South Dakota State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Mental Health/Substance Misuse	Increase the percentage of women receiving a Well Women visit annually from 77.3% in 2020 to 85.0% by 2025. (BRFSS)	1.1: Develop partnerships with diverse, multisector stakeholders to promote preventative care for women of childbearing age. 1.2: Create toolkit of resources on Maternal Mental Health/Substance Misuse and Health Equity for OCFS field offices. 1.3: Increase depression screening and referrals to PCP among low-income women within OCFS Public Health Nursing offices.	***Inactive -*** *ESM WWV.1 - % of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening* ***Inactive -*** *ESM WWV.2 - % of WIC clients whose PHQ 9 score met criteria for a referral and were referred* ESM WWV.3 - # of messages posted promoting well women care ESM WWV.4 - % of women with positive depression screen who are referred to their PCP within OCFS field offices ESM WWV.5 - Percentage of people who viewed developed messages on	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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			women's health and clicked on the link for more information.		NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
	A) Increase postpartum visit attendance from 90.9% to 92.9% by 2030. B) Increase contraceptive prescription rates from 38.5% to approximately 48.5% by 2030.	Develop partnerships with diverse, multisector stakeholders to promote postpartum care for women of childbearing age.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Safe Sleep	1) Reduce the number of SUID deaths related to unsafe sleep environment from 139.8/100,000 in 2019 to 103.9/100,000 by 2025. (NVSS) 2) Increase the percent of infants placed to sleep without soft objects or loose bedding from 60.3% in 2021 to 66.3% by 2025. (PRAMS)	5.1: Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media and print. 5.2: Collaborate with Public Health Nursing offices across the state to educate birthing families/infant caregivers on evidence based safe sleep practices. 5.3: Collaborate with Public Health Nursing Offices across the state to educate birthing families/infant caregivers on evidence based safe sleep practices.	***Inactive -*** *ESM SS.1 - % of Child Death Review (CDR) team members who scored above 80% on a post-test* ***Inactive -*** *ESM SS.2 - % of daycares who respond to survey and indicate that they follow safe sleep guidelines* ESM SS.3 - % of birthing hospitals that receive information on certification process that become safe sleep certified	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Child Health					
Parenting	Increase the percent of children	6.1: Promote developmental screenings and related materials through	***Inactive -*** *ESM DS.1*	NPM - Percent of children,	NOM - Percent of children

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Education and Support	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)	service delivery programs within the Office of Child and Family Services 6.2: Create new and promote existing parenting resources to support healthy children and families 6.3: Collaborate with partners to identify gaps in parenting education and support and reduce duplication of efforts	*- % of Community Health Offices that distribute tracking cards* ESM DS.2 - Percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age. ESM DS.3 - % of individuals who showed self-reported improvements to Knowledge, Attitudes, and Practices within topic areas from trainings	ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
	Increase the percentage of children with and without special health care needs, ages 0 through 17, who have a medical home from 50.3% in 2021-2022 to 55.3% by 2025. (NSCH)	Support community based organizations to provide resources and services to their communities.	***Inactive -*** *ESM MH.1 - % of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services* ESM MH.2 - Percent of families who received effective care coordination	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very

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					good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Adolescent Health					
Mental Health/Suicide Prevention	Decrease the adolescent suicide rate among 10 through 19-year-olds from 19.6 per 100,000 (20-2022) to 12.8 per 100,000 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)	7.2.1: Promote evidence-based programs and practices that increase protection from suicide risk. 7.2.2: Develop and disseminate equitable and accessible Suicide Prevention and Mental Health education material, resources, and messaging 7.2.3: Develop partnerships with diverse, multi-sector local and state agencies to address youth mental health and suicide prevention among all South Dakota youth	***Inactive -*** *ESM IH-Adolescent.1 - # of students trained in teen Mental Health First Aid* ESM IH-Adolescent.2 - Number trained in Youth Mental Health First Aid ESM IH-Adolescent.3 - % of unique viewers engaging with posts and media on mental health and suicide	NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization - Adolescent, Formerly NPM 7.2) - IH-Adolescent	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Healthy Relationships	Decrease the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics from 12.1% in 2022 to 11.5% by 2025. (EHR NetSmart) Decrease the South Dakota teen birth rate, ages 15 through 19,	1.1: Promote evidence-based programs and practices that increase healthy relationship skills, STI prevention and pregnancy prevention. 1.2: Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens. 1.3: Develop and disseminate equitable and accessible healthy relationship, STI prevention, and pregnancy prevention materials, resources and messaging.		SPM 1: 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	

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	from 17/1000 in 2021 to 16.56/1000 by 2025. (NVSS)	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.		from 58% in 2022 to 60.74% in 2025.	
Children with Special Health Care Needs					
Access to Care and Services	Increase the percentage of CYSHCN who report receiving care in a well-functioning system from 20.9% (2019-20) to 21.5% by 2025. (NSCH)	11.1: Enhance equitable family access to needed supports and services. 11.2: Identify and implement strategies to equitably advance medical home components for families of CYSHCN through access to family centered care coordination. 11.3: Coordinate the state newborn screening infrastructure focused on equitable testing and access to follow up services.	***Inactive -*** *ESM MH.1 - % of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services* ESM MH.2 - Percent of families who received effective care coordination	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
	Increase the percentage of children with and without special health care needs, ages 0 through 17, who have a medical home from 50.3% in 2021-2022 to 55.3% by 2025. (NSCH)	Support community based organizations to provide resources and services to their communities.	***Inactive -*** *ESM MH.1 - % of families enrolled in care coordination services who report an improvement in obtaining needed*	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

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			referrals to care and/or services ESM MH.2 - Percent of families who received effective care coordination		NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Cross-Cutting/Systems Building					
Data Sharing and Collaboration	Increase the extent to which data equity principles have been implemented in SD MCH data projects from 54.2% in 2021 to 65% in 2025.	3.1 Provide access to timely data to internal partners and policymakers to support evidence-based decision making. 3.2 Provide access to relevant data to external partners and communities to support community-level initiatives for prevention. 3.3 Make the application of data equity principles a required element for sharing data and of epidemiologic reports produced by OCFS so that communities, internal and external partners can use it in their own efforts to advance equity. 3.4 Increase collaboration around American Indian data between state and tribal partners 3.5 Improve internal capacity to share data via referrals between different OCFS programs. 3.6 Increase internal capacity for big data linkage.		SPM 3: Percent of data equity principles implemented in South Dakota MCH projects	