South Carolina 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					
Improve utilization of preventive health visits to promote women's health before, during, and after pregnancy.	Increase the percentage of SC women with a past year preventive health medical visit to 85% by 2025.	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.	ESM WWV.1 - Number of downloads of the family services directory. ***Inactive -*** *ESM WWV.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 WWV.3 - Launch the Go Before You Show Campaign*	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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					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
Improve utilization of preventive health visits to promote women's health before, during, and after pregnancy.	Increase the percentage of SC women with a post-partum check up to 92% by 2025.	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.		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.	Decrease the percentage of cesarean deliveries among low-risk first births to 23% by 2025.	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. Develop and implement evidence-based post-birth educational messaging for women at risk of maternal morbidity and mortality.	ESM LRC.1 - Percent of SC birthing facilities that adopt evidence-based safety bundles. ***Inactive -*** *ESM LRC.2 - Pilot the CDC Locate Model in one of SC's Level III hospitals* ***Inactive -*** *ESM LRC.3 - Percent of birthing facilities that receive education on providing post-birth messaging to women at risk of maternal morbidity and mortality* ESM LRC.4 - Develop and disseminate annual	NPM - Percent of cesarean deliveries among low-risk first births (Low-Risk Cesarean Delivery, Formerly NPM 2) - LRC	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

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			topic-specific data briefs centered around SC MMMRC Committee findings		
Improve utilization of preventive health visits to promote women's health before, during, and after pregnancy.	96	Incorporate education on the importance of a postpartum visit at delivery discharge.	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					
Improve access to risk-appropriate care through evidence-based enhancements to perinatal systems of care.	Increase the percent of VLBW infants born in a hospital with a Level III+ NICU to 88% by 2025.	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.	ESM RAC.1 - Generate a report to examine data trends with regard to racial/ethnic disparities in VLBW births at Level I and Level II facilities. ***Inactive -*** *ESM RAC.2 - Number of providers that complete training on non-punitive conversation regarding substance use* ESM RAC.3 - Percent of Medicaid prenatal care	NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC	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 NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

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			providers screening pregnant 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.	Increase the percent of SC infants placed to sleep on their backs to 75% by 2025.	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.	ESM SS.1 - Number of culturally appropriate translations of material created for populations at risk of infant mortality. ***Inactive -*** *ESM SS.2 - Number of participants that complete financial literacy curriculum among maternal and child health program settings*	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
Strengthen implementation of evidence-based practices that keep infants safe, healthy and prevent mortality.	Increase the percent of SC resident infants ever breastfed to 90% by 2025.	Using results from a SWOT analysis, strengthen statewide breastfeeding efforts to support all mothers desiring to breastfeed.	***Inactive -*** *ESM BF.1 - Conduct a SWOT analysis with lactation support professionals to strengthen statewide breastfeeding efforts* ESM BF.2 - ESM 4.1 BF - All WIC staff receive training on the USDA WIC Breastfeeding Curriculum presented	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	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

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			by Every Mother, Inc.		
Strengthen implementation of evidence-based practices that keep infants safe, healthy and prevent mortality.	Increase the percent of SC residents breastfed for at least 6 months to 60% by 2025.	Using results from a SWOT analysis, strengthen statewide breastfeeding efforts to support all mothers desiring to breastfeed.		SPM 2: Percent of infants breastfed for at least the first 6 months.	
Child Health					
Increase developmental screenings and referral to early intervention services for children.	Increase the percent of children, 9 through 35 months, receiving a developmental screening using a parent- completed screening tool to 50% by 2025.	Collaborate with partners to expand access to care/resources for early intervention services for children 0-5, with and without special health care needs.	ESM DS.1 - Collaborate with partners to develop a state-wide developmental screening registry ESM DS.2 - Increase % of individuals identified as having a birth defect through the SCBDP who are referred to Babynet	NPM - Percent of children, 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	NOM - Percent of children 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
Improve coordinated and comprehensive health promotion efforts among the child and adolescent populations.	Increase the percent of children, 1-17, who had a preventive dental visit in the past year to 82% by 2025.	Establish interagency partnerships to improve coordination between oral health services and well child visits.	ESM PDV-Child.1 - Number of new partnerships to improve coordination between oral health services and well child visits	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC 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 0 through 17, in excellent or very

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					good health (Children's Health Status, Formerly NOM 19) - CHS
Improve coordinated and comprehensive health promotion efforts among the child and adolescent populations.	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.	Increase the physical activity among children, working with internal partners and school districts.	ESM PA-Child.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 after the school day	NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child	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 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
Improve care coordination for children and youth with special health care needs.	50	Incorporate education on the importance of a medical home with the care coordination provided by Title V's partner, Help Me Grow SC.	***Inactive -*** *ESM MH.1 - Percent of SC AAP members that complete training on NBS abnormal notification and referrals* ESM MH.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	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

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					past year (Forgone Health Care, Formerly NOM 25) - FHC
Adolescent Health					
Improve coordinated and comprehensive health promotion efforts among the child and adolescent populations.	Decrease the percent of adolescents, 12-17, who bully others to 9% by 2025.	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.	ESM BLY.1 - Publish a white paper describing the impact and cost of bullying on families, stratified by race/ethnicity and related equity metrics	NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Improve coordinated and comprehensive health promotion efforts among the child and adolescent populations.	Increase the percent of adolescents, ages 12-17, with a preventive medical visit in the past year to 85% by 2025.	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.	***Inactive -*** *ESM AWV.1 - Number of telehealth providers that adopt a standard of care for adolescents* ESM AWV.2 - Percent of school districts that offer telehealth services and access to students	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	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 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

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					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 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

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					NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Children with Special Health Care Needs					
Improve care coordination for children and youth with special health care needs.	Increase the percentage of CYSHCN receiving care in a medical home to 55% by 2025.	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.	***Inactive -*** *ESM MH.1 - Percent of SC AAP members that complete training on NBS abnormal notification and referrals* ESM MH.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	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

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Enhance and expand transition in care/services for CYSHCN from pediatric/adolescent to adulthood.	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.	Support telehealth efforts that provide transition care access for CYSHCN. Collaborate with the SC Telehealth Alliance to identify telehealth specialist networks for CYSHCN.	***Inactive -*** *ESM TR.1 - Percent of pediatric providers that use telehealth to assist CYSHCN transition to adult care* ESM TR.2 - Percentage of CYSHCN ages 16-21 who have a valid transition care plan in place	NPM - 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 (Transition, Formerly NPM 12) - TR	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
Cross-Cutting/Systems Building					
Reduce disparities in SDoH, including barriers to medical care, especially behavioral and mental health care, fatherhood involvement, and racism/discrimination.	Launch the CDC Hear Her Campaign to raise awareness about warning signs during and after pregnancy.	Address SDoH by further sharing results from our public input survey SDoH questions (including reactions to racism), and reverse data walk.		SPM 3: Implement the CDC Hear Her Campaign	
Reduce disparities in SDoH, including barriers to medical care, especially behavioral and mental health care, fatherhood involvement, and racism/discrimination.	Launch a social marketing campaign to strengthen families' confidence in the availability and feasibility of accessing resources.	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 communities across the state.		SPM 4: Develop a social marketing/awareness campaign to increase families' efficacy to access available resources and services	