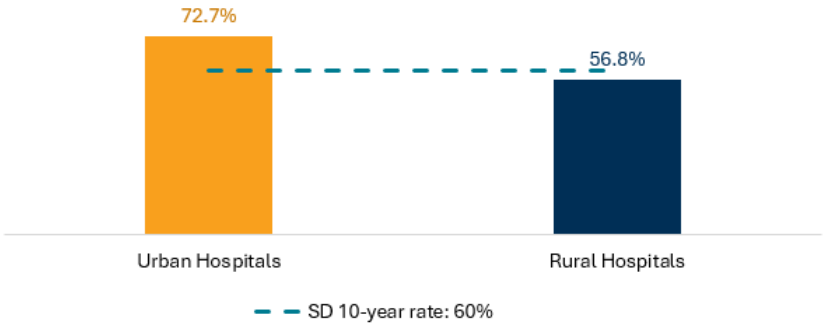
Maternal Health Workforce

South Dakota relies on a mix of OB/GYNs, family practice physicians, Certified Nurse Midwives, and doulas. Recent policy changes expanded Medicaid reimbursement for doula care, and the state has supported training scholarships to grow this workforce.

South Dakota has 58 rural counties out of a total of 66 counties.[13] In 2024, nearly half of South Dakota's women of reproductive age 15-44 years (80,682 women, or **48.1%**) lived in rural counties.[14, 21] However, only 33.8% of maternity care providers practice in rural counties in South Dakota.[18]

Between 2010 and 2022, South Dakota experienced continued losses of hospital-based obstetric services. By 2022, 60% of all short-term acute care hospitals in the state no longer offered obstetric care, ranking South Dakota 47th out of 50 states for obstetric service availability.

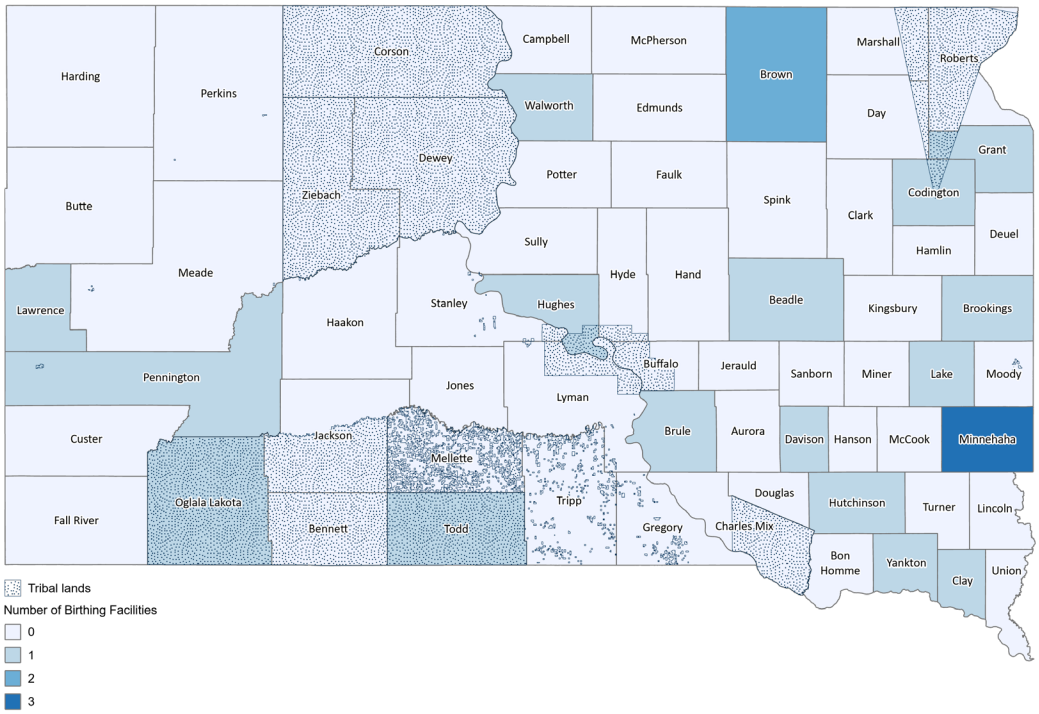
Figure 12. 2022 SD OBGYN Services among Short-term Acute Care Rural and Urban Hospitals[15]



As seen in Figure 12, the situation is severe in rural areas, where **13.6%** of rural hospitals lost obstetric services during the 2010–2022 period, and **56.8%** of rural hospitals lacked these services by 2022.[15]

The picture is alarming in urban areas as well: while no urban hospitals closed OB services during that period, **72.7%** of them were already without obstetric care, an unusually high rate compared with other states, where urban hospitals generally maintain stronger maternity service capacity.[15] The map in Figure 13 displays the latest data available on the distribution of hospitals that provide ob/gyn care. It is worth noting the hospitals that provide ob/gyn care in Tribal lands are all Indian Health Services. In 2024, women residing in South Dakota had 392 cross-state births (3.43%).[16] For women who live in the northwest corner of the state, the closest available in-state hospital is either in Pennington County or Lawrence, which means that a woman in labor may drive up to three hours to reach the nearest service within the state. Most counties providing ob/gyn services are the same ones that also have one of the 20 urban areas in the state.

Figure 13. 2025 SD Birthing Hospitals by County[22]



South Dakota reflects one of the highest maternity care deserts in the country, with 57.6% of SD counties considered maternity care deserts, well-above the national comparison where 35% of US counties considered maternity care deserts.[17] Maternity care deserts are counties where no hospitals or birth centers are offering obstetric care, and no obstetric providers. Women living in maternity care deserts and counties with low access to care have poorer health before pregnancy, receive less prenatal care, and experience higher rates of preterm birth.

March of Dimes developed a standardized framework to describe access to maternity care across U.S. counties that is useful to understand the challenges experienced by SD women during the perinatal journey. This framework categorizes counties into four levels: maternity care deserts, low access, moderate access, and full access. The classification, seen in Table 2, is based on the availability of obstetric providers, hospitals or birth centers offering obstetric care, and the proportion of women of reproductive age without health insurance.

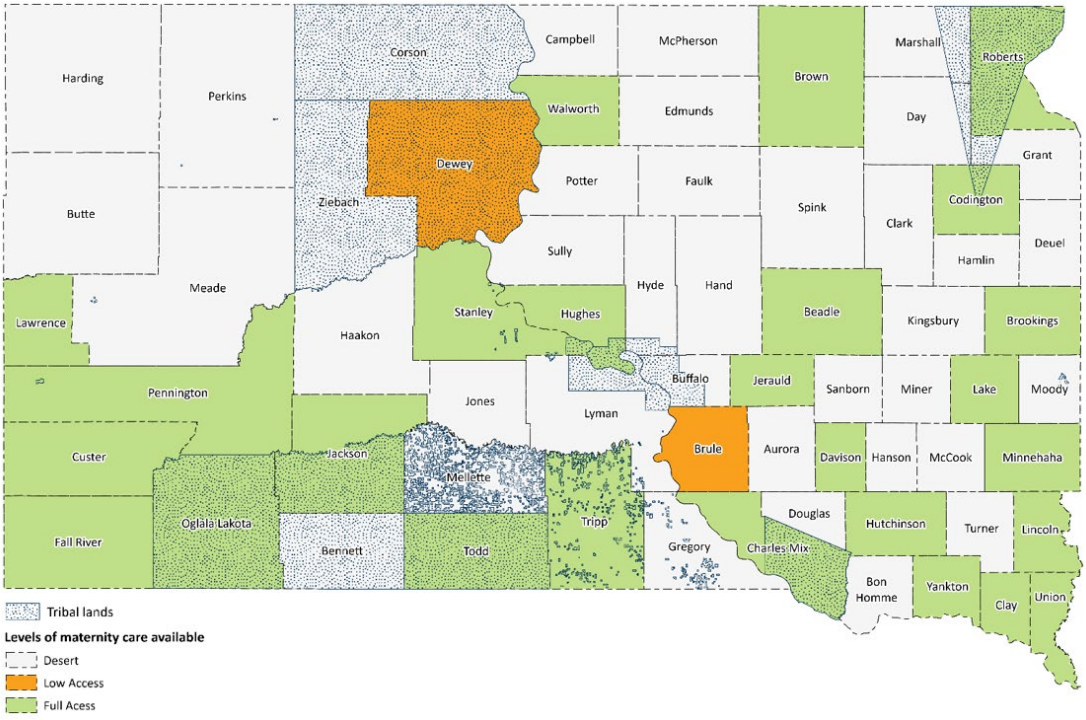
Table 2. Definitions of maternity care desert and access to maternity care[18]

Maternity care levels	Hospitals & Birth Centers Offering Obstetric Care	Obstetric Providers† (per 10,000 births)	Proportion of Women 18–64 Without Health Insurance
Care Desert	Zero	Zero	Any
Low Access	< 2	< 60	≥ 10%
Moderate Access	< 2	< 60	< 10%
Full Access*	≥ 2	≥ 60	Any

*A county is full access if it meets one or more of the criteria. †Includes family physicians who provide obstetric care, obstetricians, certified nurse midwives/certified midwives. Calculated per 10,000 births.

Over 57% of SD counties are maternity care deserts, forcing many birthing mothers to travel long distances for prenatal visits and delivery (Figure 14).[17]

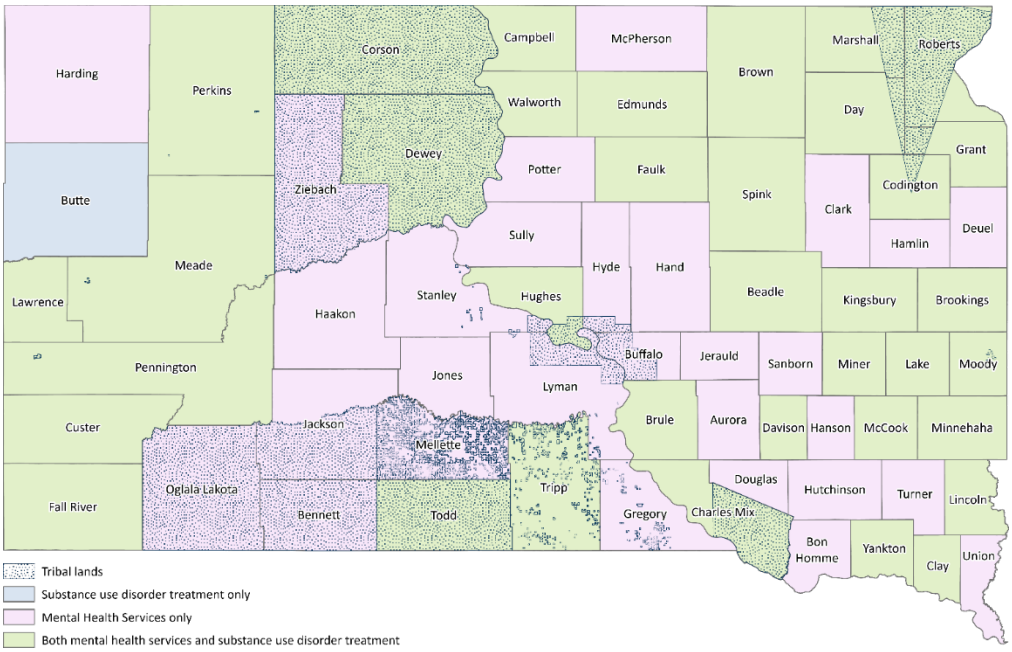
Figure 14. 2024 SD Levels of Available Maternity Care[18, 19]



Behavioral Health Providers

Screening for depression and substance use is integrated into state programs, but access to treatment providers is limited, particularly in rural and Tribal areas (Figure 15).[20]

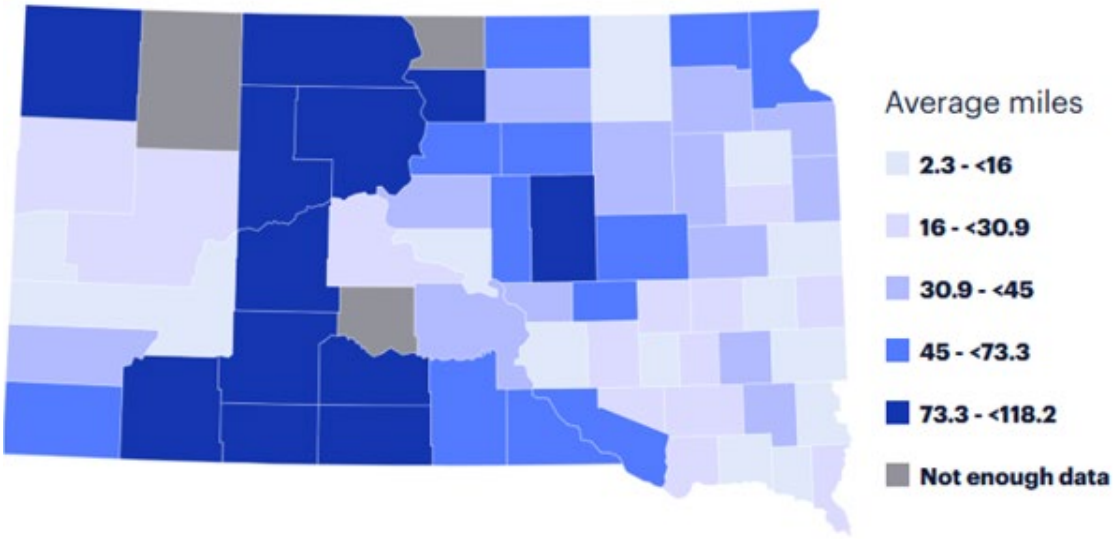
Figure 15. SD Distribution of Behavioral Health Services[20]



Travel Distances

In South Dakota, 23.7% of women had no birthing hospital within 30 minutes compared to 9.7% in the US (Figure 16).[18]

Figure 16. Distance to Birthing Hospital by County[18]



Maternal Health Strengths

Maternal health and wellness across South Dakota are currently supported through various programs, initiatives, and services. Data from the needs assessment and other programs highlight the strength of efforts that are taking place to support maternal and infant health.

Strong leadership and infrastructure. The South Dakota Department of Health (SD DOH), through its Division of Family and Community Health (FCH), administers the Title V Maternal and Child Health Block Grant and leads maternal health initiatives statewide. Recent restructuring created dedicated leadership for maternal health, including the establishment of a Women's Health Director position to oversee the Women's Health domain and coordinate cross-sector efforts. South Dakota's maternal health infrastructure is strengthened by coordination across Title V programs and other DOH programs such as WIC, Bright Start Home Visiting, Pregnancy Care Program, Title X Family Planning, as well as Medicaid, and external partners such as IHS, Tribal Health Centers, nonprofit organizations, academia, and other community voices. This alignment enables consistent, evidence-based care across the reproductive lifespan and ensures maternal health is integrated into broader public health priorities.

Community-based resources. The assessment data highlighted strengths in community-based services and state agency support. This includes local programs, such as WIC and early childhood services. These and other local programs provide pregnancy testing, prenatal visits, transportation assistance, referrals, and health education. The 211 Helpline Center offers a centralized, statewide directory of resources, including mental health support, housing, childcare, and food assistance, helping families navigate complex systems and connect with services tailored to their needs.

Community factors that impact health outcomes. There is growing awareness of community factors that impact health outcomes, including social needs and cultural practices.

Access to care through Medicaid: With the implementation of Medicaid Expansion on July 1, 2023, more South Dakotans gained access to comprehensive healthcare coverage, including family planning services. Coverage for postpartum women expanded to 12 months post-delivery. Additionally, the BabyReady Program was implemented on April 1, 2024. The program provides additional case management services to moms eligible and enrolled in Medicaid. Medicaid also supports access to doula services, telemedicine, and community transportation, reducing barriers for women in rural and medically underserved areas.

Data and evaluation capacity. SD DOH continues to expand its maternal health data infrastructure to better identify risks and track outcomes. The DOH recently hired a Women's Health Epidemiologist focused on maternal mortality and severe maternal morbidity (SMM). This expanded analytic capacity supports stronger monitoring, reporting, and evidence-based program design.

Public campaigns and advocacy. A variety of public education efforts and nonprofit organizations, including health advocacy groups, local coalitions, and community-based organizations, provide ongoing education, outreach, and support for women's and maternal health. These groups elevate awareness of maternal mental health, family planning, breastfeeding, and community health factors, while advancing policy and practice changes through community voice and advocacy.

Existing Maternal Health Initiatives

Title V Maternal Child Health Program

In South Dakota, the MCH Title V Block Grant is administered through the Office of Lifespan Health (OLH). The MCH Title V Block Grant serves as the lead agency for maternal and child health initiatives, ensuring that program activities are aligned with state and federal priorities. They are responsible for coordinating maternal health programs, funding, and resources, and guide evidence-based practices and interventions. The Women's Health Director plays a role in linking the existing maternal health workgroup and its activities to the MIHTF. The MCH Title V Block Grant team completed the most recent 5-year needs assessment in 2025. Data collection efforts included a community survey, partner meetings, and community conversations, which elicited information about the health status and needs of women in SD. The results were used to inform the MIHTF Women's Health Committee and the full strategic plan. Collaboration with the MCH Title V Block Grant will allow SDMIHTF to better leverage resources and provide evaluation, epidemiology, and media services, as well as support for data-driven decision-making and the sustainment of program activities.

Pregnancy Care Program

The SD DOH's Pregnancy Care Program provides expecting moms of all income levels with a Pregnancy Care nurse at no cost to answer questions and offer advice and support during pregnancy. In addition to providing ongoing support, the assigned nurse helps connect the woman to prenatal care, valuable community resources, and education. Florida State University (FSU) provides the curriculum for the Pregnancy Care Program curriculum, *Partners for a Healthy Baby.* This curriculum was developed by a multidisciplinary faculty team at FSU with expertise in obstetric medicine, early childhood development, psychology, infant mental health, social work, and early intervention. *Partners* is a "two generational" curriculum that addresses the needs of both the parents and the child. We know that unless the family is stable, they cannot possibly meet the health and developmental needs of their young children. For that reason, *Partners* covers a wide array of issues related to family development, family health, and safety. If a need is identified, the DOH will purchase additional curriculum supplements to address risk factors for severe maternal morbidity.

Bright Start Nurse Home Visiting

Bright Start is a home visiting program for expectant, first-time moms from pregnancy through the baby's second birthday. Bright Start nurses work with mothers to build trusted relationships, and services integrate prenatal and parenting education, health assessments,

promoting child development and early literacy, and ongoing support of the mom's health and life course goals. Bright Start services are individualized to the needs of the family and may include helping moms make decisions around their personal health, breastfeeding, home safety, infant safe sleep, and parenting. Nurses work with families to identify needs early, and connect mothers to community resources such as healthcare, family planning, childcare, early childhood programs, job training, and continuing education opportunities. Nurses support mothers wherever they feel most comfortable, including at home, in another mutually agreed upon location, or by telehealth.

The South Dakota Department of Health offers Bright Start nurse home visiting statewide. Service delivery is funded through a partnership with South Dakota Medicaid and the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, and implements the Nurse Family Partnership model. In state FY2025, Bright Start served 716 families and completed 7,381 visits.

Maternal Mortality Review Committee (MMRC)

The SD Maternal Mortality Review Committee (MMRC) was established by SD DOH in 2021. MMRC meets regularly to examine pregnancy-associated and pregnancy-related deaths. The MMRC will serve as a critical resource within the MIHTF, providing essential data, analysis, and expertise to inform strategic planning, program implementation, and efforts to improve maternal health outcomes in South Dakota. Their collaboration with other agencies and organizations enhances coordination and ensures that interventions are evidence-based and effectively targeted to address the needs of pregnant women and families.

BabyReady Medicaid Whole Pregnancy Care

BabyReady is intended to improve maternal health outcomes for Medicaid recipients through enhanced care coordination, enhanced reimbursement, and reduced barriers of care. Care coordination services can include person-centered care planning, health education, system and resource navigation, and transitional care. BabyReady providers also refer women to the SD DOH programs supporting pregnant women to active participants on their caseload including Bright Start, Pregnancy Care, and Women, Infants, and Children (WIC) programs.

Tribal Based Services and Initiatives

Together, Indian Health Service (IHS), Tribal Health Centers, and Great Plains Tribal Leaders Health Board (GPTLHB) initiatives represent essential pillars of South Dakota’s maternal health system for native women, bringing cultural care and expanding access in at risk regions. IHS facilities and Tribal Health Centers provide essential prenatal, delivery, and postpartum care in rural and frontier areas, often serving as the only accessible option for American Indian families. These facilities are trusted providers that also connect families with culturally grounded, community-based services. The GPTLHB supports Tribal nations through maternal and child health programs that strengthen culturally relevant, community-driven care. Key initiatives include Great Plains Healthy Start, which provides case management, health education, screening, and home visiting services using the Family Spirit curriculum; the Tribal Maternal, Infant, and Early Childhood Home Visiting Program (TMIECHV), which delivers

voluntary home visits to families with children ages 0–5; and the Rural Communities Opioid Response Project (RCORP–NAS), which integrates prevention, treatment, and cultural supports for women and infants affected by substance use. Aligning statewide maternal health strategies with these Tribal-led services is critical to advancing maternal health.

Community Health Centers

Community Health Centers (CHCs), including Federally Qualified Health Centers (FQHCs), serve as vital access points for reproductive and prenatal care, especially in rural and medically underserved areas of South Dakota. While CHCs generally do not offer birth services or late-stage prenatal care, they play an essential role in early maternal health. Core services include pregnancy testing, early prenatal visits, family planning, immunizations, behavioral health, and chronic disease management. They also help connect patients with social supports and community resources. This broad scope of preventive and enabling services helps women enter pregnancy healthier, receive care earlier, and stay connected to necessary follow-up care, contributing significantly to improved maternal and infant health outcomes statewide.

Rural Maternity and Obstetrics Management Strategies (RMOMS)

The RMOMS program addresses challenges rural mothers face such as long travel distances, financial pressures, and limited services by creating an integrated care model. Through partnerships with the Department of Health, Medicaid, Urban Indian Health, and rural hospitals, RMOMS provides coordinated medical and social support, including help with food, housing, transportation, and mental health needs. It also leverages telehealth for remote monitoring of high-risk conditions and offers 24/7 virtual nursing support to local hospitals during labor. Expecting mothers receive both medical and social determinant screenings to connect them with needed resources.

Doula Workforce Expansion

In South Dakota, doula services became a covered benefit for Medicaid recipients on January 1, 2025. Medicaid reimburses up to $1,800 per pregnancy for doula services, which may include counseling and education on pregnancy and infant care, assistance with developing birth plans, continuous labor support, and coordination with community-based resources to link families with additional supports. In September 2024, the DOH collaborated with SD Doulas, a 501c3 organization, to create training toolkits and resources, along with a comprehensive postpartum doula training and certification. As a result of this training, 18 doulas were trained and vowed to enroll as a Medicaid-verified doula provider.

South Dakota Perinatal Quality Collaborative

The South Dakota Perinatal Quality Collaborative (SDPQC) is a nonpartisan, statewide partnership dedicated to advancing education, strengthening clinical practices, and improving perinatal health outcomes. Founded in August 2024, the SDPQC is housed within South Dakota State University's Community Practice Innovation Center. Its initial focus is on advancing maternal care, with a special emphasis on perinatal mental health, supported through two grant-funded projects under the BIRTH-SD initiative.

Substance Use Programming

The South Dakota Department of Social Services (DSS) provides specialized programming for pregnant women and women with dependent children in three major metro areas, Sioux Falls, Yankton, and Rapid City. These programs offer a supportive living environment where women can complete substance use disorder (SUD) treatment while caring for their dependent children (ages 0–14 depending on the program). Services are designed to help mothers heal from substance use disorder and transition back into their homes and communities with stability and support. Wraparound recovery services are available both before admission and after discharge, ensuring continuity of care. Treatment options range from low-intensity residential services, which allow women to maintain employment and community supports in a sober living environment, to medically monitored intensive inpatient services for those with severe SUD. In addition to these specialized programs, the Division of Behavioral Health supports a range of recovery resources across the state. This includes housing for addiction recovery for women in six South Dakota cities, peer support services for SUD through Face It TOGETHER (offered both in-person and virtually), and intensive case management for pregnant and postpartum women and women with dependent children up to age 12 through the ReNew and ReNewed Hope Programs at Bethany Christian Services. Broader behavioral health initiatives such as statewide crisis services, suicide prevention programming, and the Let's Be Clear opioid prevention campaign also strengthen the support network available to women and families.

The First 1,000 Days Interagency Forum

This initiative is supported by the Sisseton-Wahpeton Oyate of the Lake Traverse Reservation and is a long-standing initiative in place that helps to promote healthy families and children in the first 1,000 days of life. This initiative is providing community education on infant safe sleep to help reduce infant mortality rates within the tribal community.

Rural Health Transformation Project

South Dakota has secured approximately $189.4 million in federal funding in the first year of the Rural Health Transformation Project to strengthen rural healthcare systems across the state. One of the state's initiatives is to implement maternal and infant health hubs. This initiative aims to reduce maternal and infant health disparities and improve access to high-quality care in rural and Tribal areas in South Dakota. The hubs focus on both clinical care and broader care coordination, supported by spoke sites that integrate community social-support networks. The initiative also supports community and Tribal organizations to develop and sustain doula programs. The activities under this initiative are also written into the Maternal and Infant Task Force strategic plan to encourage alignment and partner collaboration between the two projects.

Challenges and Gaps Improving Maternal Health and Wellness

While there are strong efforts and initiatives in place to address maternal and infant health and wellness, there are still challenges and gaps that limit opportunities to improve health and wellness. During the strategic planning process, MIH Task Force members participated in various peer engagement opportunities and data collection methods to identify issues

impacting maternal and infant health and well-being. Participant feedback highlighted challenges and gaps in access to care, services, and resources, as well as community factors that impact health. This feedback was also reinforced in the needs assessment findings and other OLH data sources.

Access to care. More than half of South Dakota counties are classified as maternity care deserts, with no hospital-based obstetric services. Recent closures of rural obstetric units have further reduced access, forcing many women to travel long distances for prenatal, delivery, or postpartum care. These challenges are particularly acute in rural and tribal communities where transportation barriers, limited childcare, and geographic isolation make access to care especially difficult. Even when services are available, they are not always utilized due to lack of awareness, inconsistent messaging, or cost barriers. For example, postpartum visits remain underutilized despite their availability, and safe sleep practices are not consistently adopted even when cribs or bassinets are provided. Postpartum care is not always a benefit covered by insurers, which creates further gaps in care. In addition, women face challenges receiving culturally appropriate care due to gaps in health care practices and provider education.

Referral to care. A referral to care and other services is also challenging for women, including referral for post-partum follow-up care. Healthcare providers do not always know where to refer patients, which presents gaps in awareness and knowledge of available services. Referrals also need to be conducted in a way that supports the patient to foster a relationship with new service providers and make them feel at ease. Families also report challenges in navigating systems of care, with referrals sometimes failing to foster strong, trusting relationships with new providers.

Workforce shortages. Challenges with access to care include a lack of health care providers, including specialists such as OBGYN or mental health providers, to support postpartum mothers. Recruitment and retention of maternal health providers remain a critical barrier to care. Shortages affect not only obstetricians and certified nurse midwives (CNMs), but also doulas, labor and delivery nurses, behavioral health specialists, and lactation consultants. Provider shortages lead to delayed or fragmented care, limited access to specialists, and increased strain on existing staff, particularly in rural and medically underserved regions.

Access to services and resources. Access to services and resources also impedes opportunities to improve maternal and infant health and wellness. This includes a lack of awareness and utilization of services such as postpartum care, despite its availability. There is also variation in the utilization of cribs and safe sleep spaces, either because they are available, but are not being used by parents/guardians or they are accessible due to cost. In addition, there are gaps in the education of parents/guardians regarding safe sleep practices. Services need to focus on postpartum care and safe sleep practices. In addition, women are facing challenges with substance use and gaps in available services to support their needs.

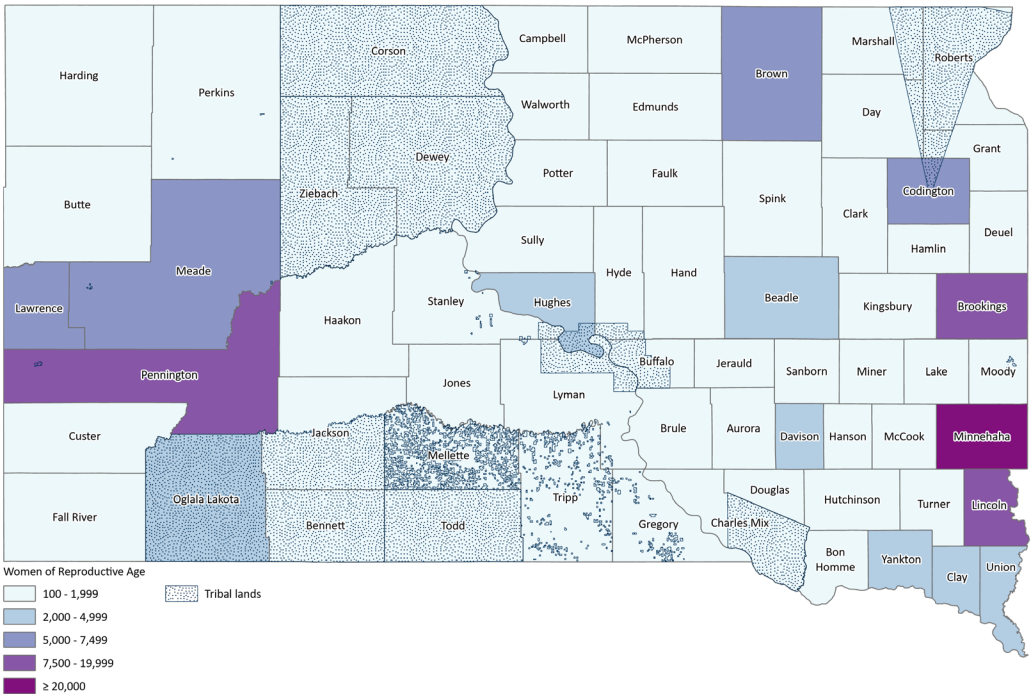
Health disparities. American Indian women in South Dakota experience pregnancy-associated mortality nearly five times higher than White women. Geographic and socioeconomic

disparities compound these risks, with women who live in rural communities less likely to receive early prenatal care or timely postpartum visits. Women also report challenges receiving personalized, coordinated, trauma-informed care, highlighting the need for more consistent provider education and cross-cultural training.

Community factors that impact health also continue to challenge maternal and infant health, including structural factors in the community. The drivers create different needs and priorities among women across the state. A lack of childcare is a notable stressor for families due to limited access and availability. There are also gaps in family and social support for women. Access to transportation and safe, affordable housing pose challenges for women in accessing necessary care and services.

Other data highlights challenges in women's health between urban and rural areas of the state. South Dakota's population of women of reproductive age reveals what can be described as *two South Dakotas* (see Figure 17). In counties such as Minnehaha, Pennington, and Lincoln, tens of thousands of women reside in relatively close proximity, allowing for stable estimates of health indicators and supporting the presence of specialized services. In contrast, many rural counties have populations of fewer than 2,000 women of reproductive age, and some, like Jones or Sully, have fewer than 1,000. In these frontier settings, even a single maternal or infant death can cause rates to swing dramatically from year to year, complicating the interpretation of trends and masking true risk patterns.

Figure 17. 2024 SD Distribution: Population of Women of Reproductive Age (15-44 years) per County[21]



This divide also carries direct implications for service delivery: while urban counties must plan for concentrated demand, rural counties face the challenge of reaching small numbers of women spread across vast geographies with limited local providers. Recognizing these *two realities within one state* is essential for designing data systems and public health strategies that serve all women.

Maternal and Infant Health Taskforce

Mission

The Maternal and Infant Health Task Force works to improve the health of mothers and infants through data-informed innovation, collaborative partnerships, and sustainable solutions that address disparities to build lasting improvements in care and outcomes.

Vision

We build a future South Dakota where every mother and infant thrives.

Key Drivers

- Access to quality care
- Innovative technology and data systems
- Workforce capacity and training
- Relationship building with communities

Guiding Principles

- **Community-centered approach:** We engage families and local stakeholders as active partners, empowering them to drive decisions and shape solutions that directly respond to their community's needs.
- **Data:** We use data as a tool for transparency, illuminating health disparities and guiding informed decision-making to advance accountability in our work and well-being for all.
- **Collaboration:** We are committed to a multi-sector, statewide approach that values open dialogue, mutual respect, and active engagement among partners to develop forward-thinking and long-term solutions.

Membership

Table 1. Task Force Leadership

Name	Organization	Title
Katelyn Strasser, Task Force Chair and Systems of Care Committee Lead	SD Department of Health	Deputy Division Director
Laurel Rick, Infant Health Committee Lead	SD Department of Health	Infant Health Coordinator
Shelby Kommes, Maternal Health Committee Lead	SD Department of Health	Women's Health Director

Beth Walstrom, Data Lead	SD Department of Health	Assistant Administrator of Data, Office of Lifespan Health
Sandra Melstad	SLM Consulting, LLC	Consultant
Holly Arends	South Dakota Foundation for Medical Care	Evaluator

Table 2. Task Force Members

Name	Organization	Title
Stephanie Hanson	SD State University/SD Perinatal Quality Collaborative	Assistant Professor/Executive Director
Denise Hanisch	Department of Health	Medical Director
Josh Brown	SD Department of Health	Prevention Services Manager, Office of Lifespan Health
Eric Emery	SD Legislature	Representative
Sydney Davis	State Senator District 17	CRNA
Kaylyn Davis	SD Department of Health	Infant and Child Mortality Data Abstractor, Office of MCH Data Analytics & Insights
Ben Tiensvold	Community Health Workers of SD	Executive Director
Kimberlee McKay, MD	Avera Research Institute	Research Medical Director, RMOMs-SD PI
Hope Kleine	SD Department of Health	Administrator, Office of Lifespan Health
Marty Link	SD Department of Health	Deputy Division Director
Josie Petersen	SD Department of Health	Assistant Administrator, Office of Rural Health
Nikki Krier	SD Department of Health	Title X Director
Audrey Rider	SD State University Extension	Early Childhood Field Specialist
Katie Kopp	Sanford Health	Director of Nursing, Birth Place Services
Joe Kippley	Sioux Falls Health Department	Public Health Director
Lacey McCormack	Avera Research Institute	Director of Rural Research
Laura Nordbye	SD Department of Social Services	Child Care Licensing Program Manager, Office of Licensing & Accreditation
Alyssa Christensen	Avera McKennan Hospital	Nurse Manager
Taylor Rehfeldt	SD Legislature	Representative
Jen Tinguely	City of Sioux Falls Health Department	Medical Director
Nicky Cooney	Wellmark	Strategic Initiatives Consultant, Health Improvement Division

Name	Organization	Title
Chris Soukup	SD Department of Social Services	Care Management Program Administrator, Medical Services
Anna Waterland Dykstra	Indian Health Service, Four Directions Clinic in Kyle	Certified Nurse Midwife
Carrie Churchill	SD Department of Health	Administrator, Office of Home Visiting
Carly Goodhart	Sanford Health	Neonatal Clinical Nurse Specialist
Kelsie Thomas	SD Doulas	Board President
Beth Dokken	SD Department of Health	Director, Division of Family and Community Health
Kristine Randall	Sanford Health	Director, NICU
London Zerfas	SD Department of Health	Deputy Administrator
Melanie Boetel	Department of Social Services	Director, Behavioral Health
Mandy Bell	Avel eCare	VP of Product Innovation
Stacie Ugofsky	SD Department of Social Services	Lead Licensing Specialist
Wahleah Watson	Sisseton-Wahpeton Oyate of the Lake Traverse Reservation	Community Health Education Program Manager
Victoria Wakeman	Childbirth Support Specialists	Certified Doula and Trainer, Certified Lactation Peer Counselor
Terri Rattler	Great Plains Tribal Leaders Health Board	TMIECHV Program Manager
Alicia Mousseau	Oglala Sioux Tribe	Vice President
Johanna Hewitt	Indian Health Services, Pine Ridge Hospital Pediatrics	Nurse Practitioner, DNP
Joel Arriolacolmenares	SD Department of Health	Administrator, Office of Public Health Nursing
Beth Laughlin	Monument Health	Labor and Delivery Nurse Manager
Shannon Muchow	SD Department of Health	Nurse Manager, Office of Public Health Nursing
Kelly Cronin	SD Department of Health	Bright Start Home Visiting Nurse
Sandy Lown	Teddy Bear Den	Executive Director
Jordyn Gunville-Pourier	Johns Hopkins - Center for Indigenous Health	Senior Research Associate
Tony Burke	American Heart Association	Government Relations Director
Matt Tribble	Centers for Disease Control and Prevention	Public Health Analyst, Overdose Response Strategy
Steve Ardis	Midwest High Intensity Drug Trafficking Area	Officer
Renee Forred	SD Doulas; Transitions: Doula and Life Services	Doula, Owner

Name	Organization	Title
Laura Rose	The Bebela Project	Assistant Chief Financial Officer, Human Resource Director
Alejandra Ortiz	Black Hills Special Services	Infant and Child Health Epidemiologist, Contractor with SD DOH
Lorrie Lendvoy	South Dakota Foundation for Medical Care	Maternal Morbidity Epidemiologist, Contractor with SD DOH
Lindsay Munkvold	Mobridge Hospital	Registered Nurse
Cathy Mickelson	Mobridge Hospital	Registered nurse
Laura Hoefert	Madison Regional Health System	Family Medicine Physician
Jennifer Folliard	SD Doulas	Executive Director
Gretchen Stai	SD Department of Social Services	Substance Use Services Program Manager
Samantha Marts	Community HealthCare Association of the Dakotas	Administration and Program Coordinator
Lindsey Karlson	Community HealthCare Association of the Dakotas	Director of Programs and Training
Darla Biel	Center for the Prevention of Child Maltreatment	Assistant Director
Alysia Dressler	SD DOH	Bright Start Home Visiting Nurse
Amanda Tilberg	CHHSD	Bright Start Home Visiting Nurse
Taylor Gustafson	Monument Health	Obstetrics Nurse Clinician
Mandy Steen	Dakota Doulas	Doula, Owner
Jodi Berscheid	SD Department of Education	SD Head Start Collaboration Office Director
Ashlyn Plooster	Great Plains Tribal Health-Healthy Start	Care Coordinator
Madonna Wright	Great Plains Tribal Health-Generational Health Programs	Health Educator
Megan Veldkamp	South Dakota State University	Nursing Faculty

Table 3. Advisory Committee Members (those with lived/living experience)

Name	Organization	Title
Cassie Long	Department of Social Services	Nurse Consultant, Division of Medical Services/SD Medicaid
JoAnn Paulson	Sanford	Community Health Worker
Wynette Mockler	University of South Dakota	Public Health Science Program Professor
Kara Peery	Department of Social Services	Program Specialist, Economic Assistance
Theresa (Teri) Weidner-Eichstadt	Horizon Healthcare	Maternal Care Coordinator
Kathey Schneider	Children's Home Society	Assistant Program Director for Bright Start, Eastern Region
Amy Trautner	Child and Family Resource Network, SDSU	CDA Specialist
Aimee Deliramich	University of South Dakota	Licensed Clinical Psychologist, Assistant Professor of Pediatrics
Chelsey Plamp	Center for the Prevention of Child Maltreatment	Project Coordinator

Approach

To ensure a comprehensive strategic plan, we have built an interdisciplinary MIH Task Force. Recruitment of members spanned four months, resulting in 53 members from local and state health agencies, federally qualified health centers, community-based organizations, state legislature, health systems, academia, payer organizations, and tribal health.

Katelyn Strasser, MIH Task Force leader and Deputy Division Director for the Division of Family and Community Health, along with other South Dakota Department of Health staff, conducted outreach to potential members affiliated with existing partnerships, initiatives, and programs that support maternal and infant health across the state. Individuals were invited to attend a kick-off webinar to learn about the MIH Task Force, as well as an in-person kick-off event of the MIH Task Force to learn more and identify opportunities to engage moving forward.

Meeting participants and other interested partners were contacted via e-mail and formally invited to join the Task Force. Members were asked to electronically sign a one-year "Partnership Pledge" and choose from an "active" or "passive" membership to engage in the Task Force. While both levels are members, active members commit to actively engaging in discussions, decision-making, and collaboration. Existing Task Force members will be asked to sign the "Partnership Pledge" on an annual basis, while new members will continue to be recruited as needed through partners, initiatives, and programs supported by the Title V

program and the Task Force committees. The Office of Lifespan Health Advisory Committee, comprised of nine members with living and lived experiences relative to maternal and child health, will also be a resource to support the implementation of the Maternal and Infant Health Task Force strategic plan.

Task force members self-selected into one of three committees: maternal health, infant health, or systems of care. The focus areas for the maternal and infant committees are preestablished based on the purpose of the MIH Task Force and Title V priority areas for women and infants. The maternal group's priority is postpartum care, the infant group is focusing on infant safe sleep, and the system of care has broader goals of access to care, care coordination, and partner collaboration.

Over the course of the project, task force leadership will continue to evaluate if the areas in the state with highest rates of maternal mortality and morbidity are represented on the task force. This is included as an intended outcome in the evaluation plan so that progress is continuously monitored.

Planned Activities

The full MIH Task Force and the three individual committees met quarterly in the first year to inform the strategic planning process. Since March 2024, the full task force has held five meetings, including one in-person kick-off event. The kick-off meeting included an overview of the MIH Task Force and relevant maternal and infant health data, as well as small group discussions by focus area: data, infant health, women's health, and systems of care. Discussions were focused on understanding strengths and opportunities regarding focus areas and advancing the health and well-being of women and infants across the state. The meeting provided an opportunity to identify current efforts underway to address infant and maternal health, as well as next steps to address gaps that exist in the system of care.

Following the kick-off event, committees convened independently to discuss identifying priority areas and corresponding evidence-informed strategies and activities. At the same time the systems of care committee was finalizing their action plan in October 2025, the application for the Rural Health Transformation Project through Centers for Medicare & Medicaid Services (CMS) opened. The SD Maternal and Infant Health Task Force chair also serves as the lead for the Rural Health Transformation (RHT) Project maternal initiative in South Dakota. The systems of care committee tried to align many of their activities to work proposed in the RHT application so that work and partnerships could be as coordinated as possible.

In January 2026, action plans were completed and the committees began moving into implementation. Committees meet at least quarterly to discuss progress on the strategic plan, provide updates to the members, and offer opportunities for members to engage across various committees. The full task force will convene again in-person on September 28, 2026, for updates and collaboration on current strategic plan activities.

Strategic Plan

The overarching maternal health goals that will inform the Maternal and Infant Health Task Force include the following:

- Use data to inform evidence-based program design and policy decisions
- Elevate community voices in shaping maternal health policy and practice
- Enhance cross-sector collaboration among state, Tribal, and community health partners.

This plan outlines strategies and activities that will be implemented by 2030 by the Infant Health, Maternal Health, and Systems of Care Committees. Strategies outlined to address maternal and infant health align with Title V priorities and requirements. This plan was informed by feedback from the strategic planning process, committee discussion, maternal and infant health data, and the 2025-2030 Title V Needs Assessment. These efforts address the goals of the five-year Maternal Health Innovation award from HRSA.

South Dakota's innovation is centered on improving data capacity to understand the burden of severe maternal morbidity in the state. The South Dakota project supports an epidemiologist to review current maternal morbidity data and proposed an improved process and system for future morbidity data collection and analysis. Understanding the causes of severe maternal morbidity will continue to drive data-informed prevention.

This project also supports Public Health Nursing to improve technology and develop the public health nursing workforce that delivers care to pregnant and postpartum women. This project will bring further capability to analyze data from the electronic health record and implement new technology such as arcGIS to visualize and allocate resources where they are most needed to improve maternal health. The statewide Public Health Nurses function as the local public health support in most areas of the state. Maternal Health Innovation resources will give nurses the tools and resources to implement evidence-based practices in their current programs and services and identify areas where further development is needed to adequately serve mothers in rural areas.

Activities related to these innovations are outlined in the systems of care committee work plan. Task force committee members will be updated on these innovations and have a chance to give feedback on their implementation. Task force evaluation also focuses on ensuring innovations are completed.

Women's Health

Objectives

A. Increase the percentage of women with a postpartum checkup within 12 weeks after giving birth from 89.3% in 2023 to 93.6% in 2030.
B. Increase the percentage of women with a postpartum checkup and recommended care components from 78.4% in 2023 to 85.9% in 2030.

Postpartum Care Plans

- **Topic Areas:** Quality Services, Maternal Health Gaps
- **Strategy:** Improve the quality and consistency of postpartum education, screening, and care supports

Activities	Timeline	Person(s) Responsible
Identify and promote the use of individualized postpartum care plans and other tools that support comprehensive postpartum visits.	2026-2027	Shelby Kommes, Women's Health Director; Maternal Health Committee Members; Doulas; Bright Start Home visiting nurses; Pregnancy Care Program nurses; Perinatal Health Workers (Doulas, Midwives)
Promote consistent messaging on women's health and postpartum topics.	Ongoing	DOH Communications Team; OLH Advisory Board; Maternal Health Committee Members
Support the integration of maternal mental health resources and referrals into postpartum care pathways, including digital mental health supports.	2026-2030	Shelby Kommes, Women's Health Director; Maternal Health Committee Members; South Dakota Doulas; Valerie Kelly, BabyReady Program; Birth Workers; Birthing/Postpartum Providers (OBGYNs, Midwives); Mental Health Providers

Patient Navigation

- **Topic Areas:** Quality Services, Maternal Health Gaps
- **Strategy:** Reduce barriers and improve connection to postpartum care and support.

Activities	Timeline	Person(s) Responsible
Develop and promote postpartum visit reminders and referral pathways support postpartum follow-up and continuity of care.	2026-2028	Shelby Kommes, Women's Health Director; Maternal Health Committee Members; Birthing Facilities; Hospital Care Coordinators/Social

Activities	Timeline	Person(s) Responsible
		Workers; South Dakota Doulas/CHWs
Support BabyReady Medicaid program, which emphasizes importance of prenatal and postpartum visits.	2027-2028	Shelby Kommes, Women's Health Director; Shannon Muchow, Pregnancy Care Program Manager; Pregnancy Care Program nurses; Valerie Kelly, BabyReady Medicaid Program
Support community-based and family-centered approaches to postpartum care, including postpartum support groups, peer support, and efforts that bring services closer to families.	2027-2028	Shelby Kommes, Women's Health Director; Maternal Health Committee Members; South Dakota Doulas
Develop and promote resource directories and tools that connect families to locally available postpartum supports and services.	2025-2027	Shelby Kommes, Women's Health Director; Maternal Health Committee Members; Bright Start Home Visiting nurses; South Dakota Doulas / CHWs; Office of Lifespan Health (Child Health Coordinator, Infant Health Coordinator, CYSHCN Program Director, Healthy Relationships Coordinator); Healthcare providers (OBGYNs, Midwives, Family Practice Providers, Social Workers, Care Coordinators, etc.); Canopie, Inc.

Maternal Mortality

- **Topic Areas:** Quality Services, Maternal Health Gaps
- **Strategy:** Strengthen partnerships and systems efforts that support maternal health and postpartum outcomes.

Activities	Timeline	Person(s) Responsible
Collaborate with healthcare systems, public health programs, and community organizations to identify	Ongoing	Shelby Kommes, Women's Health

Activities	Timeline	Person(s) Responsible
gaps, respond to recommendations, and improve maternal health and postpartum outcomes.		Director; RHT Consultant; Maternal Mortality Review Committee Members; Lorrie Lendvoy, Women's Health Epidemiologist; Beth Walstrom, Assistant Administrator of DataBirthing Hospitals and Clinics; SDAHO; SD PQC
Strengthen alignment of maternal health initiatives and expand partnerships focused on improving postpartum care engagement and support.	Ongoing	Women's Health Director; Amy Mattke, SD PLAN Nurse Consultant; Maternal Mortality Review Committee (MMRC) Members; Maternal Health Committee Members; SD PQC, Stephanie Hanson
Support efforts that strengthen and expand the maternal health workforce, including community-based supports such as doulas, particularly in rural and underserved communities.	2026-2031	Shelby Kommes, Women's Health Director; Rural Health Transformation Team; South Dakota Doulas/ CHW's; South Dakota Foundation for Medical Care, Great Plains Tribal Leaders Health Board; Canopie, Inc.

Infant Health

Objectives

A. Increase the percent of infants placed to sleep on their backs from 76.9% in 2023 to 84.4% in 2030 (FAD).
B. Increase the percent of infants placed to sleep on a separate approved sleep surface from 27.2% in 2023 to 34.7% in 2030 (FAD).

C. Increase the percentage of infants placed to sleep without soft objects or loose bedding 77.2% in 2025 to 84.7% in 2030 (FAD).
D. Increase the percent of infants room-sharing with an adult from 78.8% in 2023 to 86.3% in 2030 (FAD).

Community-Based Crib Distribution and Safe Sleep Education

- **Topic Areas:** Quality Services, Maternal Health Gaps
- **Strategy:** Strengthen statewide safe sleep practices by supporting crib distribution and consistent education through MCH programs and partner organizations

Activities	Timeline	Person(s) Responsible
Use SD Infant and Child Death Review data to identify high-risk communities and tailor outreach, provider education, and prevention activities to address local infant mortality trends.	Ongoing – new action items from this activity will begin October 2026	Infant Health Coordinator; Infant & Child Epidemiologist; Infant Health Committee Members
Promote safe sleep and infant health best practices, materials, and resources via social media, print outlets, professional journals, newsletters, and at events.	Ongoing – continuing from FY26	Infant Health Coordinator; Infant Health Committee Members
Support and expand statewide crib distribution efforts to increase access for families and strengthen the overall effectiveness of the program through partnerships and consistent data-informed decision-making.	Ongoing – continuing from FY26	Infant Health Coordinator; Bright Start Home Visiting Program and Pregnancy Care Program

Health Care and Social Service Provider Education

- **Topic Areas:** Quality Services
- **Strategy:** Implement and sustain standardized safe sleep education and messaging across healthcare, public health, human service, and community-based organizations statewide to reduce sleep-related infant deaths.

Activities	Timeline	Person(s) Responsible
Partner with Cribs for Kids and all SD hospitals that see infants under the age of 1 to promote bronze safe sleep certification within their system.	Ongoing – activity continued from FY26	Infant Health Coordinator; Infant Health Committee
Support and recognize committed partners for their ongoing efforts to reduce infant mortality and promote safe sleep practices in South Dakota.	Ongoing – activity continued from FY26	Infant Health Coordinator; Infant Health Committee Members

Activities	Timeline	Person(s) Responsible
Promote C4K Safe Sleep Ambassador Training to SD healthcare professionals, service providers, community members, and parents.	Ongoing – activity continued from FY26	Infant Health Coordinator; Infant Health Committee Members
Expand Infant Health Committee membership to strengthen statewide safe sleep and infant health initiatives.	Ongoing	Infant Health Coordinator; Infant Health Committee Members

Caregiver/Parent Education

- **Topic Areas:** Quality Services
- **Strategy:** Collaborate with multisector partners to provide safe sleep education to expecting and new parents/caregivers.

Activities	Timeline	Person(s) Responsible
Leverage trusted local partners, cultural traditions, and caregiver support networks to create new opportunities for educating parents and caregivers about safe sleep and other key infant health practices.	Begin October 2026	Infant Health Coordinator; Infant Health Committee Members; Women's Health Director
Incorporate South Dakota infant mortality and sleep-related death data into educational materials, presentations, and outreach activities to reinforce the importance of safe sleep practices.	Ongoing	Infant Health Coordinator; Infant & Child Epidemiologist; Infant Health Committee Members
Develop and tailor community-informed safe sleep materials that close knowledge gaps and strengthen understanding of safe infant care practices.	Begin October 2026	Infant Health Coordinator; Infant Health Committee Members

Systems of Care

Objectives

A. Increase the percentage of South Dakota mothers who began prenatal care in the first trimester from 80.4% in 2023 to 88% in 2028. (Source: SD PRAMS)
B. Increase the number of evidence-based nursing projects conducted to inform Public Health Nursing practice from 0 to 5 in 2030.
C. Increase the percent of mothers reporting that they received the mental health care they needed after the baby was born from 78% in 2023 to 90% in 2028 (Source: SD PRAMS).

Awareness of and Access to Care

- **Topic Areas:** Quality Services, Maternal Health Gaps, Data Capacity
- **Strategy:** Implement and maintain GIS-based mapping to identify service gaps, inform resource allocation, and enhance public and provider awareness of maternal health resources statewide.
- **Timeline:** 2025-2027

Activities	Timeline	Person(s) Responsible
Produce maps with arcGIS to visualize the areas of highest maternal need. Use these maps to direct staffing within the Office of Public Health Nursing Services.	2025-226	Joel Arriolacolmenares, Administrator, Office of Public Health Nursing Services
Understand barriers (e.g., needs assessment or landscape assessment) in maternity care deserts to deliver prenatal/postpartum care, including barriers to APPs or other practitioners providing prenatal/postpartum care regardless of ability to deliver babies at facility	2026-2027	RHT Consultant

Awareness of and Access to Care

- **Topic Areas:** Quality Services, Maternal Health Gaps, Data Capacity
- **Strategy:** Integrate telehealth and remote patient monitoring into routine perinatal care to increase visit adherence, enhance early detection of complications, and reduce barriers to access.

Activities	Timeline	Person(s) Responsible
Map and define “lanes” of care management and navigation among existing programs (e.g. Bright Start, Pregnancy Care Program, CHWs, doulas, hospital care coordinators).	2026-2027	RHT Consultant; CHWSD Collaborative; SD DOH; South Dakota Doulas; hospital systems; FQHCs; Community-based organizations
Develop a standardized patient navigation model which reimburses care navigation. (Review the literature, adapt model to fit SD).	2026-2027	DOH, RHT Consultant
Conduct landscape analysis to explore opportunities and barriers to billing and reimbursement for maternal health services and programs provided by healthcare systems and hospitals and state government.	2026-2027	RHT Consultant, DSS Medicaid, Healthcare systems, FQHC, Avel eCare

Activities	Timeline	Person(s) Responsible
Develop and deliver a training program on the minimum clinical standards for perinatal care in telehealth settings (particularly for primary care, family medicine, and rural providers).	2026-2028	DOH, RHT consultant Healthcare providers, SDAHO, SDAFP

Maternal and Child Health Workforce Development and Capacity Building

- **Topic Areas:** Quality Services, Maternal Health Gaps
- **Strategy:** Grow, retain, and strengthen the MCH workforce through education and training opportunities in perinatal health.

Activities	Timeline	Person(s) Responsible
Train Public Health Nurses in professional nursing governance.	2025-2026	Joel Arriolacolmenares, SD Public Health Nursing Managers, Public Health Nurses
Begin review of evidence-based practice in maternal public health with the public health nurses in the nursing governance structure.	2026-2027	Joel Arriolacolmenares, SD Public Health Nursing Managers; Public Health Nurses
Provide OB simulation opportunities in rural and Tribal areas – working on a funding application. Implementation dependent on funding	2025-2026 (subject to funding)	SD PQC; Avera Health; SDDOH

Foster Multi-Sector Partnerships and Collaboration

- **Topic Areas:** Quality Services, Maternal Health Gaps
- **Strategy:** Connect medical care with social services by building strong partnerships between health care providers, community programs, and social support agencies to ensure coordinated care for pregnant and postpartum women.

Activities	Timeline	Person(s) Responsible
Conduct landscape analysis of coordinated care services that connect medical care with social services (e.g., transportation, housing) for pregnant and postpartum women (e.g., Provider education and support for referral, health systems, patient advocates).	2026-2027	RHT Consultant; SD DOH; SD DSS Economic Assistance, Health Systems; 211 Helpline; EMS; Medicaid; Economic Assistance; 211 Helpline; Red River Secure Transport; ROCS Transit

Activities	Timeline	Person(s) Responsible
Establish three maternal and infant health hubs that link to rural spoke sites through the rural health transformation project.	2026-2028	DOH RHT leads- Katelyn Strasser, Shelby Kommes; Avera McKennan and Native Women's Health Care
Develop a presentation highlighting the impact of childcare access on maternal and infant health and childcare resources.	2026	SD DOH and SD DSS
Share the childcare data/resource presentation with at least 3 programs or organizations that serve women and children.	2026	SD DOH MCH staff and SD DSS childcare staff
Convene the First 1,000 Days Interagency Forum to share maternal and infant health information.	Ongoing	Sisseton-Wahpeton Oyate of the Lake Traverse Reservation Department of Human Services

Foster Multi-Sector Partnerships and Collaboration

- **Topic Areas:** Quality Services, Maternal Health Gaps, Data Capacity
- **Strategy:** Facilitate data sharing and interoperability to identify maternal care needs, coordinate care, and evaluate interventions.

Activities	Timeline	Person(s) Responsible
Produce a report on severe maternal morbidity.	January 2026-September 2026	SD DOH-Women's Health Epidemiologist
SD DOH, Medicaid, and Avera partner on SD-MOMENTS to produce a shared set of clinical and social service data.	2025-2026	Avera, SD Medicaid, SD DOH

*** Partner Agencies:** Community Health Workers Collaborative of South Dakota (CHWSD), South Dakota Department of Health (SD DOH), South Dakota Doulas (SD Doulas), Federally Qualified Health Centers (FQHCs), Community-Based Organizations (CBOs), South Dakota Association of Healthcare Organizations (SDAHO), South Dakota Academy of Family Physicians (SDAFP), Public Health Nursing, South Dakota Perinatal Quality Collaborative (SDPQC), South Dakota Department of Social Services Economic Assistance (SD DSS EA), Rural Office of Community Services Transit (ROCS Transit)

Evaluation, Continuous Improvement & Return on Investment

The South Dakota Department of Health Maternal Health Innovation Program (MHIP) will use a practical, mixed-methods evaluation approach to monitor strategic plan implementation, demonstrate progress toward funder expectations, and support continuous quality improvement. These mixed methods combine quantitative outcome and process measures, qualitative input from partners and committee members, implementation tracking, and population-level analysis to understand progress, identify barriers, and guide continuous quality improvement.

The evaluation will align with the MHIP logic model and strategic priorities for postpartum care, infant health and safe sleep, and systems of care. Activities will focus on six domains:

1. Reach
2. Implementation
3. Systems Change
4. Outcomes
5. Sustainability
6. Quality Improvement

These domains will help assess whether SD DOH MHIP activities reach priority populations, are implemented as intended, strengthen statewide systems, improve outcomes, and support long-term sustainability. Each domain will have indicators that will be monitored, analyzed, and findings reported to committee leads and program leadership.

Evaluation Domain Indicator Matrix

Domain	Key Indicators	Data Sources	Review / Use
Reach	Representation of priority populations and high-risk geographies.	Partner tracking log; member intake form.	Quarterly; adjust recruitment and engagement.
Implementation	Planned activities completed, barriers, facilitators, gaps, and duplications.	Activity logs; minutes; action item logs.	Monthly; guide project management and reporting.
Systems Change	New or updated policies, workflows, protocols, partnerships, and data agreements.	Document review; interviews; committee records.	Semi-annual; document system-level impact.
Outcomes	Maternal and infant outcome trends, including equity	Vital records; MMRC; PRAMS;	Annual/as available; set targets and monitor trends.

Domain	Key Indicators	Data Sources	Review / Use
	stratifications where available.	discharge/SMM; Medicaid data.	
Sustainability	Owners, SOPs/workflows, resource plans, and transition strategies for priority interventions.	Innovation inventory; SOPs; budgets; agreements; interviews.	Semi-annual/annual; plan transition and scale.
Quality Improvement	QI opportunities, PDSA tests, action closure, and measures showing movement.	QI tracker; dashboards/run charts; minutes; action logs.	Monthly/quarterly; prioritize tests and spread wins.

The evaluations will be conducted by the contracted resource serving as the FCH QI Coordinator. This role will coordinate data collection, maintain tracking logs, prepare evaluation summaries, facilitate review of findings, and support timely use of results for decision-making and quality improvement. Using a contracted staff resource provides dedicated evaluation capacity, consistent follow-through across committees, and a neutral organizing role for synthesizing information from multiple partners and data sources. This approach also helps reduce burden on program staff, supports timely completion of required deliverables, promotes consistency in documentation and reporting, and allows findings to be translated into practical recommendations for implementation and quality improvement.

Data Sources & Measurement Strategy

MHIP will use multiple data sources, including committee activity logs, partner tracking tools, member rosters, meeting documentation, innovation and intervention inventories, pulse surveys, key informant interviews, public health nursing encounter data, vital records, PRAMS, hospital discharge/severe maternal morbidity data, Medicaid claims or encounter data where available, Maternal Mortality Review Committee findings, and other relevant administrative or program data. Measures will include process, output, outcome, and sustainability indicators, each with a clear definition, data source, reporting cadence, data owner, and intended use.

Using Evaluation Findings for Quality Improvement

Evaluation findings will be reviewed with committee leads and the strategic planning team to identify trends, gaps, duplication, and opportunities for rapid-cycle improvement. When data show gaps in reach, implementation, or outcomes, MHIP will define the issue, identify contributing factors, test targeted changes, and document lessons learned using a structured QI approach, PDSA. Findings will also support partner engagement and decisions about which innovations are ready for replication, scale-up, or sustainment.

Evaluation Schedule Summary

The MHIP evaluation schedule uses a July 2026–June 2027 cadence to support strategic plan implementation, continuous quality improvement, reporting, and leadership decision-making.

Sept. 2026	Monthly	Quarterly	Nov. 2026 & Apr. 2027	May-June 2027
Launch Complete first quarter evaluation memo, pulse survey summary, log updates, and strategic plan measurement inputs.	**Monitor** Update activity logs, partner reach, intervention inventories, risks, barriers, and QI actions.	**Review** Complete second quarter evaluation in **December 2026**, third quarter evaluation in **March 2027**	**Listen** Conduct key informant interviews and synthesize implementation, systems change, and sustainability themes.	**Synthesize** Complete **annual evaluation** synthesis and recommendations for next-year priorities.

Fig 1. Maternal and Infant Health Innovation Logic Model 2025-2026

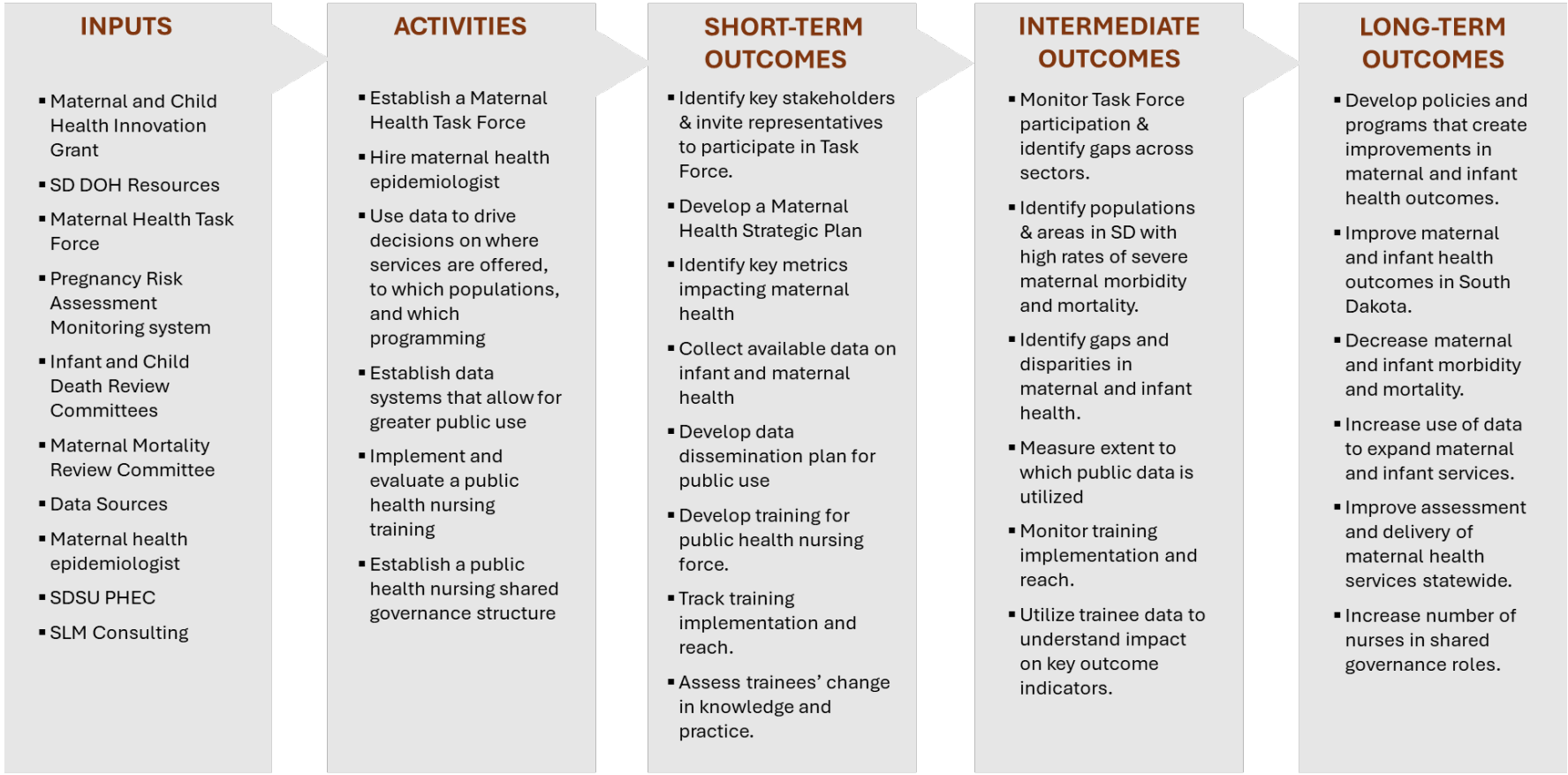


Table 4. Maternal and Infant Health Task Force Evaluation Plan 2025-2026

Partnerships

Question	Intended Outcomes	Source	Data Collection Timing	Indicators	Deliverable	Target Audience
What gaps in partnership representation exist within the task force?	Identify maternal and child health partners present and missing from representation within the task force. Increase representation among diverse organizations/sectors participating in the task force. Participants reflect communities with highest mortality rates.	Partner Tracking Tool; Meeting attendance	Once task force is developed. Ongoing annually.	Number of partners present on the task force; organizations & sectors represented on task force; communities represented by county; partner collaborations formed	Annual Evaluation Report	SD DOH, Grant Reporting

Question	Intended Outcomes	Source	Data Collection Timing	Indicators	Deliverable	Target Audience
How were partners engaged in the strategic planning and implementation processes?	Identify partners/sectors involved with building the strategic plan. Demonstrate varied partners/sectors implementing strategic plan activities.	Task force meeting minutes; strategic plan tracking tool; partner tracking tool	Ongoing; Annually	Number and types of organizations/partners/ sectors involved in developing SP and implementing SP activities; number and types of SP activities implemented; partner feedback on SP development and final plan.	Annual Evaluation Report	SD DOH, Grant Reporting

Task Force & Strategic Plan

Question	Intended Outcomes	Source	Data Collection Timing	Indicators	Deliverable	Target Audience
To what extent are the task force activities implemented?	Demonstrate task force activities are implemented per the project timeline.	Task force meeting minutes; task force activity tracking tool; task force progress tracking/reporting	Ongoing; Annually	Number and types of activities implemented; location of task force activities; number of people or communities reached with activities.	Annual Evaluation Report	SD DOH
To what extent were strategic plan goals and objectives achieved?	Strategic plan was developed per the project timeline. Identify and monitor strategic plan activities to inform on barriers, successes, and alignment of activities with plan goals. Determine impact of strategic plan activities.	Task force meeting minutes; strategic plan tracking tool; partner surveys	Ongoing; Annually	Number and type of SP activities conducted; barriers to SP implementation; successes for SP implementation; reach of SP activities (community, counties, # of people impacted)	Annual Evaluation Report; Partner Survey Summary Report; Strategic Plan Annual Brief	SD DOH

Data Use

Question	Intended Outcomes	Source	Data Collection Timing	Indicators	Deliverable	Target Audience
In what ways were data resources used throughout the project?	Identify key metrics & data sources to monitor throughout the project. Identify gaps in maternal and infant health outcomes. Develop processes to measure maternal data utilization.	Data to Action Committee, Infant Health Committee, Maternal Health Committee, Systems of Care Committee, Office of Lifespan Health Advisory Committee, Data Utilization Tracking Tool; ArcGIS dashboards	Annually	Number & types of data sources used; number & types of data requested; data utilization (who is using data, what data is used, for what purpose is data used); data requests unfulfilled (indicate missing data)	Annual Evaluation Report	SD DOH
To what extent are target populations being reached by the program?	Identify target populations and locations based on maternal and infant health data analyzed. Increase access to services through intentional targeting of high	Data to Action Committee, Data Utilization Tracking Tool; task force progress tracking tool; strategic plan tracking tool; ACS 5-Year estimates; SP/task force	Annually	Key indicator data (TBD); high-risk communities/ counties; targeted county/community demographics; number and type of activities conducted in identified communities; community feedback	Annual Evaluation Report; Community Feedback Summary Report	SD DOH

Question	Intended Outcomes	Source	Data Collection Timing	Indicators	Deliverable	Target Audience
	needs areas and populations based on data.	activity community survey		on activities conducted (qual/quant); Number of programmatic changes due to dashboard use		

Training

Question	Intended Outcomes	Source	Data Collection Timing	Indicators	Deliverable	Target Audience
How extensive was the training implemented across the public health nursing workforce?	Develop a public health nursing training. Identify reach and implementation of the trainings provided.	Public health nursing training tracking tool; training mid-point survey; training post-survey; training rosters from SD TRAIN	Ongoing; quarterly	# of trainees reached; communities/counties where training occurred; number & types of organizations receiving training	Public Health Nursing Program Training Outcomes Summary, Annual Evaluation Report	SD DOH
To what extent did nursing trainees demonstrate gains in knowledge and practice taught in the training?	Increase nursing workforce knowledge gains in core competencies. Enhance EHR documentation fidelity.	Training mid-point survey; training post-survey; My Insight; KPI EHR dashboard	Ongoing; bi-annually	TBD once surveys are developed; # of EHR documentation completed post-visit (no initiation/no completion)	Public Health Nursing Program Training Outcomes Summary, Annual Evaluation Report	SD DOH

Shared Governance

Question	Intended Outcomes	Source	Data Collection Timing	Indicators	Deliverable	Target Audience
How have nursing shared governance practices been implemented?	Develop nursing shared governance among public health nursing workforce. Increase number of nurses in governance roles. Increase number of initiatives implemented by nursing governance efforts.	Nurses' meeting notes (measure engagement or quality); post-training surveys, EHR documentation reviews	Bi-annually	# of nurses in governance roles; # of initiatives implemented; # & type of practice recommendations created based on evidence	Annual Evaluation Report	SD DOH

Return on Investment

This robust evaluation and continuous quality improvement framework is designed to capture data that can be used to show impact and return on investment. Although the plan's activities are in early implementation, the evidence-based strategies selected have promising social and financial returns on investment. The maternal health committee focuses on increasing the percent of women attending postpartum care visits and improving the care coordination and components of these visits through a variety of activities, including this program's innovation of supporting maternal health through public health nursing. This is an opportune time to focus on postpartum care in South Dakota, with Medicaid providing full medical coverage for the postpartum period of twelve months following the end of pregnancy. Evidence suggests that postpartum coverage up to 12 months is associated with lower maternal morbidity and mortality. [24] That is crucial in South Dakota, where most maternal mortality deaths occur in the period of 43-365 days postpartum. Each life lost has a profound impact on their family and community. It's reported that from 2018 to 2020, the national economic burden of lives lost to maternal mortality in the US was $27.4 billion, approximately $32 million per maternal death. [25] One of the activities on the plan is to support the integration of maternal mental health resources and referrals into postpartum care pathways, including digital mental health supports. Mental health has been noted as major contributing factor in South Dakota's maternal mortality deaths, and the South Dakota Pregnancy Risk Assessment Monitoring System data indicates that 13% of mothers reported signs of postpartum depression in 2023. In a state where access to mental health care is sometimes limited due to lack of providers or long drive times to care, web and home-based interventions could be effective at not only limiting costs for the mothers but also showing improvements in self-efficacy, social support, and psychological well-being. [26] Early data from the implementation of a mental health app with South Dakota mothers show high rates of engagement with the resources. The engagement and outcomes of these mental health supports will continue to be tracked and translated into return on investment through the project period.

The strategic plan, in collaboration with the Rural Health Transformation Project, also supports the development of the doula workforce, especially in community and Tribal-led programs. Doulas are trained, non-clinical professionals who provide physical, emotional, and educational support to women before, during, and after birth. They are increasingly recognized as important members of maternal care teams, especially in rural and tribal communities. South Dakota already supports the profession, as evidenced by the expansion of Medicaid reimbursement for doula services in 2025. Doulas provide evidence-based interventions to support birth and newborn care, and they aid in supporting traditional birth practices for Native Americans, screen for perinatal mood disorders, and connect families to social and medical resources. Research has shown that the use of doulas leads to better maternal and infant outcomes while reducing costs through fewer cesarean deliveries, lower preterm birth rates, and an increase in breastfeeding rates. In the postpartum period, doulas encourage postpartum visit attendance, improved mother-baby bonding, and provide education on responsive parenting and decisions such as safe infant sleep practices.

Finally, the ongoing evaluation will highlight the impact of more coordinated statewide infrastructure, decreased costs related to delayed care and hospitalizations or emergency room visits for maternal morbidity, improved data and data sharing, sustainable service delivery, stronger healthcare and public health systems, and improved maternal and infant health outcomes.

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