OFFICE OF **RURAL HEALTH**

SOUTH DAKOTA DEPARTMENT OF HEALTH

Strategic Analysis of South Dakota's Rural Healthcare Programs

Final Recommendations Report

October 18, 2024

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**The information contained in this report reflects the health needs of rural communities across the state of South Dakota. Please note that not all recommendations or actions outlined within this report fall under the purview or authority of the Department of Health, Office of Rural Health. The Office of Rural Health may not have direct control or responsibility over all suggested measures and their implementation.*

I. Executive Summary

Rural communities across the country and South Dakota face access to care challenges worsened by the COVID-19 pandemic and the national shortage of physicians and clinicians. South Dakota is uniquely structured as one of the most rural states with a geographically dispersed population. This presents a significant challenge for healthcare providers to serve small-town and remote populations in a financially viable manner. Consistent with other rural communities nationwide, barriers to access care for South Dakotans include health provider shortages, limited healthcare facilities within their communities, difficulty retaining and recruiting providers, and social drivers of health. Rural residents in South Dakota have a higher rate of death and a higher prevalence of poverty and serious medical conditions, which can impede access to care due to financial constraints and contribute to worse health outcomes and complex care needs. [1]

The South Dakota Department of Health (SDDOH) Office of Rural Health (ORH) contracted with Guidehouse to conduct a Strategic Analysis of South Dakota's rural healthcare needs and programming and develop actionable recommendations to improve access to healthcare in rural South Dakota. The Strategic Analysis approach includes:

- An environmental scan
- Various data analyses
- Stakeholder engagement
- Leading practice identification

The Strategic Analysis concludes with four core issues, shown in **Figure 1**.

Figure 1. Core Issues

1 | Lack of access to care to serve the current population

Access to physical care sites is limited in rural and Tribal areas, further exacerbated by a healthcare workforce shortage and recruitment and retention challenges.

2 | Increased demand for care

While access to healthcare is challenged, demand is increasing as the population grows and grows older.

3 | Social factors create barriers to care and health services

South Dakotans, especially those aging and in rural and Tribal areas, are disproportionately impacted by social barriers to adequately and consistently receive care.

4 | Limited partnerships to address access, demand, and social factors

Community-based organizations, legislators, State Departments, and healthcare organizations have limited formal channels to share data, discuss health challenges, and expand access to care.

[1] Maughan DJ, Oloruntoba O, Smith ML, "Socioeconomic Status and Access to Healthcare: Interrelated Drivers for Healthy Aging," Front Public Health, 2020 Jun 18;8:231. doi: 10.3389/fpubh.2020.00231. PMID: 32626678; PMCID: PMC7314918.

This Final Recommendation Report includes three recommendations, seven sub-recommendations, and 23 actions to address core issues, as summarized in **Figure 2**.

Figure 2. Recommendations, Sub-Recommendations, and Actions

Sub-Recommendations	Actions
Recommendation 1. Expand access to health services, providers, and care sites.	
1.1 Expand Physical Care Sites	1.1a Explore and establish funding pipelines to incentivize health systems to expand and build new care sites across South Dakota. 1.1b Assess partnerships to co-locate and provide health and social services in one location.
1.2 Bring Healthcare Services to the Patient	1.2a Expand the reach of physical care sites through mobile clinics. 1.2b Provide incentives and support programs for healthcare professionals to travel to underserved areas, including rural and Tribal areas. 1.2c Expand telehealth services and telemedicine. 1.2d Extend existing provider-to-provider e-consult platform at rural and Tribal provider care sites. 1.2e Explore opportunities to subsidize non-emergency medical transportation in communities with transportation barriers. 1.2f Expand outreach, resources, and health education to educate communities on available health resources and appropriate use of care.
Recommendation 2. Bolster the healthcare workforce pipeline in South Dakota to build the supply of providers and healthcare professionals (e.g., nurses, physician assistants (PAs), behavioral health specialists) to meet the growing health needs in rural areas.	
2.1 Create Interest in Healthcare Careers	2.1a Support programs that promote careers in healthcare and public health, especially in rural and Tribal areas. 2.1b Establish funding opportunities (e.g., grant program) to support career and technical education programs for healthcare careers. 2.1c Partner with academic institutions to offer incentives to meet non-traditional student needs.
2.2 Build the Pipeline	2.2a Expand outreach and education to physicians, clinicians, and other healthcare professionals.

Sub-Recommendations	Actions
	2.2b Launch or support existing tele-mentoring platforms to facilitate learning networks between specialists and primary care providers in rural areas. **2.2c** Implement dual credit programs and share resources to make training available and accessible in rural communities.
2.3 Deploy the Pipeline	**2.3a** Expand and enhance recruitment assistance programs for physicians and healthcare professionals. **2.3b** Explore funding pipelines to support healthcare workforce recruitment and retention efforts. **2.3c** Provide technical assistance to support and enhance existing recruitment and retention efforts of healthcare professionals.
Recommendation 3. Strengthen strategic collaboration, internal operations, and management to address healthcare challenges in rural South Dakota.	
3.1 Engage & Convene Stakeholders	**3.1a** Develop a Rural Healthcare Advisory Committee. **3.1b** Support the development of a Rural Health Association. **3.1c** Enhance creation and distribution of communications and materials (e.g., newsletters, email distros, infographics) to stakeholders.
3.2 Optimize ORH Management & Operations	**3.2a** Refine mission of ORH and develop a strategy to address rural healthcare access challenges. **3.2b** Implement data collection processes and create a rural healthcare dashboard. **3.2c** Promote health equity across all work.

II. Introduction

Overview

Rural South Dakotans encounter many challenges when accessing healthcare services, attributed to social barriers, workforce challenges, and partnerships across the rural healthcare ecosystem. Over the years, South Dakota has made significant investments in healthcare programs to mitigate these barriers, including the 2021 expansion of telemedicine coverage for services where the patient and provider are in the same community and a nearly $1,800,000 investment in Emergency Medical Services (EMS) Telemedicine in Motion in partnership with Avel eCare. [2,3] However, despite these investments, provider shortages still exist, rural and Tribal populations struggle to access needed healthcare services, and providers continue to have issues with financial sustainability.

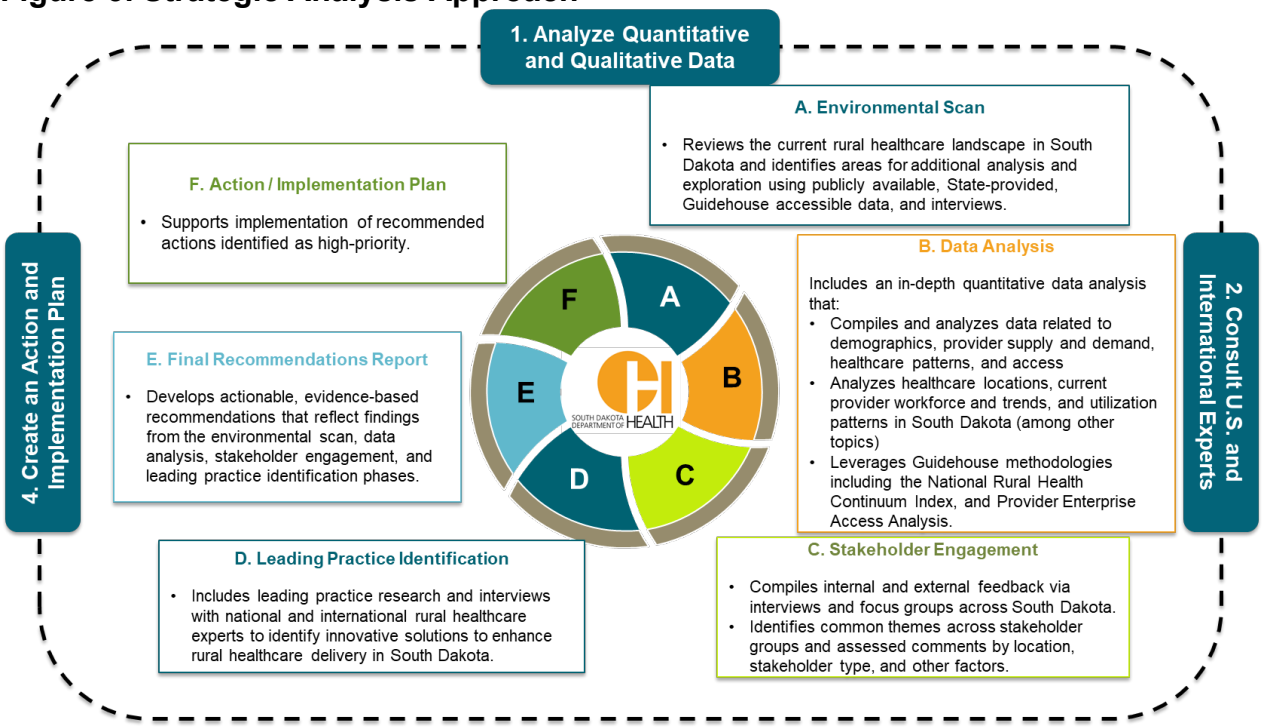
To improve access to healthcare for rural South Dakotans, ORH contracted with Guidehouse from November 2023 to October 2024 to conduct a Strategic Analysis of South Dakota's rural healthcare programs. The analysis includes an assessment of the State's rural healthcare access needs, current State programming, and adequacy to meet those access needs.

The approach to conducting this analysis, as shown in **Figure 3**, includes the following phases to develop a comprehensive understanding of current gaps in access to healthcare in rural South Dakota and develop actionable, evidence-based recommendations to enhance rural healthcare access:

- An environmental scan
- Various data analyses
- Stakeholder engagement
- Leading practice identification

[2] "Newest South Dakota EMS Initiative: Telemedicine in Motion," SDAHO. https://sdaho.org/2023/03/10/newest-south-dakota-ems-initiative-telemedicine-in-motion/
[3] "South Dakota Telehealth Policy," gpTRAC. https://www.gptrac.org/policy/south-dakota?activeTab=7218b27d-9c0e-4be2-a09e-9d6a1590fe31

Figure 3. Strategic Analysis Approach



The Strategic Analysis process highlights four core issues, further described in **Section IV**, that impact access to care in rural South Dakota, including:

1. Lack of access to care to serve the current population.
2. Increase in demand for care.
3. Social factors create barriers to care and health services.
4. Limited partnerships to address access, demand, and social factors.

This Report includes key takeaways from the Strategic Analysis, core issues, three recommendations, seven sub-recommendations, and 23 actions, described in **Section V**, to address these core issues that impact access to healthcare in South Dakota. Individual Strategic Analysis deliverables (e.g., Data Analysis Summary) include additional detail related to methodologies, assumptions, and takeaways.

III. Methodology

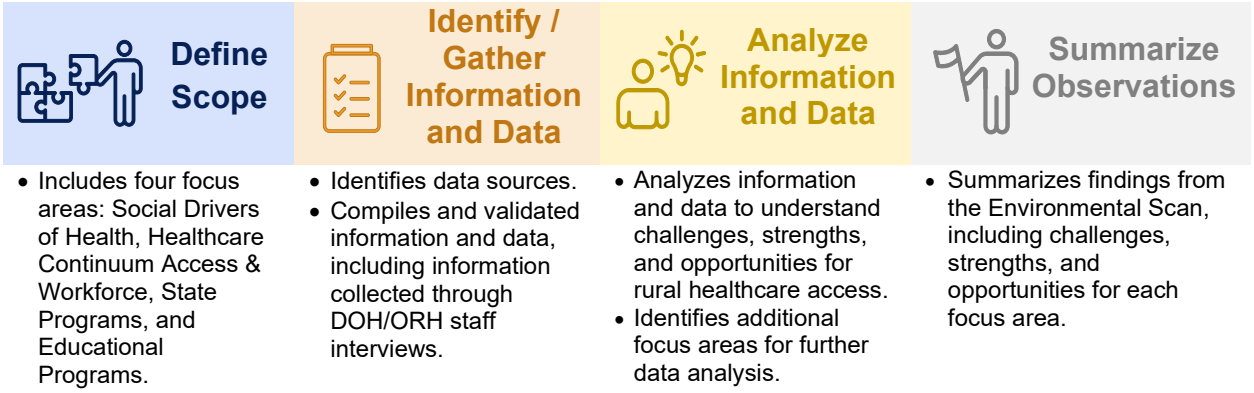
Overview

The Strategic Analysis uses a data-driven approach, encompassing qualitative and quantitative data, to identify the core issues and create actionable recommendations, as shown in this Report, to improve access to care. The approach is multidisciplinary, using public and proprietary data and combining input from public and private sector stakeholders to develop a robust understanding of the core issues and create actions to address these issues affecting access to healthcare in rural South Dakota. This section describes each phase of the Strategic Analysis in detail.

A. Environmental Scan

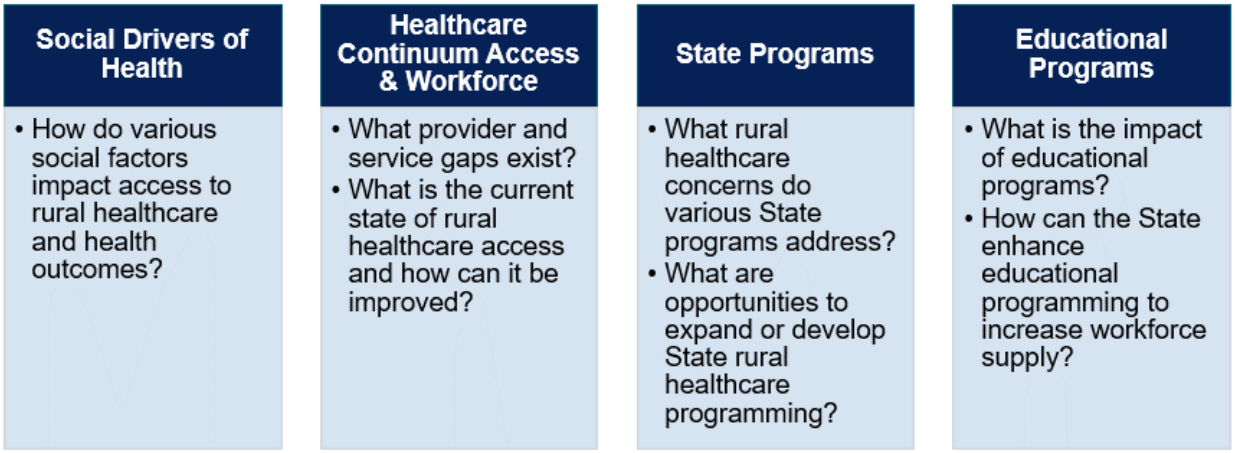
The Environmental Scan established a common fact base regarding the current state of rural healthcare access. **Figure 4** summarizes the steps completed to conduct the Environmental Scan.

Figure 4. Environmental Scan Process



The Environmental Scan includes four focus areas and sub-questions to guide its research, including those listed in **Figure 5.** These focus areas enable a broader understanding of South Dakota's strengths, challenges, and opportunities for rural healthcare access.

Figure 5. Environmental Scan Focus Areas and Sub-Areas



B. Data Analysis

Figure 6 summarizes the various quantitative data analyses conducted to identify gaps in care and assess demand for healthcare services.

Figure 6. Data Analysis Overview

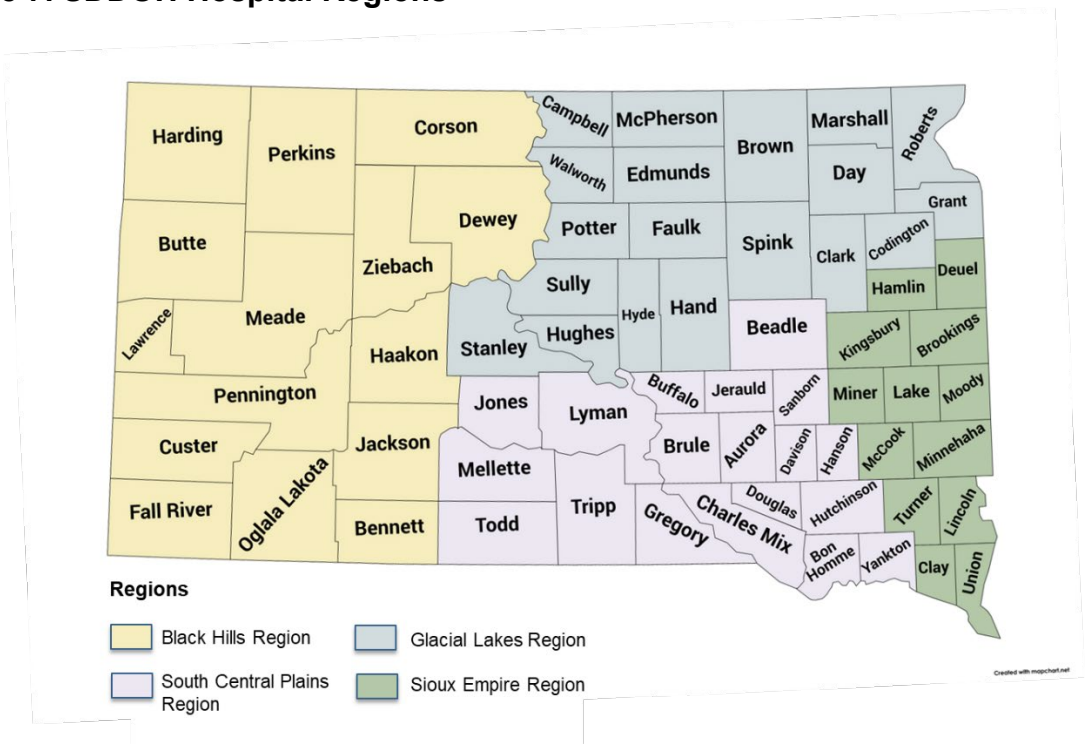
Analysis	Purpose
Demographics Analysis	Identifies current and future demand needs across rural South Dakota.
Access Locations Gap Analysis	Summarizes the current state of healthcare locations in rural South Dakota and uses Guidehouse tools to understand gaps in location-based access to rural healthcare based on the type of locations available.
Access Enablement	Provides insights into operational improvements that can expand access to the current provider workforce.
Utilization Analysis	Analyzes healthcare utilization patterns to understand where and what types of care rural South Dakotans seek across the State.
Outmigration Analysis	Evaluated the potential for residents to leave their local area and travel further to seek care based on proximity to an Emergency Department, Behavioral Health Provider, and Primary Care Providers.
Provider Access Analysis	Describes the current provider workforce and points of access across the State, using a provider needs assessment and analyzing network adequacy.
Digital Access & Virtual Care	Summarizes the current environment, including policy and infrastructure, for enabling digital access and virtual care by analyzing Guidehouse-developed databases, publicly available State policies, and provider surveys

The Strategic Analysis uses region, rurality, and Tribal classifications to better understand the variances in access to healthcare by area. This Report references these classifications continuously and defines each classification below.

Region Classification

Figure 7 includes the four hospital regions SDDOH uses to conduct planning activities. Due to the composition and limitations of the data, the data analyses use county or zip-code-level definitions by region, as appropriate. Geographies outside of South Dakota are included in some analyses to avoid underestimating care needed in each region and because patients living in these zip codes utilize South Dakota healthcare facilities.

Figure 7. SDDOH Hospital Regions [4]



Rural Classification

The Strategic Analysis uses a definition of rurality that combines the Health Resources and Services Administration's (HRSA) definition of rural, the United States Department of Agriculture's (USDA) Rural-Urban Commuting Area (RUCA) codes, and other demographic data such as population density. The Strategic Analysis uses this definition to assess various gaps and demand across rural areas in South Dakota. It provides a more granular view of rurality and access to care challenges by rurality. **Figure 8** summarizes the RUCA codes and count of South Dakota zip codes in alignment with each urban and rural classification.

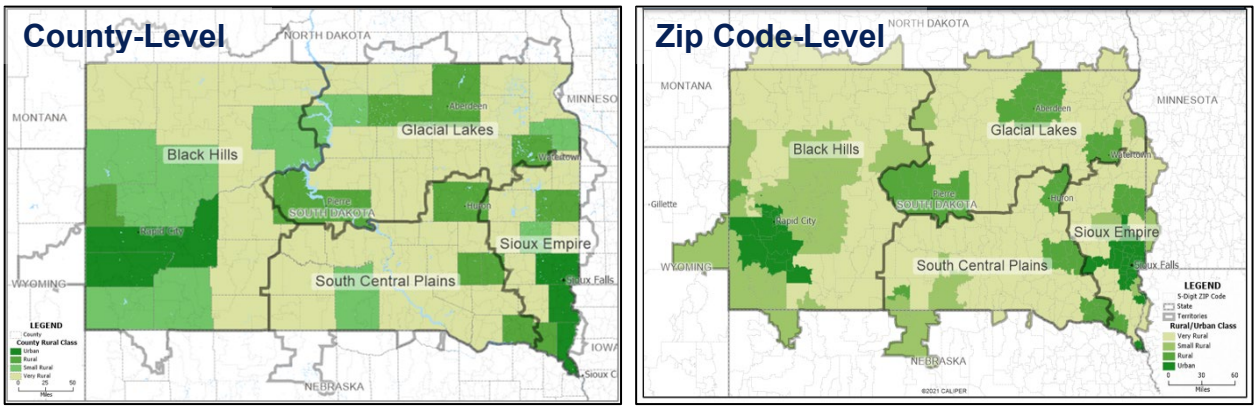
[4] Created with mapchart.net

Figure 8. Urban and Rural Classifications by Zip Code

Urban / Rural Classifications	RUCA Code and Number of Zip Codes
Urban	**RUCA codes 1-3** 52 zip codes
Rural	**RUCA codes 4-6** 59 zip codes
Small Rural	**RUCA codes 7-9** 47 zip codes
Very Rural	**RUCA code 10** 253 zip codes

The rural classification for counties with multiple RUCA codes was determined based on the zip code with most of the county's population. **Figure 9** depicts urban and rural classifications by county and zip code. Geographies outside of South Dakota are included in some analyses to avoid underestimating care in areas in which South Dakota shares a zip code with a neighboring state.

Figure 9. Rural Classifications by Region

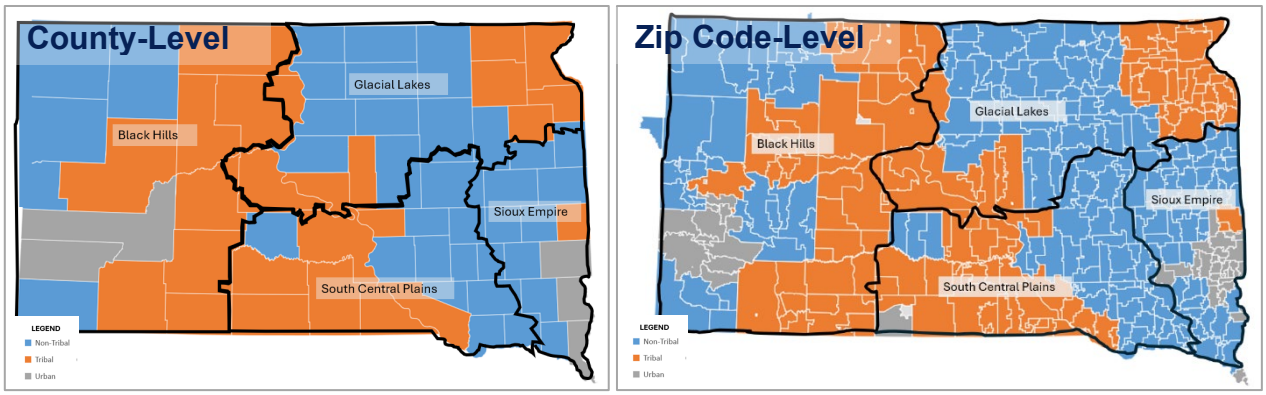


Tribal Classification

The Strategic Analysis defines Tribal and Non-Tribal Area populations to analyze differences in rural healthcare access. Tribal Areas includes counties and zip codes that are in whole or in part comprised of one or more Federally Classified Reservations. The population in a Tribal Area may include Native Americans and non-Native Americans. The "Non-Tribal" classification includes all remaining counties. The analysis excludes urban counties and zip codes.

Figure 10 summarizes maps of Tribal classifications by county and zip code.

Figure 10. Tribal Classifications by Region



C. Stakeholder Engagement

ORH invited 259 stakeholders to provide input on strengths, challenges, and opportunities for rural healthcare access. The Strategic Analysis harnessed stakeholder input to inform core issue identification and recommendation development. Eighty-three public and private stakeholders participated in either a focus group, interview, or via email by providing written input. **Figure 11** depicts the stakeholder groups engaged.

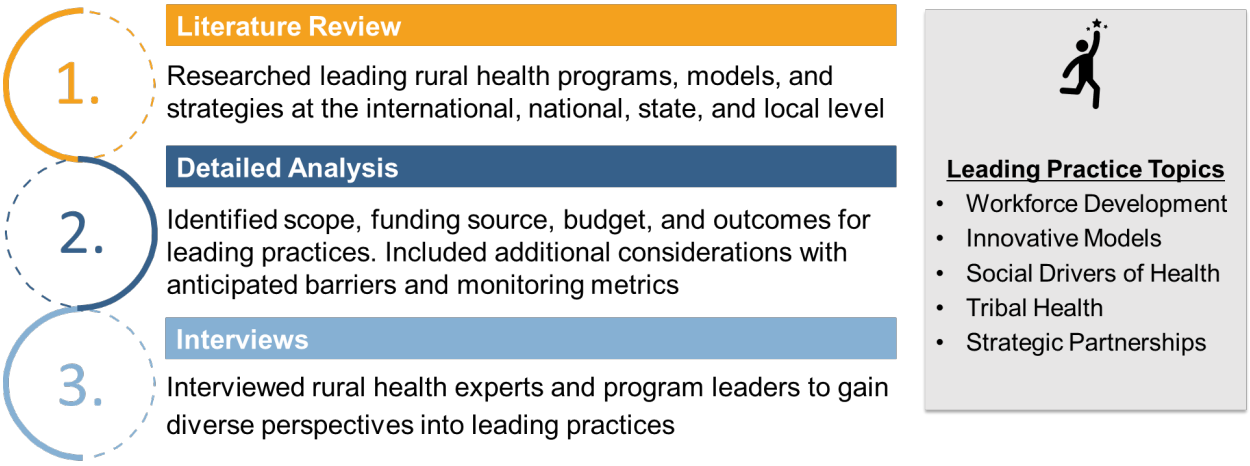
Figure 11. Stakeholder Groups Engaged

** Surveys were distributed to 40,471 licensed people through the BOMOE and BON. Since these surveys mainly supported the Data Analysis phase, these people are not included in the final stakeholder engagement counts.*

D. Leading Practice Identification

Leading practice identification aims to expand the State's knowledge base regarding innovative rural health solutions and identify potential strategies to enhance access to healthcare in rural South Dakota. The Strategic Analysis identified leading practices based on a rigorous review of available sources. **Figure 12** summarizes the leading practice identification process.

Figure 12. Leading Practice Identification Process



Expert Interview Process

Guidehouse and ORH invited 21 experts to participate in the leading practice expert interview process, and nine participated. The Strategic Analysis used the following parameters to invite rural healthcare experts and industry partners to participate in this process:

- Research organizations and State agency leaders in states that neighbor South Dakota and are similar in geographic composition and/or demographics.
- Experts and program leaders within research organizations in other states that do not neighbor South Dakota but have innovative programming, policy, or service delivery models that can enhance access to rural health.
- Federal rural health experts.
- An international expert and project subcontractor, the Australian Healthcare & Hospitals Association.
- Hospital systems in the Great Plains states near South Dakota, including Colorado, Montana, North Dakota, and Wyoming.

IV. Core Issues

The Strategic Analysis identifies four core issues across South Dakota that impact access to healthcare, as shown in **Figure 13**. The remainder of this section describes each core issue in more detail, as informed by each phase of the Strategic Analysis.

Figure 13. Core Issues Identified

1 | Lack of access to care to serve the current population

Access to physical care sites is limited in rural and Tribal areas, further exacerbated by a healthcare workforce shortage and recruitment and retention challenges.

2 | Increased demand for care

While access to healthcare is challenged, demand is increasing as the population grows and grows older.

3 | Social factors create barriers to care and health services

South Dakotans, especially those aging and in rural and Tribal areas, are disproportionately impacted by social barriers to adequately and consistently receive care.

4 | Limited partnerships to address access, demand, and social factors

Community-based organizations, legislators, State Departments, and healthcare organizations have limited formal channels to share data, discuss health challenges, and expand access to care.

1) Lack of Access to Care to Serve the Current Population.

Access to physical care sites is limited in rural and Tribal areas, further exacerbated by a healthcare workforce shortage and recruitment and retention challenges.

Proximity to care sites is important for patients to live healthy lives and get the care they need at the right time and place. Longer travel times often make it challenging for patients to complete their care plans and maintain health and well-being, and patients often delay or even forego needed care. [5] To assess South Dakota's access to physical care sites, the analysis evaluates the proximity of care sites to the population, distance, and the utilization of care sites by region, rurality, and Tribal classification. The quantitative analysis indicates that access to care sites varies by region, rurality, and Tribal classifications, with the largest access gaps in rural and Tribal areas.

South Dakota is experiencing a healthcare workforce shortage, in alignment with national trends. Compared to urban areas, there are significant disparities in access to non-physician providers for rural and Tribal areas with a few exceptions (e.g., Very

[5] Wolfe MK, McDonald NC, Holmes GM. Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997-2017. Am J Public Health. 2020 Jun;110(6):815-822. doi: 10.2105/AJPH.2020.305579. Epub 2020 Apr 16. PMID: 32298170; PMCID: PMC7204444.

Rural areas have more emergency providers (i.e., Emergency Medical Technicians and Emergency Medical Responders) per population, and Tribal areas have more dentists, Board of Addiction and Prevention Professionals, and community health workers (CHWs) than non-Tribal areas.[6] Stakeholders also indicate that rural and Tribal Area populations face healthcare access challenges compared to other areas of the State. Factors (e.g., projected rural physician shortages) compound gaps in local access and are driven by an imbalance in the distribution of providers, with excess providers located in urban areas. The largest provider deficits are projected in Small Rural and Very Rural areas, representing 30% of the State's population. The deficits are seen across all provider types. [7]

The Strategic Analysis identifies four key sub-issues:

- Access to physical care sites is more limited in rural and Tribal areas than in urban and non-Tribal areas.
- South Dakota has a shortage of physicians and healthcare professionals to meet current and projected health needs, especially in rural areas.
- South Dakota faces challenges in building a pipeline and recruiting and retaining physicians and other healthcare professionals to meet healthcare needs.
- Additional administrative activities burden providers and clinicians, leading to burnout and diminished operational capacity.

1.1 Access to physical care sites, relative to distance and population, is more limited in rural and Tribal areas than in urban and non-Tribal areas.

Proximity to Care Sites Relative to Population

The quantitative analysis shows that **urban areas have more care sites per 10,000 square miles** than rural areas, even though 57% of South Dakotans live in rural areas. Investments in service models (e.g., fee-for-service) are often made to clinics that serve larger populations with increased demand for care. However, the **Sioux Empire Region, classified as 72% urban, has the lowest number of care sites per 100,000 population** across outpatient and hospital sites compared to other regions.[8] These findings indicate that urban residents may not have to travel far to access care sites. Although the Region has a low ratio of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), hospital sites, and Indian Health Service (IHS) facilities per 100,000 population, this may be due to higher capacity at these care sites. For example, the hospital site ratio per 100,000 population is the lowest, but hospital beds per 100,000 population are the highest across the Regions.

[6] SD healthcare workforce lists and U.S. Census data are accessed via Claritas (population data). SD Strategic Data Analysis geographic definition (excluding zip codes shared with other states).
[7] SD Physician Roster, Definitive Healthcare (supplemental physician data), U.S. Census data accessed via Claritas (population data). SD Strategic Data Analysis geographic definition, excluding zip codes shared with other states. Both Tribal and Non-Tribal Areas exclude urban zip codes, and Tribal Areas are Tribal reservations zip codes and those with Tribal presence. 1) Provider need is based on the evaluation of a number of non-hospital-based providers practicing within the geography, estimating the portion of their time spent caring for patients, and comparing the resulting provider availability with what is needed to support the residents of those areas by 2028.
[8] Outpatient and hospital sites include Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Critical Access Hospitals, General Hospitals, IHS Hospital Facilities, IHS Non-Hospital Facilities, Staffed beds for Community Hospitals

Figure 14 summarizes access to care sites per 10,000 square miles and per 100,000 population by rural and Tribal classifications. When assessing access to care sites based on rurality, **Small Rural, and Rural areas have the lowest number of care sites relative to population and land mass. Tribal areas have lower rates of care sites per 10,000 square miles compared to non-Tribal areas.** [9] Tribal areas in Glacial Lakes do not have access to an IHS hospital and rely on Critical Access Hospitals for inpatient care.

Figure 14. South Dakota Care Sites by Distance and Population

SD Care Sites/10,000 Square Miles (100 x 100 Sq. Mi)

Site Type	Urban	Rural	Small Rural	Very Rural	Non-Tribal[3]	Tribal[3]
ASC	20.5	6.6	0.0	0.0	3.0	0.6
FQHCs / RHCs	61.4	18.8	9.3	21.1	10.6	17.3
Hospital Sites[2]	11.4	11.1	5.4	5.5	7.9	4.7
IHS Facility (Hospital)[3]	0.0	0.0	2.3	0.2	0.0	1.2
IHS Facility (Non-Hospital)[3]	6.8	1.1	4.7	2.0	0.7	5.3
Nursing Facility	45.5	22.1	8.6	9.2	16.4	7.8
Specialized Hospital	20.5	1.1	0.0	0.0	2.3	0.0
Total Hospital Beds[1]	4,412.1	634.3	164.1	98.4	630.2	148.9

SD Care Sites/100,000 Population

Site Type	Urban	Rural	Small Rural	Very Rural	Non-Tribal[3]	Tribal[3]
ASC	2.2	2.7	0.0	0.0	1.8	1.1
FQHCs / RHCs	6.6	7.7	12.9	57.2	19.3	10.3
Hospital Sites[2]	1.2	4.5	7.5	14.8	4.7	8.5
IHS Facility (Hospital)[3]	0.0	0.0	3.2	0.5	0.0	2.3
IHS Facility (Non-Hospital)[3]	0.7	0.5	6.4	5.5	0.4	9.7
Nursing Facility	4.9	9.0	11.8	24.7	9.8	14.2
Specialized Hospital	2.2	0.5	0.0	0.0	1.4	0.0
Total Hospital Beds[1]	476.4	258.6	226.4	266.1	374.9	272.1
Population Density	*92.6*	*24.5*	*7.2*	*3.7*	*5.5*	*16.8*

Highest *Lowest*

The color-coding scale shows the highest, second-highest, second-lowest, and lowest location numbers in each row with a range of green, yellow, orange, and red highlights, respectively.

1.2 South Dakota has a shortage of physicians and other healthcare professionals to adequately meet current and projected health needs, especially in rural areas.

Healthcare Workforce Shortages

South Dakota has provider deficits across all provider types. The Strategic Analysis compares provider distribution between South Dakota and other states (i.e., Idaho and North Dakota) and assesses provider network adequacy, physician and APP needs, and provider distribution. Key takeaways include:

- South Dakota has more providers in rural areas than non-rural areas compared to peer states in Idaho and North Dakota. However, this does not generally align with the population distribution between rural and urban areas in South Dakota.
- **Small Rural and Very Rural areas,** representing 30% of the State's population, are projected to **have the largest provider deficits across all provider types.**

[9] Guidehouse Rural Health Index (including information sourced from Definitive Healthcare) and "DOH Provider List: Search" web-based tool; U.S. Census data accessed via Claritas (2023 population); SD Strategic Data Analysis geographic definition (excluding zip codes shared with other states. 1) General + Specialized + Critical Access Hospitals + IHS Hospital Facilities, 2) General + Critical Access Hospitals + IHS Hospital Facilities + staffed beds for community hospitals. FQHC = Federally Qualified Health Center, ASC = Ambulatory Surgery Center. 3) 2023 IHS Facilities (Locations | Indian Health Service (IHS)). 4) Tribal and Non-Tribal Areas reflects ratios for select group of counties (62) that only have one Tribal/Non-Tribal classification. Data for counties with multiple classifications like Oglala Lakota, which has Tribal and Non-Tribal zip codes aligned to it, were excluded from the Tribal vs. Non-Tribal analysis.

- Based on the Centers for Medicare and Medicaid Services (CMS) standards for health plans, the network adequacy assessment indicates that **multiple counties are considered inadequate in terms of having a sufficient network of providers available to serve the community's needs**. [10]
- Although the primary care network is adequate in most counties in the State, which is important since these providers are a key entry point to healthcare services, **there are gaps in access to specialties like Gastroenterology and Endocrinology**.
- Regional variations exist for network adequacy of provider specialties, projected surplus or deficit of providers, and healthcare workforce per 1,000 persons. Sioux Empire is the only Region that scores high in all factors.
- Projected rural physician shortages and current recruitment challenges compound gaps in local access. Stakeholder feedback highlights factors such as **housing affordability, isolation from peers, and limited childcare options that negatively impact recruitment to rural areas.**

"Workforce is one of our biggest challenges. We went nine months without a primary care provider and two years without a dental hygienist. It is hard to compete with larger systems for nurses and physicians."

- South Dakota Federally Qualified Health Center Representative

Figure 15 summarizes the availability of provider types per 10,000 square miles and 100,000 population by rural and Tribal classification.

Figure 15. South Dakota Healthcare Workforce by Distance and Population

2023 SD Healthcare Workforce/ 10,000 Sq. Mi. (100 x 100 Sq. Mi)

Provider Types (Count)	Urban	Rural	Small Rural	Very Rural	Non-Tribal*	Tribal*
Emergency Providers[1]	1,713	375	145	162	259	94
APRNs[2]	2,261	303	72	40	110	65
Nurses[2]	23,487	4,123	1,292	599	1,493	844
Dentists	742	162	33	9	37.1	27.7
BH Professionals (BAPPs)	610	112	33	7	29.0	19.5
Community Health Workers	191	32	11	3	8.1	7.6
% of State Population	*45%*	*25%*	*10%*	*20%*	*37%*	*18%*
Population Density	*92.6*	*24.5*	*7.2*	*3.7*	*8.5*	*5.1*

2023 SD Healthcare Workforce/ 100,000 Population

Provider Types (Count)	Urban	Rural	Small Rural	Very Rural	Non-Tribal*	Tribal*
Emergency Providers[1]	185	153	200	437	305	185
APRNs[2]	237	125	96	116	128	120
Nurses[2]	2,457	1,706	1,732	1,728	1,734	1,566
Dentists	80	66	45	25	43.7	54.3
BH Professionals (BAPPs)	66	46	46	18	34.1	38.2
Community Health Workers	21	13	15	7	9.6	14.8

**Excludes urban zip codes*

Highest *Lowest*

[10] **Data Limitations**: The CMS network adequacy methodology does not fully account for community providers' capacity constraints in defining a county as having an "adequate" network. Non-physician data sources only had information on APRNs, RNs, and LPNs at the county level; therefore, GH assessed county-level rural classifications and county-level definitions of Tribal Areas ratios of those providers relative to land area and population. Counts of non-physician providers illustrate their relative availability across SD's Regions. Still, this data is limited by the lack of insight into how much of their time is spent providing full-time healthcare in the Regions.

When comparing regions across the State, there are **large disparities in access to providers for rural and Tribal areas** compared to urban areas, with a few exceptions. Emergency providers, Advanced Practice Registered Nurses (APRNs), and nurses were among the providers with the greatest deficit, relative to population, for **Tribal areas.** Aligned with these findings, stakeholders indicate that rural and Tribal area populations face healthcare access challenges compared to other areas of the State.

- **Analysis takeaways indicate that the Glacial Lakes Region provider deficit is expected to increase tenfold over the next five years**. The top five specialties with the largest deficits are pediatrics, psychiatry, ophthalmology, neurology, and gastroenterology.
- **The Sioux Empire Region** has enough full-time equivalents (FTEs) to support the estimated current and future demand for healthcare services, **but they are not distributed across the Region to close all local access gaps**. Very Rural and Small Rural Areas in this Region are disproportionately impacted and need 78 more providers to care for their communities adequately.
- **Analysis takeaways indicate the South Central Plains Region provider deficit is projected to double in five years**. The top five specialties with notable deficits are pediatrics, psychiatry, primary care, gastroenterology, and neurology.
- Overall, the **Black Hills Region has sizable deficits across multiple specialties and rural areas, especially in the north. The Region's provider network adequacy score for nine specialties is 0%.** Although there are enough providers to support the Region's population, most of the surplus is in the urban areas. [11] The top specialties with deficits are psychiatry, pediatrics, vascular surgery, hematology, oncology, and interventional radiology.

In addition to access to types of providers, access to specialized services is important for rural populations. **Thirty-seven of the State's 66 counties are maternity care deserts.** [12,13] These deserts are located in rural counties, and most are in the Glacial Lakes and South Central Plains Regions (12 and 10, respectively). Rural South Dakotans may be more likely to experience adverse health outcomes, likely from limited to no access to maternity care, including pre-term birth, and an increased risk of infant and maternal mortality.[14] Additionally, stakeholders indicate that service gaps exist, especially for pre-hospital services in northeastern and northwestern parts of the State, as well as long-term care and dialysis care. Stakeholders report that this may have facility, financial, and quality implications, as some rural health facilities stop providing long-term care services due to a lack of staffing and difficulty maintaining patient ratios.

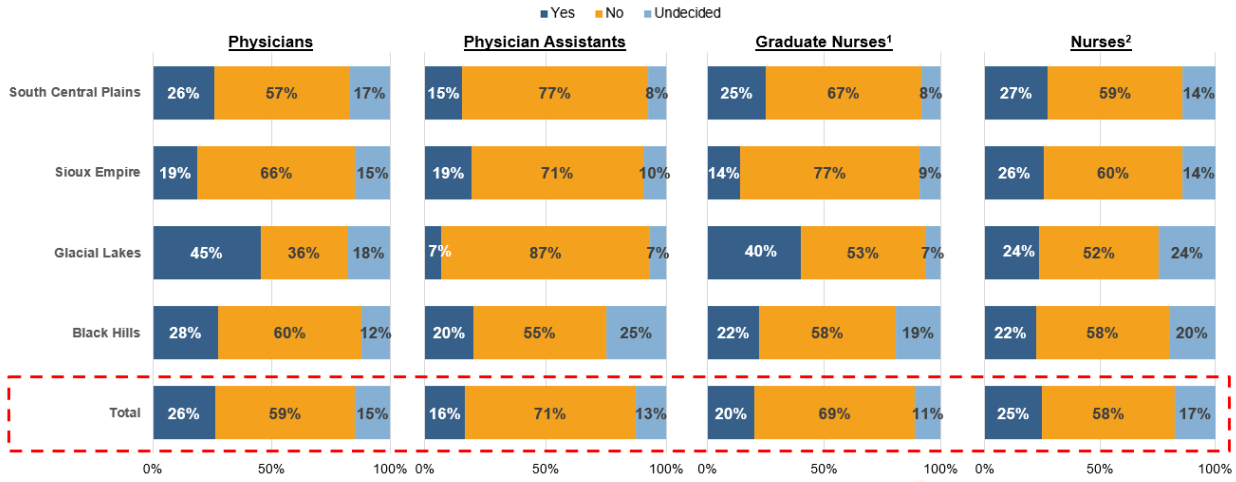
[11] Specialties include primary care, cardiology, psychiatry, oncology (medical/ surgical), general surgery, endocrinology, gastroenterology, Obstetrics & Gynecology, and Orthopedic Surgery.
[12] March of Dimes, "Maternity Care Desert," https://www.marchofdimes.org/peristats/data?top=23&lev=1&stop=641&reg=99&sreg=46&obj=9&slev=4.
[13] March of Dimes, "Nowhere to Go: Maternity Care Deserts Across the U.S. 2022 Report," https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf>.
[14] Grzybowski S, Stoll K, Kornelsen J. Distance matters: A population-based study examining access to maternity services for rural women. BMC Health Services Research. 2011;11:147.

1.3 South Dakota faces challenges to build a pipeline and recruit and retain physicians and other healthcare professionals to meet healthcare needs.

Recruitment and Retention Challenges

Findings indicate that physician and clinician shortages are strained by recruitment and retention challenges, an aging workforce planning to retire, and a lack of legacy planning. **South Dakota retains about 57.7% of its physician residents**, like national averages (57.1%). About one in five providers and clinicians working in South Dakota plan to retire or leave the workforce in the next five years; half of those providers planning to retire work in rural areas. About 67% of these providers and clinicians do not have a legacy plan to replace their role, and 92% do not intend to develop one. Forty-nine percent (49%) of those planning to retire in five years work for rural employers. **Figure 16** illustrates the providers and clinicians working in South Dakota who plan to retire or leave the workforce in the next five years by region.

Figure 16. Providers and Clinicians Working in South Dakota Planning to Retire or Leave in the Next Five Years [15]



Stakeholders report that EMS personnel retention is an ongoing challenge in South Dakota. The average EMS responder is in their late 50s or 60s, and the volunteer staffing structure makes it challenging to recruit new EMS personnel since pay may be higher in other professions. Like urban areas, stakeholders also report that rural facilities use **temporary staffing (e.g., travel nurses) to fill workforce gaps,** which is expensive for healthcare facilities (e.g., hospitals and clinics). Stakeholders indicate that this disincentivizes local staff, who are typically paid less, and financial impacts may be more significant in rural areas than urban, where the average health system margin is less than in urban areas.

[15] Survey responses from SD Rural Strategic Analysis - Board of Medical Osteopathic Examiners and Board of Nursing Survey (1,726 total responses). The analysis is based on responses from providers working in the Strategic Analysis Geography. Excluded responses with insufficient information about physician education and non-nursing degrees. 1) Graduate Nurses = Masters and Doctoral recipients, 2) Nurses = Bachelors, Associate, Diploma and Certificate recipients.

Analyses show that the lack of physician and clinician succession planning will worsen provider gaps over the next five years. With the limited supply of healthcare professionals, hospitals and care sites must compete to recruit and retain physicians and clinicians. Stakeholders indicate that rural facilities have **difficulty competing with larger healthcare systems and private practices** for wages and even have trouble filling staffing gaps with signing bonuses. Geographic isolation from other providers, incentives, and housing also affect recruitment to rural areas. Stakeholders share that policies governing supervision also make it challenging to use advanced practice provider models in rural settings. For example, stakeholders indicate physician assistants (PAs) must have physician supervision and can only work where physicians are located or are willing to supervise remotely, which limits patient access.

Educational Programs

Academic institutions, including high schools, medical schools, technical colleges, and nursing schools, are critical in building the healthcare workforce. Early career exploration programs typically target high schools. Yet, stakeholders report that high school counselors cannot always **advise students on healthcare careers,** as counselors spend their time discussing other student needs (e.g., behavioral health or issues at home). Finding staff within the schools to teach the Health Sciences Career and Technical Education (CTE) courses is challenging due to bandwidth, capacity, or willingness, and stakeholders indicate an opportunity to reach students in Tribal communities to educate them about healthcare careers. Stakeholders value ORH's Scrubs Camps and Camp Med but report gaps in coverage areas (e.g., northwestern South Dakota) and host sites and acknowledge that transportation is a barrier.

Post-high school training programs at universities and technical colleges continue to develop the future healthcare workforce. However, stakeholders acknowledge a projected decline in post-secondary enrollment across South Dakota over the next few years. Stakeholders also suggest that more non-traditional students entering college may benefit from alternative formats of education (e.g., hybrid options).

"The variety of healthcare careers available needs to be better promoted. There is high demand for lower-education healthcare jobs, and we need to ensure that students know the range of careers accessible and available through a variety of educational pathways."

- South Dakota State Agency Representative

In addition to enrollment, educational stakeholders report **difficulty finding healthcare facility partners, especially in rural areas,** with the faculty, space, and clinical site capacity to take students for clinical training opportunities. Universities offer rural rotation and fellowship opportunities, but stakeholders indicate that preceptors often face burnout, and students are challenged with a lack of affordable housing and childcare services to participate in rural medical tracks and clinical placements. Universities may offer stipends through HRSA, but funding is limited. Health systems and academic institutions are developing innovative solutions to bridge these gaps, such as establishing career coaches and dual credit

programs. Still, current efforts could be strengthened or expanded to meet the growing health needs of the State.

1.4 Additional administrative activities burden providers and clinicians, leading to burnout and diminished operational capacity.

Stakeholders voice that administrative burdens and a lack of resources create operational challenges for providers in rural areas, specifically:

- Providers report being on call often in rural communities, and administrative tasks are time-consuming.
- Payer regulations for prior authorizations, denials, appeals, and documentation processes are challenging for providers, especially with increased enrollment in Medicare Advantage plans. This is an issue because lengthy prior authorization processes can delay patient care. Additionally, Medicare Advantage plans use provider networks, or healthcare maintenance organization (HMO) plans, so it could be expensive for the patient to see someone not in the network. [16] Payment denials by insurance companies may result in additional financial burdens for patients and the health system.
- Rural healthcare systems face challenges with reimbursement structures and the traditional methodology of paying healthcare systems by volume.
- Upcoming federal regulations, like the CMS Minimum Staffing Standards for Long-Term Care Facilities, concern rural facilities because they cannot maintain staffing.

2 Increased Demand for Care.

While access to healthcare is challenged, demand is increasing as the population grows and grows older.

Population Growth

Like much of the United States, South Dakota's population is growing and aging. However, findings show that the rate is increasing slightly (0.2%) faster than the national average. [17] **Aging populations typically use more healthcare services than younger populations and often have higher rates of chronic conditions,** which require different and longer-term treatments compared to acute conditions. [18] The analyses use U.S. Census data trended over five years to

Compounding Annual Growth Rate (%)
SD: 0.6%
U.S.: 0.4%

[16] "Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization." KFF. August 8,2024. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/

[17] U.S. Census data are accessed via Claritas 2023 population data, and 2023-2028 population estimates and projections. The Strategic Analysis Geography definition includes all zip codes in SD and zip codes shared with states bordering SD; it is based on a combination of HRSA's definition of rural areas, RUCA data, and evaluation of demographic factors such as population density.

[18] *U.S. Department of Health and Human Services, "Social Determinants of Health and Older Adults," https://health.gov/our-work/national-health-initiatives/healthy-aging/social-determinants-health-and-older-adults#5.*

understand how the population is growing and how that impacts the demand for healthcare. South Dakota community characteristics, especially the degree of rurality and Tribal presence, are key factors when developing initiatives to address healthcare access challenges.

Specifically:

- **Population growth is expected across all regions,** with statewide growth outpacing the national average. Sioux Empire has the largest population (390,599, 43% of the total population) and the highest projected population growth (1% compound annual growth rate [CAGR] over five years).
- Population growth trends indicate that rural areas in South Dakota have a growth rate that matches or is below the statewide growth rate. Moreover, these **rural areas have a greater proportion of the 65+ population** than the State overall.
    - The Very Rural areas contain the largest proportion of senior residents compared to the other areas and the State overall.
- Almost a fifth (18%) of South Dakota's total population live in Tribal areas. The population residing in Tribal areas is expected to grow over the next five years (CAGR: 0.2%) but at a slower rate than the State average (CAGR: 0.9%).
- **People ages 65+ tend to have at least one chronic condition**, which can lead to a need for more frequent and more complex care. [19]

Utilization of Care Sites

Findings from the utilization analysis indicate that utilization of care sites varies by region, rurality, and Tribal classification. Hospital Outpatient Departments are utilized more in rural-classified areas than clinics, especially in the Glacial Lakes Region; this utilization pattern is the opposite in urban areas. **Urban areas (e.g., Sioux Empire Region) have higher utilization of Ambulatory Surgical Centers [ASCs] and urgent care centers**, which may indicate providers are more readily available in urban areas. Rural and Tribal areas have more **limited access to some outpatient services (e.g., ASCs, urgent care, retail clinic)**, leading to higher utilization of available care settings and forgoing some emergent care. Given the limited number of access points/clinics available in their communities, rural residents are limited to hospitals for outpatient care over clinics, which can be expensive for patients.

South Dakotans use telehealth and telemedicine modalities, which can mitigate access to care challenges. However, telehealth utilization is lower than in peer states, indicating an opportunity to increase telehealth utilization. Rural areas in South Dakota utilize telehealth the most. However, **telehealth utilization was lower in Very Rural and Small Rural areas** than in more densely populated Rural areas. This may indicate an opportunity for further telehealth expansion in less densely populated areas. **Tribal Area populations utilize telehealth at a lower rate** (122.2 per 1,000 beneficiaries)

[19] U.S. Department of Health and Human Services, "Social Determinants of Health and Older Adults," https://health.gov/our-work/national-health-initiatives/healthy-aging/social-determinants-health-and-older-adults#5.

than non-Tribal populations (174 per 1,000 beneficiaries). Further analysis is suggested to confirm why utilization rates are lower in Very Rural, Small Rural, and Tribal areas.

Virtual health can improve access to health services and specialty care. However, stakeholders report **that finding a specialist willing to participate in telehealth is challenging due to reimbursement limitations in South Dakota and the additional skill sets** required to implement telehealth modalities successfully. Despite the current impact of virtual care programs across the State, stakeholders and a review of current virtual efforts suggest **an opportunity to expand virtual health programs focused on specialty care.** Examples of existing programs include the Sanford Virtual Care Center, Avera Project NEXT, Avera Virtual Nursing and Monitoring Programs, Telemedicine in Motion, and the Avel eCare Crisis Care Program. [20,21,22,23] Many of the State's current virtual health programs target rural areas, but program data availability varies.

3 Social Factors Create Barriers to Care and Health Services.

South Dakotans, especially those aging and in rural and Tribal areas, are disproportionately impacted by social barriers to adequately and consistently receive care.

Social factors, such as geographic location, transportation, income, socioeconomic status, and race, all influence a person's health and access to healthcare. [24] These social factors can enable a person's health or create barriers to care and health disparities. To address some of these social factors and address health inequities, it is important to better understand and address the underlying causes of poor health and poor access to healthcare. The relationship between healthcare and social factors is complex and intertwined and requires a multidisciplinary approach with community partnerships to make an impact.

Three key sub-issues were identified, which are further described throughout this section.

- Transportation remains a barrier to accessing needed care, especially for rural and Tribal communities.
- Broadband and access to smartphones and computers (i.e., connected devices) are barriers to telehealth and virtual and digital care, especially for rural communities.

[20] Avel eCare, "Avel Crisis Care," https://www.avelecare.com/services/crisis-care/, https://lobbying.wi.gov/Data/PositionFileUploads/11212023_012519_WI_Crisis%20Care_11_1.pdf.
[21] SD Association of Healthcare Organizations, "Newest SD EMS Initiative: Telemedicine in Motion," https://sdaho.org/2023/03/10/newest-south-dakota-ems-initiative-telemedicine-in-motion/.
[22] Avera Health, "Avera Expands Telemedicine Efforts to Virtual Nursing," https://www.avera.org/balance/family-medicine/avera-expands-telemedicine-efforts-to-virtual-nursing/
[23] Avera Health, "Avera Receives Grant Funding to Support Nursing Workforce," https://www.avera.org/news-media/news/2022/hrsa-nursing-grants/#:~:text=Avera%20has%20received%20over%20%242.5,including%20telehealth%20and%20virtual%20nursing
[24] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 3, The Root Causes of Health Inequity. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425845/

- Rural and Tribal areas face multiple health disparities and are disproportionately affected by social factors that are barriers to accessing healthcare.

3.1 Transportation remains a barrier to accessing needed care, especially for rural and Tribal communities.

Transportation is critical in healthcare because it can directly influence a patient's ability to travel to healthcare services. If an individual does not have a means of transportation, it can be challenging to go to their medical appointment, get to the grocery store, hold a job, or engage in other daily activities that promote a healthy lifestyle. Transportation is a common reason people forego or delay medical appointments or leave prescriptions unfilled, with consequences for individual health outcomes. [25]

"Transportation is a barrier, especially when transferring a patient between the federal clinic and hospital in our area. These facilities are 25 miles apart and our local infrastructure will not cover transportation services since it extends county lines."

- South Dakota Health System Representative

Stakeholders indicate that South Dakotans utilize a variety of local transportation options, including non-emergency medical transportation (NEMT), emergency medical services, community vans, bus systems, and federal transportation programs. Stakeholders acknowledge transportation options vary by region, and there are limitations on hours of operation, appointment windows, distance, and frequency the transportation unit will travel to the healthcare facility. Additionally, stakeholders indicate that patients such as farmers or ranchers may not have insurance or qualify for State or federal insurance programs (i.e., Medicaid and Medicare) and pay large out-of-pocket expenses for emergency transport (e.g., flights). **NEMT fees may deter individuals from using transportation services to access healthcare services.**

In 2021, 56 counties in South Dakota had less than 50% access to intercity transportation. Forty-seven of these 56 counties (all rural) had no intercity transportation access. In ten counties, 50% of residents or more had access to intercity transportation. Two counties, Minnehaha and Pennington, are urban, while the rest are rural and in the Black Hills, Glacial Lakes, and Sioux Empire Regions. [26] **Limited public transportation options exist in rural and Tribal areas**, so residents depend on a personal vehicle to access healthcare. Urban and rural South Dakotans have the same percentages of households without access to a vehicle. The ten counties with the highest rates of households without a vehicle are all rural, and only ten counties (eight

[25] Wolfe MK, McDonald NC, Holmes GM. Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997-2017. Am J Public Health. 2020 Jun;110(6):815-822. doi: 10.2105/AJPH.2020.305579. Epub 2020 Apr 16. PMID: 32298170; PMCID: PMC7204444.
[26] U.S. Department of Transportation Bureau of Transportation Statistics, "Access to Intercity Transportation in Rural Areas," https://data.bts.gov/stories/s/Rural-Access-to-Intercity-Transportation/gr9y-9gjq/.

of which are rural) have 50% or higher access to intercity transportation in the State.[27,28]

Findings show that **many Tribal Area populations need to travel over 120 minutes to access an IHS Hospital Facility, and most rural South Dakotans must travel over 60 minutes to access emergency and hospital-based care**. These travel times are further than CMS' network adequacy standards. Even when patients can access a healthcare facility, stakeholders indicate that they sometimes remain at the initial facility they visit and cannot transfer to another level of care due to limited options or EMS capacity to facilitate transfers. Some health systems pay privately to transport patients due to a lack of community transportation infrastructure. Moreover, several ambulance service providers have recently closed throughout South Dakota, which creates additional barriers to transportation and access to healthcare.

3.2 Broadband and access to connected devices are barriers to accessing telehealth and virtual and digital care, especially for rural communities.

Broadband and access to devices play an increasingly significant role in healthcare and public health, enabling access to telehealth, digital care, and scheduling platforms to make appointments for care. Telehealth and telecommunications technologies deliver healthcare and health education to hard-to-reach places. Rural communities and Tribal areas often rely on telehealth to connect with specialists, check in and follow up for chronic health conditions, and receive medication management. Rural and underserved populations that benefit from telehealth services are often the least likely to have access to broadband and connected devices necessary to access telehealth. [29] Connected devices and broadband access also impact other social factors like education, employment, and social welfare. [30]

Data analysis shows that South Dakota **counties have varying broadband access levels, ranging from 56% to 96%.** Approximately 35% of counties have less than average broadband access, with most counties located in the Black Hills (41% of counties in the first quartile) and South Central Plains Region (41%). The Black Hills Region has the lowest telehealth utilization of all regions, underscoring the importance of expanding access to telehealth through broadband access.

"It is hard to access expert and specialized care in rural areas. There is no structure within the payment system to facilitate "expert" exposure and specialist access for patients. There is opportunity to better leverage the virtual consult model."

- South Dakota Medical Center Representative

[27] ArcGIS, "Where Are Households with No Vehicle Available?," https://navigant.maps.arcgis.com/apps/mapviewer/index.html?webmap=a16b9f8f0d594125aac60179b9bb9741
[28] U.S. Department of Transportation Bureau of Transportation Statistics, "Access to Intercity Transportation in Rural Areas," https://data.bts.gov/stories/s/Rural-Access-to-Intercity-Transportation/gr9y-9gjq/
[29] Rural Health Information (RHI) Hub, Telehealth and Health Information Technology in Rural Healthcare
[30] Hatef E, Ma X, Shaikh Y, Kharrazi H, Weiner JP, Gaskin DJ. Internet Access, Social Risk Factors, and Web-Based Social Support Seeking Behavior: Assessing Correlates of the "Digital Divide" Across Neighborhoods in The State of Maryland. J Med Syst. 2021 Sep 19;45(11):94. doi: 10.1007/s10916-021-01769-w. PMID: 34537892; PMCID: PMC8449832.

Access to computers is another issue that impacts access to healthcare services and virtual care. Findings indicate that **7.4% of households in South Dakota do not have a computer**, which is slightly higher than the national average (6.0%), North Dakota (6.8%), and Idaho (4.8%). When assessing variation in age, 14.3% of South Dakotans aged 65 years or older live in households without a computer, which is higher than other age groups and nationally (11.8%). [31]

Analyses also show that **Rural South Dakotans have less access to broadband than urban South Dakotans**. On average, in the top thirteen counties (top quintile), one of every three people has no broadband access. Charles Mix and Jones counties have the lowest access, with one out of every two having no broadband. [32] Moreover, **Rural South Dakotans have the lowest percentage of households without access to a smartphone** compared to the State average, urban South Dakotans, and peer states. While rural communities utilize telehealth the most, telehealth utilization is lower in Very Rural and Small Rural areas than in more densely populated Rural areas.

Stakeholders indicate that provider communication, patient handoffs, and specialty care are challenging in virtual care environments. Additionally, **stakeholders report challenges finding specialists willing to participate in telehealth** due to reimbursement. Moreover, additional skills and steps are required to implement telehealth modalities. A provider may or may not want to contact a specialist while caring for a patient, but there is **no set structure or network to facilitate and account for contacting other providers in separate health systems** and looping other providers into the care delivery process.

Enabling digital health access is multifactorial and requires a thoughtful approach to address some core issues, such as provider-specific offerings, access to broadband, insurance and payment options, device availability, and digital literacy. Most South Dakotan insurers cover digital care, and the State passed policies to protect telehealth options. In South Dakota, Medicaid and Medicare fee-for-service cover telehealth, remote patient monitoring (RPM), and audio-only visits. [33,34] In 2021, Governor Kristi Noem signed a law allowing providers to see patients via telehealth without first seeing them in person. [35] In South Dakota, health insurers are prohibited from excluding a service from coverage solely because it was provided through telehealth. [36]

Telehealth is also not a “one-size-fits-all” solution to expanding access to healthcare and may not be suitable for all patients, depending on their level of care.

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[31] 2022 U.S. Census Bureau, American Community Survey, Types of Internet Subscriptions by Selected Characteristics 2) 2022 U.S. Census Bureau, American Community Survey, Types of Computers and Internet Subscriptions.
[32] Federal Communications Commission, “Connect 2 Health,” https://www.fcc.gov/reports-research/maps/connect2health/map.html#ll=31.54109,-96.459961&z=4&t=broadband&hmt=health&bbm=fixed_access&dmf=none&hhm=none&zlt=county
[33] CCHPCA SD https://www.cchpca.org/south-dakota/?category=federally-qualified-health-center-fqhc&topic=eligible-originating-site
[34] DSS SD https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/FQHC_and_RHC.pdf
[35] South Dakota Legislature. Codified Laws34-53-3.https://sdlegislature.gov/Statutes/34-52-3
[36] CCHPCA SD https://www.cchpca.org/south-dakota/?category=federally-qualified-health-center-fqhc&topic=eligible-originating-site

3.3 Rural and Tribal areas face multiple health disparities and are disproportionately affected by social factors that are barriers to access healthcare.

Rural and Tribal populations are more likely to experience more health disparities and inequities compared to their urban and non-Tribal counterparts, which can be attributed to some social factors that impact health, such as poverty, transportation insecurity, and limited access to healthcare. [37] Findings indicate that **rural and Tribal populations in South Dakota are disproportionately affected by social factors** that negatively impact access to healthcare and overall health. Below is a summary of the data analysis findings illustrating these disparities.

Rural Areas

- There are disproportionately **fewer care sites in South Dakota's rural and Tribal areas relative** to population and distance. For example, Small Rural and Tribal areas have fewer care sites (e.g., outpatient settings and hospitals) per 100,000 population than other regions, meaning residents must travel longer distances for hospital care.
- **Rural South Dakotans die at a higher rate than urban South Dakotans** for all leading causes of death except cancer. [38] Specifically, rural South Dakotans die at a much higher rate from suicide and chronic conditions, especially chronic lower respiratory diseases, Alzheimer's disease, and diabetes. [39,40]
- Stakeholders report that **insurance accessibility, cost of healthcare, system navigation, and claim denials are challenging in rural communities**. Additionally, stakeholders indicate that when people sign up for high-deductible plans and have not met the deductible, this can place financial pressure on patients and families and create access barriers.

"The ambivalence with patients taking charge of their own health is a challenge in rural South Dakota. I see many patients that are just resigned to the fact that they will not live to age 50, that they will have multiple comorbidities, and that factors like diabetes, hypertension, hyperlipidemia, renal failure, liver failure, etc. are just "common place" and an expected health outcome."

- South Dakota Board of Nursing Respondent

[37] RHIhub, "Rural Tribal Health" and "Rural Health Disparities Overview"
[38] County Health Rankings & Roadmaps, "2016-2020 and 2020 South Dakota Data," https://www.countyhealthrankings.org/explore-health-rankings/south-dakota?year=2023.
[39] South Dakota Department of Health, Office of Health Statistics, "South Dakota Mortality Report, 2023 (Provisional)," https://doh.sd.gov/media/1kslduke/mortality-report-2023-provisional-november.pdf.
[40] County Health Rankings & Roadmaps, "2016-2020 and 2020 South Dakota Data," https://www.countyhealthrankings.org/explore-health-rankings/south-dakota?year=2023.

Tribal Areas

- The State's least healthy counties (by health outcomes scores) in the Black Hills and South Central Plains Regions are in Tribal areas. [41]
- Stakeholders indicate that **quality health indicators (e.g., life expectancy) are typically lower in Tribal areas,** and Tribal area residents may have mistrust in healthcare services and providers and face historical trauma or multi-generational trauma. [42]
- Stakeholders indicate that **syphilis** is prevalent among Tribal area residents**.**
- Stakeholders indicate that **drug and alcohol use** is prevalent among Tribal area Residents.
- Stakeholders report that Tribal residents face **challenges getting to healthcare appointments.**
- In addition, the Tribal areas in the northeast counties of the Black Hills Region have the **highest unemployment rates in the State**. Due to high unemployment rates, rural South Dakotans may report more adverse health outcomes and may avoid care due to concerns about cost. [43]
- Nine of the top ten zip codes with the **lowest incomes are on Oglala, Rosebud, and Crow Creek Tribal lands.** [44]

"In the reservations, we see kids with poor home environments which contributes to drug and alcohol use, cavities, and tooth decay."

- South Dakota State Agency Representative

"The biggest challenge is transportation, especially non-emergent. There is IHS transportation services for reservations, but it has limits and getting to a specialty appointment and pharmacy or daily wound cares is tough."

- South Dakota Hospital Representative

[41] County health Rankings & Roadmaps, "Health Outcomes," https://www.countyhealthrankings.org/health-data/health-outcomes.
[42] "Inadequate Healthcare for American Indians in the United States." Ballard Brief. https://ballardbrief.byu.edu/issue-briefs/inadequate-healthcare-for-american-indians-in-the-united-states#:~:text=Historical%20trauma%E2%80%94The%20lasting%20impacts,It%20is%20often%20multi%2Dgenerational.&text=Medical%20mistrust%E2%80%94A%20lack%20of,of%20medical%20organizations%20and%20providers.
[43] Silver SR, Li J, Quay B. Employment status, unemployment duration, and health-related metrics among US adults of prime working age: Behavioral Risk Factor Surveillance System, 2018–2019. Am J Ind Med. 2022; 65: 59-71. doi:10.1002/ajim.23308
[44] 2023 United States Census Bureau data.

4 Limited partnerships to address access, demand, and social factors

Community-based organizations, legislators, State Departments, and healthcare organizations have limited formal channels to share data, discuss health challenges, and expand access to care.

Rural strategic partnerships are important to boost collaboration, solution-building, and support implementation of programs within rural communities. Strategic Analysis findings show that ORH has several rural partners across the healthcare ecosystem, including local government staff (e.g., public schools, EMS directors), hospital systems and rural health facilities, technical and higher education institutions, healthcare associations, and legislators. ORH frequently connects with rural communities and partners through various channels (e.g., conferences and summits, Scrubs Camps / Camp Med, recruitment assistance programs), which stakeholders appreciate; however, they recognize the following challenges and opportunities:

- Although there are several collaborative efforts happening at the State level, there is **limited formalized collaboration** across healthcare organizations, the State, and communities to better understand and address community rural healthcare needs.

"Southeast Tech has an amazing new simulation lab, but that was a unique alignment of State, city, and local investment. When you can get the right people together with a common goal, it's impactful. Where else can these types of partnerships happen?"

- South Dakota Health System Representative

- State programs improve access to care in rural communities, but **occasional siloing** occurs. There is an opportunity to create a more collaborative approach to address rural health needs across communities, systems, associations, and State Departments.
- There is a need for more outcome-based data to evaluate State programs, social drivers of health, and Tribal data, and to educate partners and legislators.

"When we have big conferences or board meetings, someone from one of the agencies will come and speak, and there's a real sense of partnership. There are a lot of great partnerships between the providers and the State to be preserved and built on."

- South Dakota Health Association Representative

- There is an opportunity to **strengthen data sharing and collaborative agreements** between State Departments to build the healthcare pipeline.
- Enhanced collaboration and information sharing could promote access to care in rural areas. For example, communicating what SDDOH offers across Divisions and in communities to **promote awareness of resources available**.

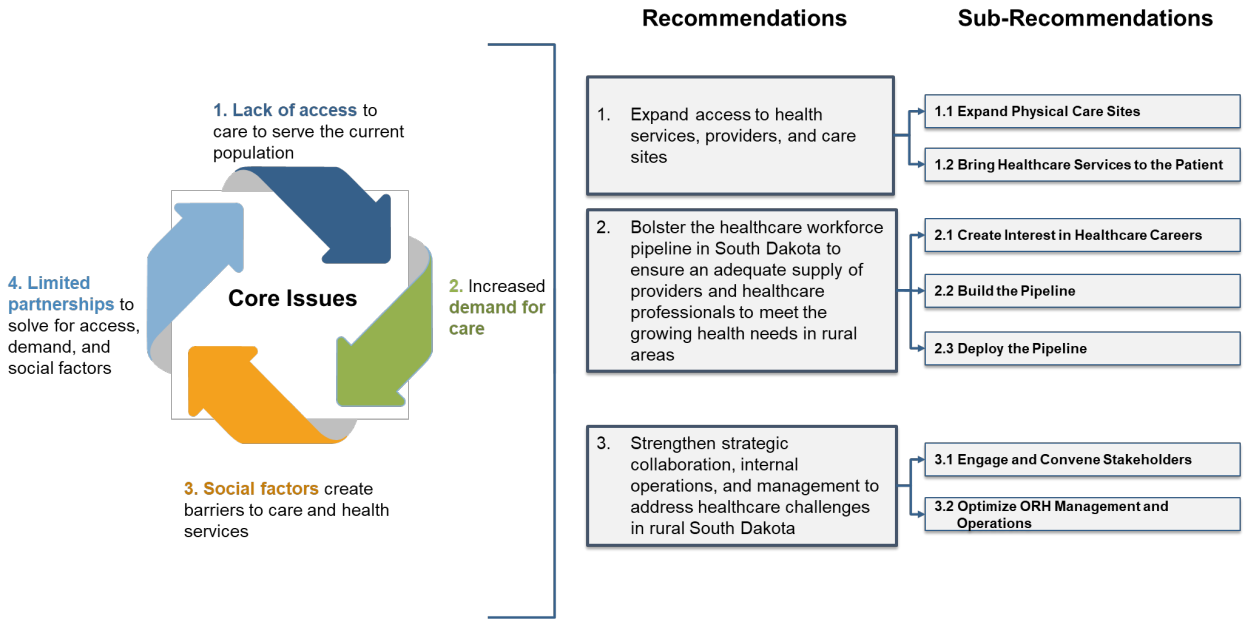
V. Recommendations

Overview

This section summarizes the actions ORH, and its partners can take to address the core issues identified and improve and advance the health of South Dakotans, especially those living in rural communities. Some recommendations require additional analysis and testing to confirm the final location of the service, patients served, necessary investments, and other factors. ORH will need to work with its partners, including federal agencies, other South Dakota Departments, healthcare facilities, local and rural health departments, tribal-serving and rural-serving organizations, and communities to coordinate efforts and implement various programs and initiatives that address health needs and promote the health and well-being of South Dakotans.

Figure 17 summarizes the recommendations and sub-recommendations to address the four core issues identified.

Figure 17. Core Issues, Recommendations, and Sub-Recommendation



Recommendation 1. Expand access to health services, providers, and care sites.

1.1 Expand Physical Care Sites.

Expand physical care sites across South Dakota, targeting underserved communities.

Intended Impact: By expanding physical care sites, South Dakota can improve access to local healthcare and the overall health of its rural communities.

Target populations for this sub-recommendation include seniors and rural residents in Small Rural and Very Rural, Tribal communities, and urban underserved communities. The Glacial Lakes, South Central Plains, and Black Hills Regions should also be targeted.

Action 1.1a Explore and establish funding pipelines to incentivize health systems to expand and build new care sites across South Dakota.

Scope: Care sites may include hospitals, clinics, and Nursing Homes. Funding pipelines may include grants, State funding, or private funding. Target populations may include Rural and Small Rural areas, urban communities, Tribal and Non-Tribal Areas, and the Sioux Empire and Glacial Lakes Regions.

Example Programs:

- HRSA New Access Points: HRSA's Bureau of Primary Health Care launched a grant program to support new access points and "expand affordable, accessible, and high-quality primary health care for underserved communities and populations." [45] There are four population types: community health centers, migrant health centers, healthcare for the homeless centers, and public housing primary care centers. Applicants must be a private entity, non-profit entity, or a public agency and "propose at least one new site to deliver primary health services for medically underserved populations." [46]

[45] Apply for FY25 New Access Points. HRSA. https://bphc.hrsa.gov/funding/funding-opportunities/new-access-points
[46] Health Center Program New Access Points (NAP). Rural Community Toolbox. https://www.ruralcommunitytoolbox.org/funding/344

Potential Programs and Partnerships:

Programs	Partnerships
• U.S. Department of Agriculture (USDA) Rural Development [47] • USDA Community Facilities Direct Loan & Grant Program in SD [48] • HRSA [49] • SD Community Foundation [50]	• Charitable Organizations • Community HealthCare Association of the Dakotas • Dakota Resources • Federal organizations (e.g., USDA, HRSA) • Foundations (e.g., Wellmark) • Governor's Office of Economic Development • Local healthcare organizations, including hospitals, providers, and rural health clinics • National Indian Council on Aging • Primary Care Development Corporation

Key Considerations:

- Small Rural, Tribal, and Rural areas have the lowest number of care sites relative to population and land mass. This suggests that existing programs (e.g., USDA Rural Development, USDA Community Facilities Direct Loan Program & Grant Program, HRSA, SD Community Foundation) are not fully addressing the need and could be expanded.
- This action will rely on partners to build and operate the new care sites, which may require time and outreach.
- The State may have limited funding or not qualify for certain funding pipelines to support the building of additional care sites, which may deter organizations from supporting this recommendation.

Action 1.1b Assess partnerships to co-locate and provide health and social services in one location.

Scope: ORH may assess services in target communities to understand the availability of healthcare resources, transportation, referrals, employment and workforce development, existing partnerships, and services for children and seniors. Target

[47] The U.S. Department of Agriculture (USDA) Rural Development provides federal oversight to state offices. The South Dakota Rural Development State Office includes over ten programs focused on community facilities, housing, telecommunications, business development, water and energy.
[48] This grant funding is available to rural areas to "purchase, construct, and/or improve essential community facilities (including healthcare facilities) to purchase equipment and pay related project expenses."
[49] HRSA's Federal Office of Rural Health Policy (FORHP) awarded nearly $4.2 million to South Dakota health systems, GPTLHB, AHEC, associations, SDDOH and a university in fiscal year 2023. This funding includes Rural Health Network Development Programs and Planning Grants to collaborate on local challenges for hospitals, clinics, and other partners.
[50] South Dakota Community Foundation provides grants to support economic development, human services, and "community-based problem solving."

populations for services may include seniors or low-income families living in rural communities, Tribal Area Residents, urban residents, and communities with limited access to care sites (e.g., Rural and Small Rural Areas, Sioux Empire Region).

Example Programs:

- Illinois Florissa – Funded through the HRSA Federal Office of Rural Health Policy, Florissa is a pediatric development center for children with complex behavioral and social needs. It uses a multidisciplinary approach to "reduce duplication of referrals to outside specialists" and provides numerous services (e.g., occupational therapy, screenings, early intervention, follow-up, training, and evaluation) in one location. A core function of Florissa is to provide education, recreation opportunities, and other support to families in the rural community. [51]
- Florida Healthy Life Center at Coconut Point – The Healthy Life Center offers "classes, workshops, holistic services, health screenings, and social meetups." It is embedded within the Lee Health Coconut Point facility and provides health education and navigation. [52]
- South Carolina Rural Libraries & Health Program – This program provides funding to a subset of libraries in nine communities in the state to establish CHWs, social workers, and telehealth to provide "screenings, referrals, health education, social support services, and access to healthy food" to rural community members. The Rural Libraries and Health Program started with five pilot libraries in 2020. It expanded to nine sites in 2022 through a grant from the South Carolina Department of Health and Environmental Control. According to the 2023 Legislative Report, the program resulted in: "3,513 South Carolinas reached,1,383 engaged via screenings, referrals, health education, and healthy food initiatives, 173 rapid COVID tests distributed at two libraries," and 7,600 pounds of produce distributed." [53]

Potential Programs and Partnerships:

Programs	Partnerships
• Monument Health Spearfish Hospital [54] • Rapid City One Stop Initiative [55] • Sioux Falls One Stop Initiative [56]	• Charitable organizations • Community HealthCare Association of the Dakotas

[51] "Florissa." Rural Health Information Hub. https://www.ruralhealthinfo.org/project-examples/805
[52] "Health & Wellness." Lee Health. https://www.leehealth.org/health-and-wellness
[53] "2023 Legislative Report." Center for Rural and Primary Healthcare. https://www.scstatehouse.gov/CommitteeInfo/Ways&MeansMeetingHandouts/Healthcare/2024/CRPH%202023%20Legislative%20Report.pdf
[54] The acute care hospital is co-located with the Monument Health Spearfish Clinic. It is open 24/7 and specialties include (but are not limited to) women's and children's, pediatric and adolescent medicine, hospital medicine, general surgery, and emergency medicine.
[55] Seven State agencies (Department of Health, Department of Social Services, Department of Revenue & South Dakota Lottery, Department of Human Services, Department of Environment and Natural Resources, Bureau of Information Technology and Bureau of Administration) are housed in a 100,000 square foot building.
[56] Twelve State agencies, including Department of Health, Education, Social Services, and Economic Development will be housed in a "one-stop shop" state agency building in Sioux Falls. A primary objective of this development is to ease customer navigation of the

Programs	Partnerships
	• Community Health Association of Mountain/Plains States (CHAMPS) • Community Health Worker Collaborative of South Dakota • Community Mental Health Centers • Community organizations (e.g., schools, churches) • Local healthcare organizations in rural areas (e.g., rural health clinics, hospitals, community health centers) • Federal organizations (e.g., USDA, HRSA) • Foundations (e.g., Wellmark) • Great Plains Tribal Health Leaders' Health Board • HRSA, Federal Office of Rural Health Policy (investor) • National Indian Council on Aging • National Indian Child Care Association • North Central Regional Center for Rural Development • South Dakota Department of Human Services • South Dakota Department of Social Services • South Dakota Department of Transportation • South Dakota Department of Education • Women Empowering Women for Indian Nations

Key Considerations:

- Existing community infrastructure (e.g., community health centers) located in a convenient location may be leveraged to alleviate the cost of capital and promote accessibility.
- Finding a physical site large enough to house all the services may be challenging.
- Sharing information about the new resource with the community may be challenging if there are no existing partners or communications channels.
- Forming strong partnerships (e.g., physicians or school staff for referrals) and community buy-in will be critical to the model's success.

government services by offering them in one place. A similar model could be used in local communities to house a mix of government, social services, and health services in one location.

- Crossing geo-political jurisdictions, sharing resources and staff, and creating new entities to provide fiscal and operational program management will be practical barriers rural areas must overcome to achieve successful implementation.

1.2 Bring Healthcare Services to the Patient.

Optimize healthcare services, including telehealth and mobile clinics, to bring healthcare services to the patient.

Intended Impact: Adding additional physicians, clinicians, and other healthcare professionals to communities, expanding innovative care models, and offering additional care modalities can meet the patients where they are.

Target populations for this sub-recommendation include seniors, rural areas including Small Rural and Very Rural, Tribal communities, and urban underserved communities across South Dakota.

Case Study – Healthcare at Home [57,58]

Mass General Brigham and Best Buy Health partnered to scale Mass General's Home Hospital program to provide services in a modality that meets patients where they are. Through this partnership, Best Buy provides logistical and technical support to the Home Hospital Program via its Geek Squad services and other functions (e.g., adopting a remote patient monitoring platform [Current Health] and personal emergency response system devices). The health system's academic medical centers often operate at full capacity; therefore, this partnership releases the capacity constraints for the brick-and-mortar facilities.

Action 1.2a Expand the reach of physical care sites through mobile clinics.

Scope: Mobile clinic services may include preventative medicine, women's health, specialty care, vision, and dental care. Target populations may include Rural and Small Rural areas, urban communities, Tribal and Non-Tribal Areas, and the Sioux Empire and Glacial Lakes Regions.

[57] "Best Buy Health and Mass General Brigham collaborate to meet patients' growing Healthcare at Home needs." November 8, 2023. https://www.massgeneralbrigham.org/en/about/newsroom/press-releases/collaboration-with-best-buy-health-to-meet-patients-growing-healthcare-at-home-needs

[58] "Mass General Brigham taps Best Buy Health to scale up its at-home care services." Heather Landi. November 8, 2023. https://www.fiercehealthcare.com/health-tech/best-buy-heath-inks-deal-mass-general-brigham-build-out-its-home-care-business

Example Programs:

- Minnesota and Michigan Homeward Health – This company partners with payers through value-based contracts to serve rural patients in Minnesota and Michigan. It is B-Corp certified and a public benefit corporation, highlighting its commitment to operating a business driven by "purpose, community partnerships, and employee empowerment." It offers services through a multidisciplinary care team in multiple modalities – including in-home visits, telehealth, and mobile clinics. It aims to target "population health at a county level" through partnerships with payers like Blue Cross and Blue Shield and Priority Health. [59] It partners with rural communities, "local providers, health systems, and local community resources – including food, transportation, and housing assistance" to close gaps in care. [60]
- Virginia Health Wagon - The Health Wagon provides clinical services to underserved populations in Virginia through four mobile units, two clinics, and one dental clinic. Services are provided at no cost to patients in 11 towns. Telehealth services are also available to help with "early detection and treatment of prevalent health concerns." [61] Mobile services include but are not limited to, Behavioral Health, Cardiovascular Clinics & Disease Management, Dental, Influenza Vaccines, Medicare and Medicaid enrollment, and Women's Health. In 2021, it served 10,857 unduplicated payments and over 32,250 visits or encounters. [62]
- Virginia Old Dominion University (ODU) Student-Run Mobile Health Clinic – ODU launched a mobile clinic in 2023 to address workforce shortages and clinical rotation challenges (e.g., finding preceptors). It receives funding from HRSA. The clinic offers various healthcare services, including mental health, physical therapy, athletic training, dental hygiene, speech, and human services. Students and university faculty provide health services, and Nurse Practitioners operate them. The van includes "private rooms and equipment to provide patient care." Students can also use telehealth to connect with specialists and community providers. [63] In the summer and fall of 2023, the mobile clinic had "roughly 100 adults and more than 500 children for back-to-school sports physicals." [64]

[59] Homeward earns B Corp certification as it expands payer partnerships in Minnesota and Michigan. Fierce Healthcare. https://www.fiercehealthcare.com/providers/homeward-earns-b-corp-certification-it-expands-payer-partnerships-minnesota-and-michigan
[60] "Homeward Earns B Corp™ Certification Recognizing Social Impact." https://homewardhealth.com/press-release/b-corp-certification/
[61] "Innovation." The Health Wagon. https://thehealthwagon.org/innovation/
[62] "About our Mobile Clinics." The Health Wagon. https://thehealthwagon.org/mobile-clinics/
[63] "Mobile Health Clinic to Bolster Healthcare in Southampton County." Old Dominion University. https://www.odu.edu/article/mobile-health-clinic-to-bolster-healthcare-southampton-county
[64] "Old Dominion University's Student-Run Mobile Health Clinic." RHIhub. https://www.ruralhealthinfo.org/project-examples/1126

Potential Programs and Partnerships:

Programs	Partnerships
• Wellness on Wheels (WOW) mobile clinics [65]	• Community HealthCare Association of the Dakotas • South Dakota Department of Social Services • Lion's Club • Local healthcare organizations, including hospitals and rural health clinics • National Indian Council on Aging • North Central Regional Center for Rural Development • Venture capital firm (investor)

Key Considerations:

- On average nationwide, mobile clinics provide a median number of 3,491 visits annually. [66]
- Mobile clinics are usually staffed by healthcare staff who can manage patients regardless of health or social needs (e.g., RNs, nurse practitioners [NPs], APPs, Behavioral Health professionals). Additional training or recruitment will be required.
- Existing partnerships and relationships with healthcare providers will allow the State to act immediately to expand mobile care services. New partnerships may be required to advance this recommendation, which may require time and outreach.
- Training mobile clinic staff to promote culturally affirming care will require time and resources.
- There are opportunities to partner with academic institutions for student-run mobile clinics.

Action 1.2b Provide incentives and support programs for healthcare professionals to travel to underserved areas, including rural and Tribal areas.

Scope: Incentives may include travel vouchers or reimbursements, an enhanced loan repayment program, free childcare, stipends, scholarships, rural or tribal rotational program, a high-needs service bonus for those who serve in HPSAs, or payment for licensure renewal for active or retired providers. Healthcare professionals may include Registered Nurses (RNs), APRNs, NPs, CHWs, physicians, Behavioral Health (BH) professionals, dentists, emergency providers, or medical residents.

[65] Wellness on Wheels is a Department of Health initiative that provides eight services including screenings, testing, immunizations, oral health, pregnancy care and more to underserved communities in South Dakota.
[66] Malone, N.C., Williams, M.M., Smith Fawzi, M.C. *et al.* Mobile health clinics in the United States. *Int J Equity Health* 19, 40 (2020). https://doi.org/10.1186/s12939-020-1135-7

Example Programs:

- NC High Needs Service Bonus – North Carolina's State Office of Rural Health (SORH) administers this program. It offers incentive bonus payments to providers in exchange for providing comprehensive primary care at sites identified as "high need" within designated HPSAs. Eligible providers must not have educational (student) loan debt, and the incentive bonus payments are taxable. In 2022, the Office of Rural Health's Placement Services Team received $5.5 million in grant funding appropriated from the North Carolina General Assembly. In 2022, the Placement Services Team completed 50 medical placements, 22 dental placements, and four behavioral health placements in underserved areas across the state. [67]
- WA State Volunteer & Retired Providers Program – As defined by statute (RCW 43.80.460 and RCW 43.70.470), providers with active or retired active licenses in Washington State or other U.S. licensed providers can provide non-invasive care to rural communities, including low-income individuals. The Department of Health offers payment for malpractice insurance premiums and incentivizes care by waiving fees for license renewal. Eligible providers include acupuncturists, advanced registered nurse practitioners, chiropractors, dental hygienists, dentists, Doctor of Osteopathic Medicine, licensed practical nurses (LPNs), massage therapists, occupational therapists, PAs, psychologists, pharmacists, and more. [68] Malpractice insurance includes "up to $2,000,000 per incident and $6,000,000 aggregate." [69] Forty counties participate in the program, including 163 approved sites. [70]

Potential Programs and Partnerships in South Dakota:

Programs	Partnerships
• Rural Health Fellowship Program (National Rural Health Association) [71] • South Dakota's State Loan Repayment Program (SLRP) [72]	• Academic institutions • Community Health Worker Collaborative of South Dakota • Community Paramedics • Fire stations in communities that can house healthcare services • Federal Programs

[67] Medical, Dental, and Behavioral Health Recruitment and Incentives. Placement Services Team – NCDHHS. https://www.ncdhhs.gov/divisions/office-rural-health/office-rural-health-programs/provider-recruitment-and-placement/medical-dental-and-behavioral-health-recruitment-and-incentives

[68] "Eligible Volunteer Provider Types," n.d. https://www.wahealthcareaccessalliance.org/vrp-program/eligible-volunteer-provider-types

[69] Community Health Systems--HSQA-CHS--2900. "Program and Services." Washington State Department of Health, n.d. https://doh.wa.gov/public-health-provider-resources/rural-health/programs-and-services

[70] "Safety Net Sites," n.d. https://www.wahealthcareaccessalliance.org/vrp-program/vrp-approved-sites

[71] The National Rural Health Association operates the Rural Health Fellows Leadership Program. This one-year program is open to 10-15 individuals per year and the goal is to "develop a network of diverse rural leaders that will step forward to serve in key positions in the association, affiliated advocacy groups, and local and state legislative bodies with health equity as a main focus."

[72] South Dakota's State Loan Repayment Program (SLRP) provides money to repay qualifying educational loans to providers who complete a two-year commitment. Providers include primary, mental, and dental care providers practicing in rural and urban HPSAs in South Dakota. Eight of South Dakota's 66 counties have communities participating in the SLRP program, primarily in and around Rapid City and Sioux Falls.

Programs	Partnerships
	• Health Resources and Services Administration • Indian Health Service • Local healthcare organizations, including hospitals, clinics, etc. • Local town boards, economic development groups • National Rural Health Association • South Dakota Department of Social Services • South Dakota Governor's Office of Economic Development • Veterans Affairs

Key Considerations:

- Additional analysis will be required to understand which incentives are most effective across different healthcare providers.
- Partnerships with academic institutions and local healthcare organizations will be necessary to offer and expand rotational programs for healthcare professionals.
- Due to limited capacity, finding preceptors and other healthcare staff to oversee rotational programs will be challenging.
- Housing and other student supports (e.g., childcare) should be considered when creating new rotational programs.
- The State will need to comprehensively assess federal and State policies, including reimbursement, privacy and security, access, quality, and other performance thresholds to understand regulatory and policy barriers.

Action 1.2c Expand telehealth services and telemedicine.

Scope: Services may include providing tablets to clinics, subsidizing cellphones, providing digital literacy training to patients, and installing telehealth hubs in non-traditional healthcare settings (e.g., library) with same-day and next-day telehealth appointments.

Target populations may include seniors, individuals with mental health needs, Very Rural, Small Rural, and Tribal communities, and South Dakotans with limited broadband availability, especially within the Black Hills and South Central Plains Regions.

Example Programs:

- South Carolina Digital Equity Collaborative (DEC) – DEC is an extension of the State Office of Rural Health. It is a multi-sector collaborative comprised of rural, local, urban, and statewide stakeholders across sectors who work to ensure equitable broadband access across South Carolina. In 2024, the South Carolina

Office of Rural Health received nearly $1.5 million in grant funding from HRSA. [73] DEC activities to date include:

- A collaborative effort to provide tablets, digital literacy training, and internet service to seniors.
- Installation of a telehealth hub in a rural area.
- Development of the State's first Community Broadband Strategy Plan. [74]

Potential Programs and Partnerships:

Programs	Partnerships
• N/A	• Broadband companies, local providers of television, phone, and internet services • Community-based organizations (e.g., library, food bank, church, bank, barbershop) • Fire stations (a private place to receive care but also that has support for connectivity) • Great Plains Telehealth Resource and Assistance Center (gpTRAC) • Health Link • Local healthcare organizations, including hospitals and clinics • North Central Regional Center for Rural Development • National Indian Council on Aging • Telehealth providers • USDA Rural Development South Dakota State Office

Key Considerations:

- Non-traditional community healthcare settings (e.g., libraries) must meet certain requirements (e.g., Medicare, Health Insurance Portability and Accountability Act) and have the space, equipment, and procedures to offer telehealth services effectively.
- Broadband availability will also limit the effectiveness of this action as broadband will be necessary for telehealth services. The State may collaborate with the Connect SD Broadband program to understand best practices and insights into broadband access challenges.

[73] "Tracking Accountability in Government Grants System," South Carolina Office of Rural Health. https://taggs.hhs.gov/Detail/RecipDetail?arg_EntityId=uJtmM7gWZNPvq7Xb70A7Gg%3D%3D
[74] "Tracking Accountability in Government Grants System," South Carolina Office of Rural Health. https://taggs.hhs.gov/Detail/RecipDetail?arg_EntityId=uJtmM7gWZNPvq7Xb70A7Gg%3D%3D

- An innovative strategy will be needed to promote access to telehealth services for older adults and people with disabilities.
- Cultural and linguistic competency will also be needed when providing telehealth services at community-based organizations.
- The Consolidated Appropriations Act and Calendar Year (CY) 2024 Medicare Physician Fee Schedule Proposed Rule temporarily expanded telehealth flexibilities to improve access to care. Examples of flexibilities include adding a patient's home as an originating site for health, allowing certain clinicians (e.g., occupational therapists, physical therapists [PTs]) to be included in the telehealth practitioner definition, temporarily suspending requirements about in-person visitation prior to telehealth service, and "continuing payment for telehealth services RHCs and FQHCs provide using the methodology established for those services from the PHE." [75] Currently, clinics can bill for medical telehealth visits, but this is only covered until the end of 2024; implementing various telehealth services may be challenging due to state reimbursement policies. [76]

Action 1.2d Expand existing provider-to-provider e-consult platforms to rural and Tribal provider care sites.

Scope: ORH may create pathways to maximize the utilization of provider-to-provider e-consult platforms and support health systems to extend these platforms to rural and Tribal provider care sites. E-consult platforms can connect patients to specialty care and provide professional support to providers in geographically isolated areas. Physician specialties may include primary care, obstetrics and gynecology, psychiatry, pediatrics, ophthalmology, gastroenterology, neurology, cardiology, emergency medicine, hematology, and oncology.

Target regions may include Black Hills, Glacial Lakes, and Central Plains.

Example Programs:

- California – Ravenswood Family Health Network and Stanford Health Care – In 2022, an FQHC in California partnered with a large health system (Stanford Health Care) to implement a provider-to-provider e-consult pilot program for 12 specialties. To date, over 900 provider-to-provider e-consults have been conducted. Providers receive onboarding training, and e-consults are embedded into the electronic health record workflows. [77]
- New Hampshire Primary Care Psychiatry E-Consults at Dartmouth-Hitchcock Medical Center (DHMC) – From May 2016 to February 2019, primary care physicians (PCPs) submitted 343 e-consults to psychiatrists at DHMC in

[75] MLN Factsheet – Telehealth Services. CMS Medicare Learning Network. https://www.cms.gov/files/document/mln901705-telehealth-services.pdf
[76] "Bill to extend telehealth flexibilities clears House committee." AMA. https://www.ama-assn.org/practice-management/digital/bill-extend-telehealth-flexibilities-clears-house-committee#:~:text=Congress%20extended%20key%20telehealth%20flexibilities,the%20Consolidated%20Appropriations%20Act%2C2023.
[77] "Community partnership leverages eConsults to bridge primary and specialty care." OCHIN. https://ochin.org/featured/econsult-partnership-bridges-care/

Lebanon, New Hampshire. PCPs submitted 343 e-consults for patients 18 and older. Only 300 cases were available for analysis due to a lack of documentation in the chart by the PCP or loss of follow-up. Consulted psychiatrists made 602 recommendations, and the average response time from psychiatrists was 26 hours (as opposed to "months" to schedule an in-person visit). Additionally, 96% of e-consults were sufficiently answered with one response, and 42% of the patients lived more than 50 miles from the consulted psychiatrist.[78]

- Texas – Specialty Provider-to-Provider E-Consult – This e-consult program was implemented at a multi-site FQHC serving four predominately rural counties in Central Texas. A research study compared referral utilization between 511 Base patients who received face-to-face referrals from July 2017 to July 2018 and 491 Intervention patients who received e-consults from August 2018 to August 2019. Primary care physicians were encouraged to submit an e-consult first and give face-to-face referrals if requested by the specialist. PCPs could give face-to-face referrals first if warranted. Specialist e-consults decrease intervention wait time. As this study continued, in-person wait times decreased as fewer patients required in-person care. Overall median wait times decreased from 54 days to 7 days. Other findings suggested that the patient's PCP managed 82.91% of e-consults and did not require a face-to-face consult. Additionally, 24% of the patients who received a face-to-face referral after e-consult completed an appointment with a specialist.[79]

Potential Programs and Partnerships:

Programs	Partnerships
• Telemedicine in Motion for EMS [80] • Connect SD Broadband Program [81] • Avel eCare [82]	• Hospitals and clinics • Individual specialty providers with low patient loads • South Dakota Governor's Office of Economic Development

Key Considerations:

- Continuous participation from individual specialty and primary care providers will be necessary to sustain the e-consult program.

[78] Avery, Jade et al. "Primary Care Psychiatry eConsults at a Rural Academic Medical Center: Descriptive Analysis." *Journal of medical Internet Research* vol. 23,9 e24650. 1 Sep. 2021, doi:10.2196/24650.
[79] Anderson, Daren et al. "The Impact of eConsults on Access to Specialty Care for the Uninsured in Rural Texas." Journal of health care for the poor and underserved vol. 33,2 (2022): 779-789. doi:10.1353/hpu.2022.0063
[80] Avel eCare launched a program with the SDDOH for EMS agencies. EMS agencies who participate receive an iPad to connect ambulances to emergency medicine doctors and nurses.
[81] As part of this public-private partnership, $5 million was allocated to expand high-speed internet service in SD. Since the program began in 2019, nearly 32,000 South Dakotans have received access to high-speed internet.
[82] In addition to Avel eCare's efforts with SDDOH, Avel eCare and the SD Unified Judicial System also launched a virtual Crisis Care program. Through this program, law enforcement has on-demand access through tablets to behavioral health experts who can talk with law enforcement and help make recommendations for care for the person and situation. Avel eCare also offers telehealth services for schools, where school staff are connected virtually with nurses to have nursing coverage in K-12 schools to immediately respond to student needs.

- To advance this recommendation, new partnerships and infrastructure (e.g., technology platforms, workflow integration) may be required, which would require time and outreach.
- The State may need to comprehensively assess federal and State policies, including reimbursement, privacy and security, access, quality, and other performance thresholds to understand regulatory and policy barriers.

Action 1.2e Explore opportunities to subsidize non-emergency medical transportation in communities with transportation barriers.

Scope: Opportunities may include providing technical assistance or guidance to communities on applying for funding opportunities to support medical transportation or providing funding pipelines to subsidize medical transportation services.

Target populations include communities with limited access to public transportation, rural and Tribal areas, and seniors. Target regions include Sioux Empire, Glacial Lakes, and Black Hills.

Example Programs:

- Minnesota Tri-Valley Opportunity Council Rural Transportation – The Tri-Valley Opportunity is supported by the Minnesota Department of Human Services and expanded existing transportation services across eight counties in rural Minnesota in 2022. Transportation modalities include public buses that operate seven days a week and volunteer drivers who receive mileage reimbursement to transport rural community members to "medical appointments, education, work activities, or other personal matters." [83] The Program received the "2016 Award for Outstanding Public Transportation Service in Rural Public Transportation from the U.S. Department of Transportation Federal Transit Administration" and "helped people utilize reliable transportation through 167,519 rides." [84]
- Idaho Ride United Transportation Access—Idaho United Way started Ride United Transportation Access in 2018. It offers free transportation for patients receiving services at "United Way's crisis and recovery centers, local free clinics, and mental health providers." [85] It builds on local needs assessments and helps beneficiaries get to "dental appointments, local school meetings, and housing support." [86] Ride United aims to serve asset-limited, income-constrained populations, referred to as Asset, Limited, Income, Constrained, Employed (ALICE). Case managers and social workers at United Way partner locations book rides, which Lyft drivers provide as part of a broader partnership with Lyft.
- Oregon Non-Emergent Medical Transport – Greater Oregon Behavioral Health, Inc., a nonprofit, is charged with "administering the behavioral health Medicaid benefit, non-emergent medical transportation, and community engagement in 12

[83] Tri-Valley Opportunity Council Rural Transportation. Rural Health Information Hub. https://www.ruralhealthinfo.org/project-examples/488
[84] Tri-Valley Opportunity Council Rural Transportation. Rural Health Information Hub. https://www.ruralhealthinfo.org/project-examples/488
[85] United Way of Southeastern Idaho, "Ride United," https://unitedwaysei.org/ride-united/
[86] RideUnited Transportation Access. https://unitedwaysei.org/wp-content/uploads/2024/02/Ride-United-General-Pubic-Handout.pdf

rural and frontier counties in Oregon, as a co-owner of the Eastern Oregon Coordinated Care Organization (EOCCO)." [87] It "operates the free ride program for fee-for-service and EOCCO members to get to medical, behavioral, and dental health services" during standard business hours. It offers multiple ride types, including "volunteers, rural public transportation providers, private non-profit transportation services, and for-profit transportation services." [88]

Potential Programs and Partnerships:

Programs	Partnerships
• Medicaid Non-Emergency Medical Travel (South Dakota Department of Social Services) [89] • Federal Transit Administration (FTA) Section 5311 Program (DOT) [90] • Rural Office of Community Services Transit [91]	• South Dakota Department of Social Services • Dakota Transit Association • South Dakota Department of Transportation (DOT) • Great Plains Tribal Health Leaders' Health Board • Indian Health Service • Local hospital or clinic • Rural Office of Community Services Transit • Transportation company (Uber, Lyft, taxi service)

Key Considerations:

- This recommendation will rely heavily on local partnerships and an existing transportation infrastructure in the targeted community.
- New equipment (e.g., vehicles, scheduling software, drivers) may be required, which may require time, partners, and funding.

[87] "About Us," GOBHI. https://www.gobhi.org/about
[88] "Non-Emergent Medical Transportation (NEMT)." GOBHI. https://www.gobhi.org/nemt
[89] DSS' Medicaid Recipient Transport is available via secure medical transportation (for those who rely on a wheelchair or stretcher), community transportation, and NEMT. NEMT operates on a reimbursement system for mileage and provides reimbursement for lodging if care is needed over 150 miles away.
[90] DOT operates the FTA Section 5311 program which "authorizes capital, administrative, operating assistance, and training grants to state agencies, local governments, Indian tribes, and nonprofit organizations providing rural transportation services in non-urbanized areas of South Dakota."
[91] ROCs Transit offers low-cost transportation services to rural South Dakotans, including free services for seniors 60+.

Action 1.2f Expand outreach, resources, and health education to educate communities on available health resources and appropriate use of care.

Scope: Resources may include educational information on diabetes prevention, smoking, healthy eating, and aging in place. Target populations include rural and Tribal areas, seniors, and patients with multiple or complex health needs or comorbidities.

Example Programs:

- Native American Aging in Place – The University of North Dakota (UND) Center for Rural Health, in partnership with Spirit Lake Nation, created the Native American Aging in Place program with support from Margaret A. Cargill Philanthropies. The program uses caregiving resources developed by UND's Native Resource Center on Native American Aging to train Native Elder caregivers and community members on caregiving techniques. The program also focuses on generating best practices and tools in coordination with Spirit Lake Nation to keep Tribal elders in their homes and out of long-term care facilities and as a model for additional Tribes. [92,93]

Potential Programs and Partnerships:

Programs	Partnerships
• SDDOH Office of Health Promotion [94] • QUIT SD [95] • Better Choices, Better Health South Dakota [96] • SD – Diabetes Coalition [97]	• Community Health Worker Collaborative of South Dakota • Great Plains Quality Innovation Network • Great Plains Tribal Health Leaders' Health Board • Hospitals or clinics and other local providers • Local health departments • National Alaska Native American Indian Nurses Association • National Indian Council on Aging • National Organization of State Offices of Rural Health

[92] "Native Aging in Place Project (NAPP)." Center for Rural Health. University of North Dakota School of Medicine & Health Sciences. https://ruralhealth.und.edu/projects/native-aging-in-place
[93] "Aging in Place. New Project will help Native elders stay in their homes and communities." University of North Dakota. https://ruralhealth.und.edu/focus/aging-in-place
[94] The SDDOH Office of Health Promotion offers a variety of educational opportunities including an Indigenous and Integrative Health Summit and skill building workshops (e.g., Creating Healthy & Wealthy Communities) for rural South Dakotans.
[95] The SDDOH operates the Quit SD website which includes information about tobacco cessation, a Tribal Tobacco Advocacy Toolkit, quit guides, phone coaching, and other resources.
[96] The South Dakota State University Extension Operates the Better Choices, Better Health South Dakota. This program includes "chronic disease self-management education workshops to help adults living with ongoing physical and/or mental health conditions." Courses are offered in person or through distance learning.
[97] The Diabetes Coalition includes a group of vested partners focused on prevention and disease management of diabetes. The coalition offers ten services spanning from patient and provider education, virtual coordination with nurses, evaluation and state planning.

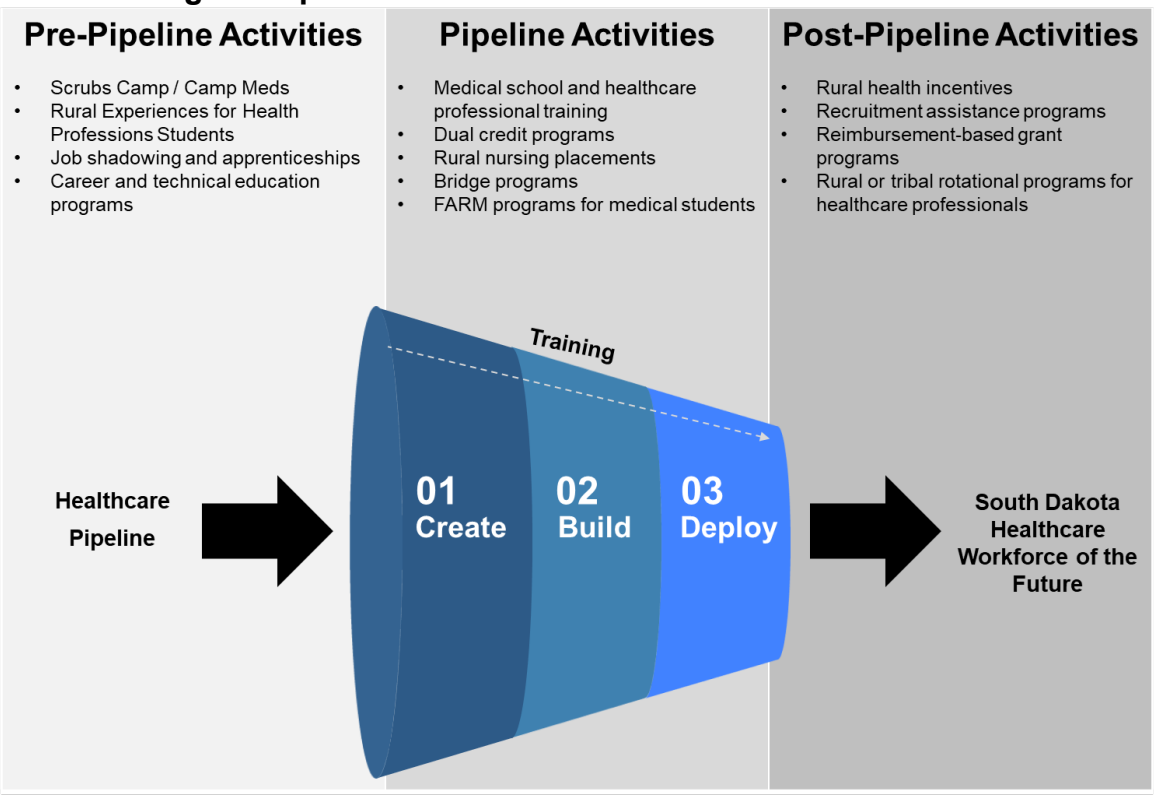
Programs	Partnerships
	• North Central Regional Center for Rural Development • Rural and Tribal communities • Rural Health Information Hub • South Dakota Department of Health Marketing (Communications) Team • South Dakota Association of Healthcare Organizations • South Dakota Department of Social Services • South Dakota State University Extension

Key Considerations:

- Outreach and health education materials should be culturally and linguistically affirming to promote effective communication and outreach.
- Sustaining this recommendation may require collaboration at the local level through “champions” to increase the reach of outreach and messaging.

Recommendation 2. Bolster the healthcare workforce pipeline in South Dakota to ensure an adequate supply of providers and healthcare professionals to meet the growing health needs in rural areas.

Figure 18. Building the Pipeline of The Healthcare Workforce of the Future



01. Create Interest in Healthcare Careers

Create awareness of and build interest in healthcare careers through career fairs, job shadowing, and college programs.

Intended Impact: Education and career exploration classes will inspire students and individuals to pursue various healthcare careers in South Dakota and their local communities to close the gap of healthcare professionals.

02. Build the Pipeline

Train and upskill the healthcare workforce and partner with colleges to build the future healthcare workforce.

Intended Impact: Bolstered training and learning for medical and nursing school students and existing healthcare professionals will expand and enhance capabilities and skills and enable a competent and skilled healthcare workforce.

03. Deploy the Pipeline

Increase the supply of providers and clinicians, especially within underserved communities.

Intended Impact: Supplying areas with providers and healthcare professionals in underserved communities will support their health needs.

2.1 Create Interest in Healthcare Careers.

Create awareness of and build interest in healthcare careers through career fairs, job shadowing, and college programs.

Intended Impact: Education and career exploration classes will inspire students and individuals to pursue various healthcare careers in South Dakota and their local communities to close the gap of healthcare professionals.

Target populations for this sub-recommendation include students (e.g., high school, middle school, technical colleges, medical school, nursing school), South Dakotans residing in rural and Tribal areas, and people who may be interested in healthcare or public health.

Case Study – Oklahoma State University (OSU), College of Osteopathic Medicine (COM) at the Cherokee Nation [98,99]

The Cherokee Nation and OSU Center for Health Sciences created a tribally affiliated medical school, which graduated its first class in 2024. It is the only tribally affiliated medical school in the United States and is funded through a combination of resources from the Cherokee Nation, OSU, and the Health Resources and Services Administration.

Tribes in Oklahoma have agreements with the Indian Health Service to operate their own health systems but had challenges recruiting providers. Cherokee Nation and OSU collaborated to address recruitment challenges and signed an affiliation agreement to build a medical school. Availability of space and funding from the Cherokee Nation and the federal government were key driving factors for the medical school establishment. OSU leases space from the Cherokee Nation, and Tribes can offer scholarships for students who are Tribal members. Cherokee Nation and OSU engaged in a joint design process to build the facility on the Cherokee Nation Tahlequah campus.

Action 2.1a Support programs that promote careers in healthcare and public health, especially in rural and Tribal areas.

Scope: Current programs, like Scrubs Camp and Camp Med, are valued and expose students to healthcare careers. However, there is an opportunity to increase the number of students who can participate, diversify, and build upon existing partnerships, and expand to additional geographies (e.g., northwestern South Dakota) to widen the funnel

[98] "OSU COM at the Cherokee Nation." OSU Center for Health Sciences. https://medicine.okstate.edu/cherokee/
[99] "Historic inaugural class graduates from OSU College of Osteopathic Medicine at the Cherokee Nation." OSU Headlines: News and Media. https://news.okstate.edu/articles/health-sciences/2024/osu-graduates-inaugural-class-com-cherokee-nation-tribal-medical-school.html

of students who pursue healthcare careers. Programs may include job shadowing, career fairs, and exploration, expansion of Scrubs Camps, bridge programs for in-demand healthcare careers (RNs, NPs, PTs, BH professionals, women's health specialists), pre-apprenticeship programs for high school students that prepare students for apprenticeship and entry-level careers, an American Indian Area Health Education Center (AHEC).

Example Programs:

- Pre-Apprenticeship Training in Healthcare (PATH) Academy –The PATH Academy offers healthcare career exploration opportunities to students ages 16 and up through direct training and essential skills that align with national certificates (e.g., first aid, basic life support pulmonary resuscitation) and prepare students for entry-level healthcare jobs and apprenticeships. Students are paired with employment specialists who help match them to job opportunities after the program. The national AHEC program is sponsored by grant funded HRSA. Nearly 145 students participated in the PATH Academy program in 2022. [100]
- Arizona American Indian AHEC – Arizona launched an American Indian Area Health Education Center (AI-AHEC) to build a future healthcare workforce that serves American Indians and Alaskan Natives through training, education, and adoption of "Grow Your Own" strategies." The AI-AHEC focus areas include:
    - "Community-based Experiential Training,
    - AHEC Scholars Community Immersion,
    - Continuing Education for Health Professionals,
    - 9-12th grade and undergraduate student structured pipeline activities,
    - K-8 grades unstructured pipeline activities,
    - Community events on health-related topics, and
    - AIH-AHEC three-year strategic plan development." [101]
- Montana American Indian AHEC – The SORH and AHEC Program Office partnered to develop an American Indian AHEC to "strengthen and develop health profession opportunities for American Indian people, therefore expanding access to quality healthcare for American Indian Montanans." Montana State University (MSU) and the AHEC Program Office are accepting applications for the host organization that will manage the AHEC Center. MSU and the AHEC Program Office will provide a "framing committee to support the development of the new center's formal work plan." [102] Example activities of the framing committee include:
    - "Recruit and support individuals from underrepresented minority populations and disadvantaged and rural backgrounds into health professions."
    - "Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas."

[100] University of Alaska Anchorage, "Alaska's AHEC Program," https://www.uaa.alaska.edu/academics/college-of-health/departments/acrhhw/about-ahec.cshtml
[101] "American Indian Health – Area Health Education Center Overview." March 20, 2023. Arizona Advisory Council on Indian Health Care. American Indian Health – Area Health Education Center Overview (azed.gov)
[102] "American Indian AHEC Center Development." Montana State University. https://healthinfo.montana.edu/ahec/AIAHEC.html

- "Conduct and participate in interdisciplinary healthcare trainings."
- "Provide continuing education and information dissemination to healthcare professionals in underserved areas." [103]

Potential Programs and Partnerships:

Programs	Partnerships
• Scrubs Camp / Camp Med programs [104,105]	• Boards and Associations • Community Health Association of Mountain/Plains States (CHAMPS) healthcare facilities • South Dakota Area Health Education Center (SD AHEC) • South Dakota Department of Education • South Dakota Department of Labor • Universities and Colleges

Key Considerations:

- This recommendation will rely heavily on local partnerships with academic institutions.
- New partnerships may be required to advance this recommendation, which may require time and outreach.
- New training, career exploration, and outreach materials may be required to engage rural and Tribal communities.
- Stakeholders suggested expanding Scrubs Camp to northwestern parts of the State.

Action 2.1b Establish funding opportunities (e.g., grant program) to support career and technical education programs for healthcare careers.

Scope: Programs may include starting or expanding high school health science programs, education on rural health careers, and technical education programs. Grant funds can be used to purchase or improve curriculum, add staff members, upgrade technology or equipment, etc.

[103] "American Indian AHEC Center Development." Montana State University. https://healthinfo.montana.edu/ahec/AIAHEC.html
[104] Scrubs Camp is offered to high school students to gain exposure to the medical field. It provides interactive workshops, simulations, and mentorship opportunities to students. Of the Scrubs Camps between February and June 2024, two were on the State's western side (in Pine Ridge and Custer), and eight were on the State's eastern side.
[105] Camp Med events are free, one-day health career learning opportunities for middle school students in South Dakota. They typically occur in local middle schools. Five to ten different health careers are showcased at each Camp Med, and students are divided into small groups of five to ten to learn more about healthcare professions.

Example Programs:

- Washington State High School CTE Grant Program – Established in 2023 by Washington's Senate Bill 5582 (Section 11), Washington State has a competitive grant program to support high school career and technical education programs in starting or expanding health science programs. Grant funds can be used to purchase or improve curriculum, add staff members, and upgrade technology and equipment. Applicants with partnerships between employers and sponsors/cosponsors are prioritized.The Senate Bill developed the grant award criteria by consulting with the Workforce Training and Education Coordinating Board and the Washington State Apprentice and Training Council. The program is legislatively appropriated and includes $100,000 to develop the nurse training plan and $12 million over two years for the grant program for student nurse preceptorships. [106]
- Alaska Rural Health Career & Technical Education Programs – Operated in partnership with the State of Alaska Department of Education and Early Development, AHEC's Career and Technical Education Programs (CTEP) "provide districts with qualified instructors to implement career pathways in a format that best meets the needs of each school." [107] The CTEP program involves four academic courses offered in requesting school districts across Alaska. Each course is recognized based on industry credentials.

Potential Programs and Partnerships:

Programs	Partnerships
• DOE Career & Technical Education – Health Science Career Cluster [108] • Scrubs Camp and Camp Med program	• Community Health Association of Mountain/Plains States (CHAMPS) • HOSA • Rural Healthcare Advisory Committee (see action 3.1) • South Dakota Area Health Education Center (SD AHEC) • South Dakota Department of Education • Universities, technical colleges, and local high schools

[106] Senate et al., "AN ACT Relating to Reducing Barriers and Expanding Educational Opportunities to Increase the Supply of Nurses in Washington," State of Washington 68th Legislature 2023 Regular Session, n.d., https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Senate%20Bills/5582-S.pdf?q=20230215083442

[107] University of Alaska Anchorage, "Rural Health CTEPS," https://www.uaa.alaska.edu/academics/college-of-health/departments/acrhhw/cteps.cshtml

[108] SD Department of Education offers 16 different career clusters, including one on health sciences. The health science career cluster includes five pathways: therapeutic services, diagnostic services, health informatics, support services, and biotechnology research and development.

Key Considerations:

- This recommendation will rely heavily on funding availability and can include a request for funding application process.
- The new grant program can complement existing efforts by providing funding to mitigate existing capacity challenges (e.g., through new equipment and additional staff) and build on existing partnerships.
- New partnerships may be required to advance this recommendation, which may require time and outreach.
- New training, career exploration, and outreach material may be required to engage rural and Tribal communities.

Action 2.1c Partner with academic institutions to offer incentives to meet non-traditional student needs.

Scope: Incentives may include hybrid or virtual curricula, after-work programs, childcare, free or reduced tuition, and course materials for high-need professions.

Example Programs:

- CO Zero Cost Training Program – Career Advance Colorado's Zero-Cost Training Program allows students to complete free nursing, law enforcement, forestry, firefighting, education, early childhood education, and construction training at community colleges across the state. The program works with 18 colleges and programs in Colorado and covers tuition, fees, course materials, and related costs for enrolled students. Students must apply for the program and federal and state financial aid to enroll. It includes over $38.6 million in State appropriations and has helped over 3,000 students utilize no-cost training since it began in 2022. [109]

Potential Programs and Partnerships:

Programs	Partnerships
• Scrubs Camp and Camp Med program	• Community organizations and foundations (e.g., economic development) • Community Health Association of Mountain/Plains States (CHAMPS) • Hospital boards • Rural Healthcare Advisory Committee (see action 3.1) • South Dakota Area Health Education Center (SD AHEC)

[109] Colorado Succeeds, "Free Training for In-demand Jobs, Career Advance Colorado Can Help Bolster Our Talent Pipeline," https://coloradosucceeds.org/resource/free-training-for-in-demand-jobs/

Programs	Partnerships
	• South Dakota Department of Education • Universities, technical colleges, and local high schools

Key Considerations:

- This recommendation will rely heavily on funding availability. If funding does not exist, additional effort and outreach may be required.
- Academic institutions may be limited or have policies or regulations limiting the type of incentives allowed for students.

2.2 Build the Pipeline

Train and upskill the healthcare workforce and partner with colleges to build the future healthcare workforce.

Intended Impact: Bolstered training and learning for medical and nursing school students and existing healthcare professionals will expand and enhance capabilities and skills and enable a competent and skilled healthcare workforce.

Target populations for this sub-recommendation include the existing healthcare workforce and medical school, nursing school, and technical college students.

Action 2.2a Expand outreach and education to physicians, clinicians, and other healthcare professionals.

Scope: Outreach and education may include topics such as:

- The importance of legacy planning.
- Participating in telemedicine.
- Available funding and grant opportunities to pursue at the State and federal level.
- Existing partnerships, collaborations, and programs.

Example Programs:

- Idaho – Conferences & webinars for critical access hospitals (CAHs) & RHCs – Idaho's SORH, the Bureau of Rural Health and Primary Care, offers an annual conference for CAHs, RHCs, and free health clinics in the State. They also provide educational opportunities (e.g., webinars) on their website, including topics like compliance and emergency preparedness. PowerPoint slides are available for download, and the SORH partners with RHCs to identify their

training needs. Participation in these events varies; typically, 12-20 RHCs join.[110]

- Alaska CACHE – Through a partnership with the State of Alaska Department of Health Division of Public Health, the University of Alaska Anchorage developed CACHE to strengthen training opportunities for healthcare professionals, providers, and facilities. The platform includes on-demand videos that offer continuing education units. While most training is free, some have a fee associated with it. The platform allows users to search by delivery method, location, categories, and dates. Healthcare facilities can use the learning management system and training for staff education. Examples of training housed within the online platform include Project Extension for Community Healthcare Outcomes (ECHO), Health Equity, Healthcare Provider Burnout, Rural Primary Care Institute, Rural Telementoring, Alaska EMS Ranges, and various behavioral health training. [111]

Potential Programs and Partnerships:

Programs	Partnerships
• SD TRAIN [112]	• Board of Medical and Osteopathic Examiners • Board of Nursing • Community HealthCare Association of the Dakotas • Community Health Association of Mountain/Plains States (CHAMPS) • Great Plains Tribal Health Leaders' Health Board • Local healthcare organizations, including hospitals and clinics • Monthly DOH calls with the Tribes • National Alaska Native American Indian Nurses Association • South Dakota Area Health Education Center • South Dakota Association of Healthcare Organizations

Key Considerations:

- Physician and clinician participation may vary by specialty and location, creating gaps and limiting the program's effectiveness.

[110] Webinars & Events. Idaho Department of Health & Welfare. https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=17288&dbid=0&repo=PUBLIC-DOCUMENTS
[111] "CACHE | College of Health | University of Alaska Anchorage." 2024. Alaska.edu. 2024. https://www.uaa.alaska.edu/academics/college-of-health/departments/acrhhw/cache.cshtml
[112] TRAIN South Dakota includes public health training opportunities spanning over 70 subjects through a variety of modalities (e.g., web-based trainings, recorded webcasts, etc.). The South Dakota Department of Health operate it.

- New training and outreach material may be required to educate physicians, clinicians, and other healthcare professionals on the nuances of caring for rural and Tribal communities.
- ORH should consider an online repository of training materials or training recordings to enable physicians and clinicians to review materials easily.
- The State should consider offering training through an online platform or repository that physicians, clinicians, and healthcare professionals can access on demand (e.g., SD TRAIN).

Action 2.2b Launch or support expanding existing tele-mentoring platforms to facilitate learning networks between specialists and primary care providers in rural areas.

Scope: The tele-mentoring platform will support continuing education and facilitate learning networking opportunities so rural providers can receive training and education from other healthcare professionals via webinars, case presentations, and didactics.

Example Programs:

- MAVEN Project – The MAVEN Project provides "mentorship, medical consultations, and medical education" to safety net clinics in the United States [113] Specialty physician volunteers provide medical consults to safety net providers. Specialties include (but are not limited to) cardiology, nephrology, palliative care, endocrinology, mental health, pulmonology, primary care, and geriatric medicine. Medical consultations have a 48-hour turnaround time; the average consultation takes less than 10 hours. It is implemented in over 20 states, 2,300 safety net providers, and 162 volunteer physicians. According to a 2022 Annual Report, the MAVEN Project was:
  - Over 200 medical education topics online.
  - Impacted 84,000 patients.
  - Reached "298 clinic sites, 162 physician volunteers, and 62 medical specialties."
  - Avoided nearly $11 million in costs.
  - Provided 7,800 medical consultations and over 600 mentoring sessions. [114]

Potential Programs and Partnerships:

Programs	Partnerships
• Project ECHO at the University of South Dakota [115]	• Hospitals and clinics • Individual specialty providers with low patient loads

[113] "Delivering on Our Mission: 2022 Annual Report." MAVEN Project. https://www.mavenproject.org/annual-report/
[114] "Delivering on Our Mission: 2022 Annual Report." MAVEN Project. https://www.mavenproject.org/annual-report/
[115] The University of South Dakota uses this "case-based learning platform" for "front-line caregivers in rural and underserved settings with experts and other health care professionals to share necessary information to improve patient and public health outcomes." Using a hub and spoke model, participants have opportunities to earn continuing education credits.

Programs	Partnerships
	• South Dakota Association of Healthcare Organizations • Universities or academic institutions

Key Considerations:

- Continuous participation from individual specialty and primary care providers will be necessary to sustain a tele-mentoring platform.
- The platform may be limited in scope based on the providers' willingness to participate.
- New partnerships and online learning platforms may be required to advance this action, which may require time and outreach to providers, universities, etc.

Action 2.2c Implement dual credit programs and share resources to make training available and accessible in rural communities.

Scope: Examples may include a CHW training program or a "grow your own" career program. Resources may include training materials, leading practices, or guidance.

Example Programs:

- Kentucky Homeplace – CHW – Like South Dakota's CHW Collaborative, Kentucky implemented a community health work students can receive dual credit during CHW training. In addition, Kentucky implemented a pilot program in which CHWs provided six-week chronic disease educational workshops for rural community members in 30 counties. The pilot reached 2,000 people, and an evaluation showed that participants had a "10% reduction in ER visits, nearly 13% reduction in non-emergency ER visits, and 23% reduction in inpatient admissions." [116]

Potential Programs and Partnerships:

Programs	Partnerships
• N/A	• Community Health Worker Collaborative of South Dakota • Healthcare associations • Hospitals and clinics • Local high schools • South Dakota Department of Education • Universities and academic institutions

[116] "Kentucky Homeplace." RHIHub. https://www.ruralhealthinfo.org/project-examples/785

Key Considerations:

- Continuous participation from universities and academic institutions will be necessary to sustain the program.
- Funding, partnerships, and materials (i.e., training materials, classes) may be required to advance this recommendation, which may require time and outreach.

2.3 Deploy the Pipeline

Increase the supply of providers and clinicians, especially within underserved communities.

Intended Impact: Supplying areas with providers and healthcare professionals in underserved communities will support their health needs.

Target populations for this sub-recommendation include rural areas, including Small Rural and Very Rural, Tribal Areas, and urban communities. Specific regions and specialties to target include:

Region	Target Specialties
1. Glacial Lakes	Pediatrics, psychiatry, ophthalmology, neurology, and gastroenterology
2. South Central Plains	Pediatrics, psychiatry, primary care, gastroenterology, and neurology
3. Black Hills	Psychiatry, pediatrics, vascular surgery, hematology, oncology, and interventional radiology
4. Sioux Empire[117]	Primary care, obstetrics and gynecology, psychiatrists, medical specialists, surgical specialists, other specialists

Action 2.3a Expand and enhance recruitment assistance programs for physicians and healthcare professionals.

Scope: Activities may include expanding programs to new rural or Tribal communities or creating new spots within the program. Physician specialties may include primary care, obstetrics and gynecology, psychiatry, pediatrics, ophthalmology, gastroenterology, neurology, cardiology, emergency medicine, hematology, and oncology. Healthcare professionals may include RNs, NPs, PAs, behavioral health specialists, midwives, or Certified Registered Nurse Anesthetists.

Target populations may include communities with the highest provider deficits and areas with the highest rates of provider retirement and lowest rates of succession

[117] Sioux Empire's provider FTEs can support the estimated current and future demand for healthcare services but are not distributed across the Region to close all local access gaps. Very Rural and Small Rural Areas are disproportionately impacted and have deficits across provider types.

planning, including Rural, Very Rural, Tribal, and Non-Tribal Areas, and South Central Plains and Glacial Lakes Regions.

Potential Programs and Partnerships:

Programs	Partnerships
• Recruitment Assistance Program (RAP) [118] • Rural Healthcare Facility Recruitment Assistance Program (RHFRAP) [119]	• Academic institutions, including Universities, technical schools, and local high schools • Community HealthCare Association of the Dakotas • Great Plains Tribal Health Leaders' Health Board • Indian Health Service • Local healthcare organizations, including hospitals and clinics • National Alaska Native American Indian Nurses Association • South Dakota Association of Healthcare Organizations • South Dakota Area Health Education Center

Key Considerations:

- A deeper assessment of recruitment and retention challenges should be conducted to promote the effectiveness of recruitment and retention efforts.
- Expansion of the RAP and RHFRAP and reimbursement-based grant programs may require buy-in from legislators.
- Legislators may benefit from additional education on rural health and recruitment and retention challenges in South Dakota.

Action 2.3b Explore funding pipelines to support healthcare workforce recruitment and retention efforts.

Scope: Funding activities may include a reimbursement-based grant program for hospitals, allowing hospitals to expense activities supporting recruitment and retention (e.g., bonuses, housing stipends).

[118] The Recruitment Assistance Program (RAP), a program for eligible facilities in communities with a population of 10,000 or less, pays clinicians (including physicians, dentists, PAs, certified nurse practitioners, certified nurse midwives, and certified registered nurse anesthetists) a specific dollar amount in exchange for three consecutive years of full-time service. In 2023, 21 South Dakota counties participated in this program.
[119] The Rural Healthcare Facility Recruitment Assistance Program (RHFRAP) pays a dollar amount to health professionals who work at eligible facilities in communities with a population of 10,000 or less. Eligible health professionals must complete a three-year, full-time service commitment. Fifty-one of the State's 66 counties have communities participating in the RHFRAP program.

Example Programs:

- Alaska Housing Finance Corporation Rural Professional Housing Grant Program— This program provides annual funding, based on a competitive process, to support "teacher, health professional, and public safety housing." It launched in 2024 and has awarded 150 projects since then. [120]

Potential Programs and Partnerships:

Programs	Partnerships
• Recruitment Assistance Program (RAP) • Rural Healthcare Facility Recruitment Assistance Program (RHFRAP)	• Academic institutions, including Universities, technical schools, and local high schools • Community HealthCare Association of the Dakotas • Great Plains Tribal Health Leaders' Health Board • Indian Health Service • Local healthcare organizations, including Hospitals and clinics • National Alaska Native American Indian Nurses Association • South Dakota Association of Healthcare Organizations • South Dakota Housing Development Authority

Key Considerations:

- A deeper assessment of recruitment and retention challenges should be conducted to promote the effectiveness of the financial incentives to support recruitment and retention efforts.

Action 2.3c Provide technical assistance to support and enhance existing recruitment and retention efforts of healthcare professionals.

Scope: Technical assistance may include providing best practices and guidance for provider recruitment and retention.

Example Programs:

- Washington State, "Grow Your Own" Toolkit – The Washington Department of Health Office of Rural Health partnered with rural health facilities, colleges and

[120] Rural Professional Housing Grant Program. Alaska Housing Finance Corporation. https://www.ahfc.us/pros/homelessness/development-grants/rph

universities, organizations, and government staff to develop a Grow Your Own toolkit. The SORH conducted surveys and interviews to collect workforce data and best practices. Examples highlighted throughout the toolkit include:

- K-12, Youth Programs
- Scholarships and Tuition Reimbursement
- Apprenticeships and On-The-Job Training Programs
- Educational Programs, Rural Residency, and Fellowship Programs
- Collaboration
- Implementation
- Best Practices." [121]

Potential Programs and Partnerships:

Programs	Partnerships
• Recruitment Assistance Program (RAP) • Rural Healthcare Facility Recruitment Assistance Program (RHFRAP)	• Academic institutions, including Universities, technical schools, and local high schools • Community HealthCare Association of the Dakotas • Great Plains Tribal Health Leaders' Health Board • Indian Health Service • Local healthcare organizations, including hospitals and clinics • South Dakota Association of Healthcare Organizations

Key Considerations:

- Existing partnerships and relationships will allow the State to act immediately and provide technical assistance.
- New partnerships may be required to advance this recommendation, which may require time and outreach.

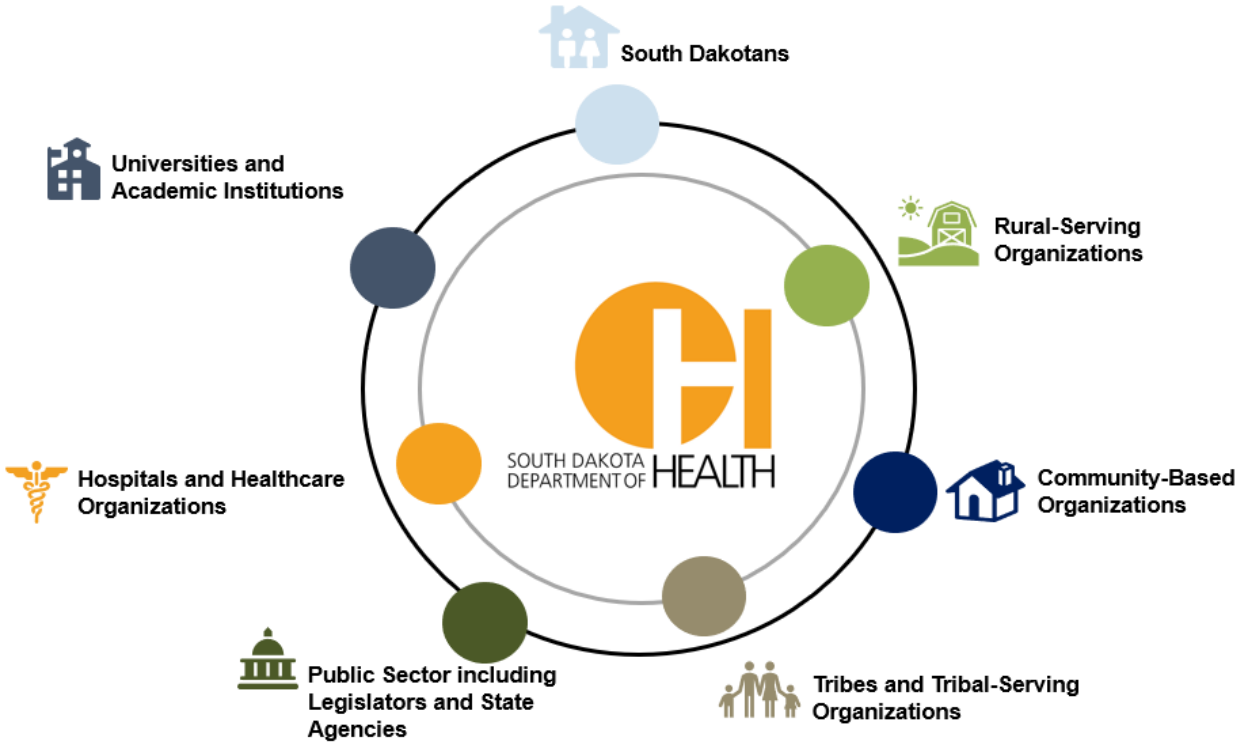
[121] "Grow Your Own Toolkit." Washington State Department of Health. https://doh.wa.gov/sites/default/files/2024-03/609027-GrowYourOwnToolkit-RuralHealth.pdf

Recommendation 3. Strengthen strategic collaboration, internal operations, and management to address healthcare challenges in rural South Dakota

Influencing Partners and Stakeholders to Address Health Challenges
The South Dakota Department of Health has partnerships and connections with various stakeholders to influence and improve rural South Dakotans' access to healthcare.

Intended Impact: Greater collaborations and stronger partnerships with key stakeholders to influence change and empower the community to improve the health of South Dakotans

Figure 19. Department of Health Partners



3.1 Engage and Convene Stakeholders

Leverage and bolster partnerships and collaboration points to enhance coordination and optimize resources.

Intended Impact: Engaging a diverse set of rural partners can encourage collaborative solution-building to address rural health challenges across the State.

Target populations for this sub-recommendation include Tribes, State Departments, legislature, local organizations, hospitals, healthcare organizations, providers, and consumers (e.g., rural community members).

Action 3.1a Develop a Rural Healthcare Advisory Committee

Scope: The Rural Healthcare Advisory Committee should comprise various stakeholders to advise Department Secretaries, Department leaders, and the legislature on solutions for rural healthcare issues (e.g., workforce, social drivers of health, etc.). Committee membership may include State Departments, local organizations, Tribes, legislators, healthcare organizations, hospitals, providers, community-based organizations, and consumers.

Example Programs:

- South Carolina Blueprint for Health – The South Carolina SORH developed the Blueprint for Health through a public-private partnership with funding from the BlueCross BlueShield of South Carolina Foundation. It aims to "bring together rural community leaders from multiple sectors to collaborate on the best ways to solve root causes of poor health and to build capacity at the local level to solve community health issues." [122] It was established to "connect people in rural communities with community partners to decrease health risks by addressing social drivers of health unique to each community." [123] An 18-month cohort for rural counties in South Carolina. Cohort participants take a leadership training course, engage in local projects to improve health, and collaborate with communities to develop a shared vision for health. [124] Since 2018, three cohorts have spanned 12 organizations or coalitions, and over 80 partnerships have been added.
- Minnesota's Rural Health Advisory Committee (RHAC) – The Rural Health Advisory Committee (RHAC) was legislatively established in 1992 and has a diverse membership of stakeholders with a vested interest in rural health (e.g., academic institutions, legislative officials, etc.). The RHAC meets virtually a few times a year to discuss rural health issues, advise state agencies, plan, and collaborate on proposed rural health solutions, and establish mechanisms for collaboration between communities and providers. The governor appoints members, and they must adhere to the requirements outlined in the statute, including non-urban residences. [125] The outcomes of the RHAC include:
    - Twenty-two members appointed by the Minnesota Governor. [126]

[122] "Blueprint for Health." South Carolina Office of Rural Health. https://scorh.net/blueprint-for-health/
[123] "Giving Rural Communities a Blueprint for Health." South Carolina. https://www.bcbsscfoundation.org/stories/south-carolina-office-rural-health-blueprint-health#:~:text=Blueprint%20for%20Health%20has%20been,areas%20through%20local%20collaborative%20efforts
[124] "Blueprint for Health." South Carolina Office of Rural Health. https://scorh.net/blueprint-for-health/
[125] "2023 Minnesota Statutes. 144.1481. Rural Health Advisory Committee." Minnesota Legislature. https://www.revisor.mn.gov/statutes/cite/144.1481
[126] "Rural Health Advisory Committee. Required committee members." Minnesota Department of Health. Office of Rural Health and Primary Care. RHAC Required Member Types, Nov 2023 (state.mn.us)

- Five virtual meetings scheduled in 2024, all open to the public. [127]
- Seven publications since 2013. [128]
- Two major projects focused on longevity and telehealth.
- Three mid-level projects focused on training, residencies, recruitment, retention, and emergency services spanning two to four months. [129]

Potential Programs and Partnerships:

Programs	Partnerships
• N/A	• Boards, organizations, or groups (e.g., associations) that represent dental healthcare and behavioral healthcare • Licensing boards (e.g., Board of Nursing, and Board of Medical and Osteopathic Examiners) • Community Based Organizations • Great Plains Tribal Health Leaders' Health Board • Healthcare organizations and facilities • HRSA • Legislators • Rural Office of Community Services • South Dakota Department of Social Services • South Dakota Department of Tribal Relations • SD Housing Authority • Wellmark

Key Considerations:

- Advisory Committee membership should be comprehensive and inclusive of various health and public health partners across South Dakota. Rural and Tribal stakeholders are critical to the Committee.
- Clear roles and responsibilities, including governance, will be needed to manage and execute priorities effectively.

[127] "Rural Health Advisory Committee Meetings." Minnesota Department of Health. Office of Rural Health and Primary Care. Rural Health Advisory Committee Meetings - MN Dept. of Health (state.mn.us)
[128] "Rural Health Advisory Committee Publications." Minnesota Department of Health. Office of Rural Health and Primary Care https://www.health.state.mn.us/facilities/ruralhealth/rhac/pubs.html
[129] "Summary of 2023 – 2024 Work Plan Priority Areas." Minnesota Department of Health. https://www.health.state.mn.us/facilities/ruralhealth/rhac/docs/work2324.pdf

Action 3.1b. Support the development of a Rural Health Association (RHA)

Scope: Rural Health Associations consist of diverse members that collaborate, educate, and advocate for rural health policy change within their state to support rural residents, healthcare professionals, and local communities. Rural Health Associations often operate as non-profit organizations organized by a board of directors. Other organizations, like hospital associations, also have rural healthcare branches but are more limited in membership. ORH can champion the development of a Rural Health Association by convening partners, encouraging them to create a Rural Health Association, and providing a framework to do so. For example, ORH could support operationalizing a Rural Health Association, including establishing a Board of Directors, and help spread the word about membership once fully established. Members may include State Departments, healthcare organizations and associations, health facilities, local communities (e.g., nonprofits, businesses, and government), federal agencies, rural-serving organizations, and academic institutions.

Example Programs:

- Minnesota Rural Health Association – This Rural Health Association was created following a rural health advocacy need voiced by stakeholders during focus groups. It has been operating for over 30 years and includes partnerships with the "Minnesota Department of Health's Office of Rural Health, Minnesota Rural Partners, and the Minnesota Center for Rural Health." Like North Dakota, it has a Board of Directors. These Directors serve three-year terms and include an election process, except the SORH, which is always a part of the Board. The Rural Health Association helps with the Helmsley Ultrasound Tuition Assistance Program and the EXCITE New Partners Vaccine Confidence Program.[130]
- Montana Rural Health Association – This Rural Health Association's mission is to "promote a healthy rural Montana by addressing issues of healthcare delivery, health professions education, public health education, health services, rural health research, and health policy through national, state, and community leadership." There are 13 goals listed on their website spanning the core areas identified in the mission. [131]
- North Dakota Rural Health Association – The North Dakota Rural Health Association pursues advocacy opportunities. It consists of a group of stakeholders who collaborate and build solutions to address rural infrastructure in the state. The Association facilitates the Targeted Rural Health Education (TRHE) program for resident physicians to utilize and publish data within rural communities. A Board of Directors advises the Association, and the Association is organized into four committees, including:
    - Policy Committee
    - Annual Conference Committee
    - Finance Committee
    - Communication and Membership Committee. [132]

[130] "About MRHA." https://www.mnruralhealth.org/about-mrha
[131] "About Us." Montana State University. https://healthinfo.montana.edu/morh/mrha/about.html
[132] "NDRHA – North Dakota Rural Health Association." https://www.ndrha.org/

- Rural Health Association of Tennessee (RHAT) – RHAT focuses on strengthening partnerships, education, and rural health advocacy efforts across Tennessee. The member composition is diverse and includes providers (e.g., rural health care, behavioral health), school health, and more, spanning rural issues like "uninsured rates and insurance costs, safety net eligibility for rural health clinics, healthcare workforce development, substance misuse prevention and recovery, social drivers of health, etc." [133] RHAT operates a series of state (e.g., State agencies, private partners, academic institutions) and federal grant-funded programs. [134]
- Tennessee Hospital Association (THA) – THA supports rural hospitals, including CAHs, to improve "clinical, financial, and operational performance." This support can help hospitals remain financially viable and promote access to care. Specifically, THA has a Small and Rural Constituency Section that "identifies healthcare policy issues that affect small and rural hospitals, develops educational programs and networking opportunities, legislative and regulatory information, seeks grant funding and other financial opportunities, and serves as liaison to the Rural Health Association of Tennessee, Tennessee Department of Health, professional boards and national organizations, such as the National Rural Health Association, American Hospital Association and Centers for Medicare & Medicaid Services." Outside of this, it operates subsidiaries (THA Innovative Solutions and Tennessee Center for Health Workforce Development [TCHWD]), which provide various services. Examples of THA Innovative Solutions services include consulting, administrative, financial services, and human resources, offered on a "fee-for-service basis to THA members." TCWD provides funding to hospitals and health centers to help with recruitment and retention.

Potential Programs and Partnerships:

Programs	Partnerships
• N/A	• South Dakota Department of Social Services • South Dakota Department of Education • Ambulance and EMS agencies • South Dakota HOSA • South Dakota Area Health Education Center • Universities and academic institutions • Health systems • LeadingAge • Rural Office of Community Services • South Dakota Association of Healthcare Organizations • SD Housing Authority

[133] Rural Health Association of Tennessee. https://www.tnruralhealth.org/
[134] "Grant Funded Programs." Rural Health Association of Tennessee. https://www.tnruralhealth.org/programs

Programs	Partnerships
	• Tribes • Indian Health Service • Great Plains Tribal Health Leaders' Health Board

Key Considerations:

- A Rural Health Association should have a Board of Directors who oversee operations, provide leadership, and identify funding opportunities. Like Minnesota, ORH could serve on the Association's Board of Directors.

Action 3.1c Enhance creation and distribution of communications and materials (e.g., newsletters, email distros, infographics) to stakeholders.

Scope: Stakeholders may include the public, State and local agencies, hospitals and health systems, clinics, individual providers, or Tribes. Communication topics and materials may include an overview of ORH's role and programs, health challenges in rural and Tribal communities, partnerships and collaboration opportunities, program planning, data, and technology.

Potential Programs and Partnerships:

Programs	Partnerships
• The gamut of ORH programs, upcoming partnership opportunities, technical assistance, data, etc., should be included in the materials.	• SDDOH Communications Team

Key Considerations:

- The State should consider partnering with the DOH Communications Team to create graphics and push emails through existing ListServs or other functions.
- This recommendation will closely align with ORH's mission and data collection recommendation.

3.2 Optimize ORH Management and Operations

Optimize internal operations and management to drive efficiencies and better align ORH to achieve its goal of addressing rural health access challenges.

Intended Impact: Introducing new processes and refining ORH's mission can streamline operations and promote equitable approaches to collaboration, data collection, and partnerships.

Action 3.2a Refine mission of ORH and develop a strategy to address rural health challenges.

Scope: ORH's refined mission will allow it to meaningfully engage internal and external stakeholders and increase awareness of its role, initiatives, and programs.

Potential Programs and Partnerships:

Programs	Partnerships
• N/A	• South Dakota Department of Social Services (e.g., Behavioral Health Advisory Committee) • Health Systems • Hospitals and clinics • LeadingAge • South Dakota Association of Healthcare Organizations • South Dakota Department of Education • South Dakota Department of Tribal Relations • South Dakota Emergency Medical Services Association

Key Considerations:

- The State should consider utilizing existing Committees or other vehicles for communication (e.g., DOH monthly calls with the Tribes, Behavioral Health Advisory Council, Meth Summit, etc.).
- Supplemental materials (e.g., infographics – see recommendation below) may be needed to support this recommendation.

Action 3.2b Implement data collection processes and create a rural healthcare dashboard.

Scope: Data collection processes could include adding an epidemiologist to collect data from ORH's programs. The dashboard and analytics will educate the public, legislators, facilities, health systems, providers, and healthcare organizations about core health and public health issues (e.g., workforce, social drivers of health, etc.).

Example Programs:

- North Dakota TRHE –The Targeted Rural Health Education Project (TRHE) translates public health data, namely Community Health Needs Assessments, into health education articles suitable for community use and rural newspaper

publications. The project aims to disseminate health education to the public and teach health literacy concepts to health professional students who author the articles. The project is a mandatory part of the third-year medical student curriculum for students who serve in rural areas through the Rural Opportunities in Medical Education shadowing program. Since the Target Rural Health Education Project started in 2017, more than 60 students have published health education articles in 17 rural newspapers across three states. [135]

- Minnesota Health Care Workforce Data & Analytics Unit – The Minnesota SORH, the Department of Health Office of Rural Health and Primary Care, has a dedicated Health Workforce Planning and Analysis Unit that collaborates with licensing boards. The unit analyzes approximately 20 healthcare professions and synthesizes data by county and profession. The data is available to various stakeholders, including legislators. [136] Data included on their website include a Chart Book to inform the Minnesota Legislature about rural workforce needs, COVID-19 impacts on the workforce, a press release for rural workforce retention, and a publication detailing workforce exit, burnouts, and shortages. The Unit has:
    - Developed a 2023 Rural Health Care in Minnesota: Data Highlights Chartbook with demographic characteristics, an overview of the rural health system and facilities, workforce, care availability, healthcare use, and financing. [137]
    - Published a report on the healthcare workforce and COVID-19 impacts.
    - Developed eight workforce reports. [138]
    - Launched an online Health Care Workforce Data Portal. [139]

Potential Programs and Partnerships:

Programs	Partnerships
• N/A	• Healthcare organizations, including hospitals and clinics • Nursing and medical schools

Key Considerations:

- The State will need to establish the data collection channels prior to creating a dashboard; data collection may be a high-effort activity depending on the data infrastructure at healthcare organizations.

[135] Targeted Rural Health Education Project. RHIHub. Rural Project Summary: Targeted Rural Health Education Project - Rural Health Information Hub
[136] "Health Care Workforce Data & Analysis." Minnesota Department of Health. Office of Rural Health and Primary Care. https://www.health.state.mn.us/data/workforce/index.html
[137] "Rural Health Care in Minnesota: Data Highlights." Division of Health Policy. November 16, 2023. https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmn.pdf
[138] "Health Care Workforce Publications." Minnesota Department of Health. https://www.health.state.mn.us/data/workforce/reports.html
[139] "Health Care Workforce Data Portal." Minnesota Department of Health. https://www.health.state.mn.us/data/workforce/hcwdash/index.html?url_var=overallsupply#NaN

- The State should consider partnering with nursing and medical schools and encourage students to translate and push out data from the health needs assessments.
- The State should translate its community health needs assessment / public health data into practical information for rural communities.

Action 3.2c Promote health equity across all work.

Scope: ORH should review and apply health equity principles to all internal policies, programs, and practices. An example activity may include establishing an Office of Tribal Health in partnership with the Tribes to collaborate and improve healthcare utilization and health outcomes for the Tribes.

Example Programs:

- Montana Office of American Indian Health – The Montana Department of Public Health and Human Services has an Office of American Indian Health, which the Governor started as an Executive Order in 2015 to address Tribal state health issues. Montana was one of the first states in the country to develop a Director of American Health position through this authority. The goal of the Office is to "connect people and cultures across the state of Montana, translating concepts of health and informing how best to work with Montana's Tribal nations to create better health outcomes for all Montanans." [140] Core activities include outreach to Native Americans and communities and liaison between Department programs and Tribes to provide a "voice for Indigenous perspectives and knowledge." [141] Outcomes include:
  - Created a Director of American Indian Health 2020 – 2022 Strategic Plan from feedback from key partners (e.g., Tribal Health leaders and state agencies).
  - Developed three goals with objectives and success indicators as part of the Strategic Plan.
  - References 16 Tribal newsletters & resources on its website.

Potential Programs and Partnerships:

Programs	Partnerships
• N/A	• Tribes • Great Plains Tribal Health Leaders' Health Board • South Dakota Department of Tribal Relations

[140] "Office of American Indian Health." Montana DPHHS. https://www.dphhs.mt.gov/OAIH/index
[141] "Office of American Indian Health." Montana DPHHS. https://www.dphhs.mt.gov/OAIH/index

Key Considerations:

- ORH should work closely across the department to make sure its strategies and priorities align with organizational health equity strategies and activities.

VI. Additional Considerations

Beyond the recommendations, sub-recommendations, and actions outlined in this report, the Strategic Analysis uncovered other insights that may not directly fall within the State's or ORH's purview but are still important to document and consider as ORH implements actions that address access gaps.

Figure 20 summarizes additional considerations that emerged from the stakeholder engagement process and are important for ORH to consider in the context of rural healthcare overall.

Figure 20. Additional Considerations

There is an opportunity to address wraparound services / holistic health needs within a community to ***meet baseline needs***, including access to affordable housing, childcare, and nutrition.

Language barriers exist in some communities, and there is an opportunity to ***enhance linguistic services and health education,*** especially for Hispanic and Korean community members.

Having a trusted healthcare provider in the community is important for overall health, and ***frequent turnover in rural or tribal communities can diminish trust*** in the healthcare system.

Proximity to OB services is a challenge. ***Healthcare deserts*** are a potential area to target, especially in the northwest and central "frontier" areas of the State.

Some Veterans feel they do not deserve assistance through the VA, and there is a limited approved community network for urgent care that only approves out-of-network facility visits in special circumstances.

VII. Next Steps

The ORH plans to implement high-priority recommendations that align with its role in the coming years. ORH prioritized actions based on the level of effort/investment and intended impact. **Figure 21** outlines ORH's high-priority actions. In the coming months and years, ORH will coordinate with SDDOH leadership and internal and external partners to explore and pursue the implementation of these high-priority actions. In many cases, this process will include assessing the feasibility of implementation.

Figure 21. Prioritized Actions

Sub-Recommendation	Actions
Recommendation 1. Expand access to health services, providers, and care sites.	
1.1 Expand Physical Care Sites	**1.1a** Explore and establish funding pipelines to incentivize health systems to expand and build new care sites across South Dakota. **1.1b** Assess partnerships to co-locate and provide health and social services in one location.
1.2 Bring Healthcare Services to the Patient	**1.2a** Expand the reach of physical care sites through mobile clinics. **1.2b** Provide incentives and support programs for healthcare professionals to travel to underserved areas including rural and Tribal areas. **1.2c** Expand telehealth services and telemedicine. **1.2f** Expand outreach, resources, and health education to educate communities on available health resources and appropriate use of care.
Recommendation 2. Bolster the healthcare workforce pipeline in South Dakota to ensure an adequate supply of providers and healthcare professionals to meet the growing health needs in rural areas.	
2.1 Create Interest in Healthcare Careers	**2.1b** Establish funding opportunities (e.g., grant program) to support career and technical education programs for healthcare careers. **2.1c** Partner with academic institutions to offer incentives to meet non-traditional student needs.
2.2 Build the Pipeline.	**2.2c** Implement dual credit programs and share resources to make training available and accessible in rural communities.
Recommendation 3. Strengthen strategic collaboration, internal operations, and management to address healthcare challenges in rural South Dakota.	

Sub-Recommendation	Actions
3.1 Engage & Convene Stakeholders	**3.1a** Develop a Rural Healthcare Advisory Committee. **3.1b** Support the development of a Rural Health Association (RHA).
3.2 Optimize ORH Management & Operations	**3.2a** Refine mission of ORH and develop a strategy to address rural health access challenges. **3.2b** Implement data collection processes and create a rural healthcare dashboard.