South Carolina State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Improve utilization of preventive health visits to promote women's health before, during, and after pregnancy.	Update the DHEC Family Services Directory and create user-friendly means for women and their families to access it. Strengthen the referral network for women who screen positive for substance misuse and abuse. Partner with USC's Community Health Worker Institute to increase utilization of Community Health Workers in communities of greatest need.	Increase the percentage of SC women with a past year preventive health medical visit to 85% by 2025.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	ESM 1.1: Number of downloads of the family services directory. ESM 1.2: Percent of counties identified as having low utilization of preventive health visits among women that are served by a Community Health Worker ***Inactive -*** *ESM 1.3: Launch the Go Before You Show Campaign*	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live

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					births NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
Improve utilization of preventive health visits to promote women's health before, during, and after pregnancy.	Increase support of post-partum women by promoting and implementing evidence-based strategies in areas of greatest need. Increase awareness of post-partum danger signs for mothers at risk of maternal morbidity and mortality. Expand the capacity of the OB Task Force to include topics and/or initiatives that address post-partum care and mental health treatment for women. Partner with faith-based organizations to encourage ministries addressing post-partum care education and awareness.	Increase the percentage of SC women with a post-partum check up to 92% by 2025.	SPM 1: Percent of women who received a post-partum check up.		
Improve utilization of preventive health visits to promote women's health before, during, and after pregnancy.	Collaborate with DHHS/BOI to support state-wide adoption of AIM safety bundles among birthing facilities in South Carolina. Strengthen capacity and support of Maternal Morbidity and Mortality Review Committee, to include review of SMM and include family/patient voice. Implement CDC Locate to establish maternal levels of care among SC delivering hospitals.	Decrease the percentage of cesarean deliveries among low-risk first births to 23% by 2025.	NPM 2: Percent of cesarean deliveries among low-risk first births	ESM 2.1: Percent of SC birthing facilities that adopt evidence-based safety bundles. ESM 2.2: Pilot the CDC Locate Model in one of SC's Level III hospitals	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births

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	Develop and implement evidence-based post-birth educational messaging for women at risk of maternal morbidity and mortality.			ESM 2.3: Percent of birthing facilities that receive education on providing post-birth messaging to women at risk of maternal morbidity and mortality ESM 2.4: Develop and disseminate annual topic-specific data briefs centered around SC MMMRC Committee findings	
Perinatal/Infant Health					
Improve access to risk-appropriate care through evidence-based enhancements to perinatal systems of care.	Maintain a high level of communication between regional perinatal center staff and DHEC staff monitoring the Perinatal Regionalization System though quarterly meetings. Monitor the detailed functioning of the system through the use of VLBW self-monitoring tools completed by hospital staff for every VLBW delivery in a Level I or Level II hospital. Develop or adopt training materials for providers to have "non-punitive" conversation regarding substance use, educating women about the risk of NAS and infants exposed to other drugs and alcohol in the prenatal period. Provide education to providers on need to standardize diagnosis of NAS and protocols for intervention/treatment (disseminate the NAS needs assessment results). Expand the “Baby and Me, Tobacco Free” program across the state.	Increase the percent of VLBW infants born in a hospital with a Level III+ NICU to 88% by 2025.	NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	ESM 3.1: Generate a report to examine data trends with regard to racial/ethnic disparities in VLBW births at Level I and Level II facilities. ESM 3.2: Number of providers that complete training on non-punitive conversation regarding substance use ESM 3.3: Percent of Medicaid prenatal care providers screening pregnant	NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births

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				women for smoking, alcohol and drug use, domestic violence and depression using the SBIRT tool	
Strengthen implementation of evidence-based practices that keep infants safe, healthy and prevent mortality.	Collaborate with partners to develop and promote culturally appropriate safe sleep messaging, education and counseling. Develop and expand a financial literacy curriculum to address social determinants of health and optimize health outcomes.	Increase the percent of SC infants placed to sleep on their backs to 75% by 2025.	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	ESM 5.1: Number of culturally appropriate translations of material created for populations at risk of infant mortality. ***Inactive -*** *ESM 5.2: Number of participants that complete financial literacy curriculum among maternal and child health program settings*	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Strengthen implementation of evidence-based practices that keep infants safe, healthy and prevent mortality.	Using results from a SWOT analysis, strengthen statewide breastfeeding efforts to support all mothers desiring to breastfeed.	Increase the percent of SC resident infants ever breastfed to 90% by 2025.	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	ESM 4.1: Conduct a SWOT analysis with lactation support professionals to strengthen statewide breastfeeding efforts	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Strengthen implementation of evidence-based practices that keep infants safe, healthy and prevent mortality.	Using results from a SWOT analysis, strengthen statewide breastfeeding efforts to support all mothers desiring to breastfeed.	Increase the percent of SC residents breastfed for at least 6 months to 60% by 2025.	SPM 2: Percent of infants breastfed for at least the first 6 months.		
Child Health					

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Increase developmental screenings and referral to early intervention services for children.	Collaborate with partners to expand access to care/resources for early intervention services for children 0-5, with and without special health care needs.	Increase the percent of children, 9 through 35 months, receiving a developmental screening using a parent- completed screening tool to 50% by 2025.	NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	ESM 6.1: Collaborate with partners to develop a state-wide developmental screening registry ESM 6.2: Increase % of individuals identified as having a birth defect through the SCBDP who are referred to Babynet	NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Improve coordinated and comprehensive health promotion efforts among the child and adolescent populations.	Establish interagency partnerships to improve coordination between oral health services and well child visits.	Increase the percent of children, 1-17, who had a preventive dental visit in the past year to 82% by 2025.	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	ESM 13.2.1: Number of new partnerships to improve coordination between oral health services and well child visits	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Improve coordinated and comprehensive health promotion efforts among the child and adolescent populations.	Increase the physical activity among children, working with internal partners and school districts.	Increase the percent of SC children, ages 6-11, who are physically active at least 60 minutes per day every day to 38% by 2025.	NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	ESM 8.1.1: Percent of school districts participating in professional development opportunities that include methods to provide at least 30 minutes daily physical activity opportunities for all students before, during, and	NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

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				after the school day	
Adolescent Health					
Improve coordinated and comprehensive health promotion efforts among the child and adolescent populations.	Build resilience among South Carolina children through safe and supportive environments. Strengthen anti-bullying efforts by partnering with the Institute for Child Success to draft a white paper on the impact/cost of bullying. Raise awareness regarding the perpetuation and victimization of bullying and their effects through the publication of white papers.	Decrease the percent of adolescents, 12-17, who bully others to 9% by 2025.	NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others	ESM 9.1: Publish a white paper describing the impact and cost of bullying on families, stratified by race/ethnicity and related equity metrics	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000
Improve coordinated and comprehensive health promotion efforts among the child and adolescent populations.	Strengthen availability and access to telehealth services for adolescents, including those with special health care needs. Partner with the Telehealth Alliance to develop standards of care for adolescent health. Increase access to youth-centric telehealth services across all 46 counties.	Increase the percent of adolescents, ages 12-17, with a preventive medical visit in the past year to 85% by 2025.	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	ESM 10.1: Number of telehealth providers that adopt a standard of care for adolescents ESM 10.2: Percent of school districts that offer telehealth services and access to students	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000 NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

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					NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
Children with Special Health Care Needs					
Improve care coordination for children and youth with special health care needs.	Collaborate with the Pediatric Advisory Committee to develop and disseminate training for pediatricians on appropriate communication re: abnormal NBS test results and findings to families. Identify and eliminate barriers for families' accessing and establishing a medical home for CYSHCN.	Increase the percentage of CYSHCN receiving care in a medical home to 55% by 2025.	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	ESM 11.1: Percent of SC AAP members that complete training on NBS abnormal notification and referrals	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children,

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				ESM 11.2: Conduct a point in time survey of DHEC's CYSHCN to assess barriers and identify any racial/ethnic disparities in establishing a medical home	ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year
Enhance and expand transition in care/services for CYSHCN from pediatric/adolescent to adulthood.	Support telehealth efforts that provide transition care access for CYSHCN. Collaborate with the SC Telehealth Alliance to identify telehealth specialist networks for CYSHCN.	Increase the Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care to 23% by 2025.	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	ESM 12.1: Percent of pediatric providers that use telehealth to assist CYSHCN transition to adult care	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
Cross-Cutting/Systems Building					
Reduce disparities in SDoH, including barriers to medical care, especially behavioral and mental health care, fatherhood involvement, and racism/discrimination.	Address SDoH by further sharing results from our public input survey SDoH questions (including reactions to racism), and reverse data walk.	Launch the CDC Hear Her Campaign to raise awareness about warning signs during and after pregnancy.	SPM 3: Implement the CDC Hear Her Campaign		
Reduce disparities in SDoH, including barriers to medical care, especially behavioral and mental health care, fatherhood	Keep our partners and Advisory Committee members engaged by sharing and discussing all results from our disparity work and use it to guide future plans and activities impacting women, children and their families. Collaborate with the SC Center for Fathers and Families to expand fatherhood engagement and support programs to additional	Launch a social marketing campaign to strengthen families' confidence in the availability and feasibility of accessing resources.	SPM 4: Develop a social marketing/awareness campaign to increase families' efficacy to access available resources and services		

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involvement, and racism/discrimination.	communities across the state.				