South Dakota
Rural Health Transformation
Project Narrative

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Project Narrative Overview

Many of South Dakota's rural and frontier residents face challenges in accessing healthcare. Most live far from urban centers, and nearly every county is classified as rural.[1] The state is also home to nine federally recognized American Indian tribes whose reservations are largely located in frontier areas where accessing care can take an hour or more.[2] In these rural and frontier areas, fewer available jobs and lower average incomes can make it difficult for families to afford care, even when services are available. Hospitals and clinics in these regions often operate on thin margins, leading to service reductions, workforce shortages, or facility closures.[3] Transportation costs and the need to take time off work further compound barriers to preventive and specialty care.[4]

These economic realities contribute to health disparities that are more pronounced in South Dakota's small towns and Tribal communities and highlight the need for targeted action. Through this funding opportunity, South Dakota's health leaders will have the chance to deepen collaboration, coordinate resources, and advance focused initiatives that expand access and improve health outcomes for rural residents, creating a lasting foundation for rural health across the state.

In 2024, the South Dakota Department of Health (SD DOH) Office of Rural Health conducted a Strategic Analysis of South Dakota's rural healthcare needs and developed actionable recommendations to improve access to healthcare in rural South Dakota. The analysis identified four key focus areas:

1. Rural Access Gaps
    - South Dakota has a shortage of healthcare professionals to meet current and projected health needs, especially in rural areas.

- Administrative activities burden providers and clinicians, leading to burnout and diminished operational capacity.

2. Growing Health Needs
    - Demand for healthcare is increasing as South Dakota's population grows and ages.[5]
3. Community Conditions Influencing Health
    - 47 of South Dakota's 66 counties have no intercity transportation access.
    - Rural residents die at higher rates from suicide and chronic conditions.
4. Strengthening Collaboration
    - Opportunities exist to create partnerships to share data, coordinate patient care, and expand access to care.[6]

In response to these findings, this plan sets a path forward for South Dakota to strengthen the capacity and resilience of its rural healthcare system. These efforts aim not only to improve access and health outcomes but also to build lasting partnerships and infrastructure that support healthy, resilient rural communities across the state.

Rural Health Needs and Target Populations

Rural Demographics: State Definition and Criteria for Identifying Rural Areas

The SD DOH uses a comprehensive approach to define and analyze rural areas, combining federal definitions with state-level data to reflect the state's unique geography and population distribution. Under the Health Resources and Services Administration (HRSA) definition of rural from the Federal Office of Rural Health Policy, all South Dakota counties except Minnehaha and Pennington are considered rural.[7] SD DOH further applies a composite measure that integrates HRSA definitions with the U.S. Department of Agriculture's Rural-

Urban Commuting Area (RUCA) codes and key demographic indicators such as population density.[8] This provides a more granular understanding of rurality and helps the state assess access to care and workforce needs.

Under this framework:

- Urban areas include zip codes with RUCA codes 1-3 (52 SD zip codes)
- Rural areas include zip codes with RUCA codes 4-6 (59 SD zip codes)
- Small rural areas include RUCA codes 7-9 (47 SD zip codes)
- Very rural areas include RUCA code 10 (253 SD zip codes)

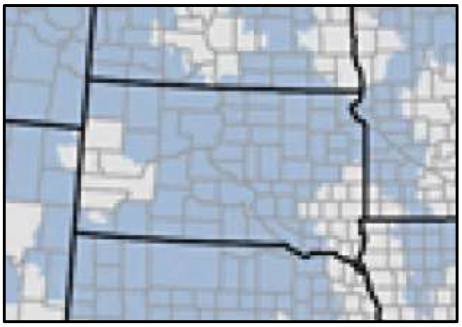
Counties spanning multiple RUCA codes are classification is based on the zip code with the largest share of the county's population. The analysis also distinguishes Tribal areas (counties or zip codes overlapping federally recognized reservations) from non-Tribal areas (all other rural areas). South Dakota's two urban counties are excluded to maintain focus on rural health needs.

This framework offers a more nuanced view of rurality than the HRSA definition alone and will guide how the state implements the initiatives outlined later in this plan. By differentiating rural, small rural, and very rural areas, SD DOH can more accurately target areas with the greatest access gaps and service needs.

Rural Demographics: Population Size and Density

South Dakota is one of the most rural and frontier states in the nation, covering over 75,000 square miles with an estimated population of 924,669 in 2024.[9] It is the 16th largest state but ranked 46th in terms of population, which places it among the least densely populated states in the country with an average population density of just 12.2 people per square mile.

As noted, nearly all of South Dakota's 66 counties are classified as rural under HRSA criteria, with 39 counties meeting the frontier designation, defined as areas with six or fewer residents per square mile. According to the Rural Health Information Hub, approximately 49.8% of the state's population -- 460,485 people -- live in non-metropolitan areas.[10] Three communities in the state have populations over 25,000, and only 17 have more than 5,000. The map below illustrates South Dakota zip codes where most residents live 60 minutes or more from an urban area of 50,000 or more.[11] South Dakota is among the states with the highest shares of FAR populations.[12]



South Dakota's communities are also diverse and face economic disparities. South Dakota encompasses nine federally recognized American Indian reservations spanning 15,000 square miles. Demographically, 84.1% of residents are White, 8.5% are Native American, and 5.4% are Hispanic or Latino, and 5.6% identify as another race or two or more races.[13] Many counties experience long-standing economic challenges: several are classified as persistently poor according to the 2023 U.S. Census Bureau report, with poverty rates of 20% or higher sustained over the past 30 years, and some rank among the poorest counties in the United States.[14]

Rural Demographics: Income Levels & Employment Sectors

South Dakota's employment base has added approximately 5,900 non-farm wage salary jobs in 2024, a gain of 1.3% over the prior year.[15] Per-capita personal income in the state reached $73,959 in 2024, placing South Dakota among the top states nationally.[16] While the state's largest industry is trade, transportation and utilities with over 91,800 workers, it is followed closely by public administration (approximately 76,600 workers) and the education and health

services sector. Healthcare is projected to grow about 12% over the next decade, driven by rising demand and shortages in key roles like nurses and nurse anesthetists, highlighting the need for strong workforce recruitment and retention.

Rural Demographics: Unemployment Rates

South Dakota consistently maintains one of the lowest unemployment rates in the nation at 1.8% in 2024, compared to 4.0% nationally. While this reflects a strong labor market, it also underscores the persistent challenge of recruiting and retaining enough healthcare professionals, particularly in rural and Tribal communities.[17]

Rural Demographics: Education Attainment

Education is a key driver of employment and income in South Dakota. Individuals without a high school diploma face the highest unemployment and lowest earnings (median salary $30,532), while those with a bachelor's degree or higher enjoy the lowest unemployment and the highest earnings (bachelor's degree median salary $52,325). Median income rises steadily with each level of educational attainment, underscoring the economic value of continued education and training.[18]

Rural Demographics: Health Insurance Coverage

Health insurance coverage in South Dakota is generally strong, with just 6.5% of residents ages 0-64 uninsured. Children are the most likely to be covered, with only 2.4% uninsured, while working-age adults (18-64) have an uninsured rate of 8.3%. Gaps are more pronounced among certain groups: younger adults (ages 18-29), lower-income households, individuals without a high school diploma, and those who are unemployed or self-employed report the highest rates of being uninsured.[19]

Health Outcomes: Rates of Chronic Conditions

Chronic diseases are the leading causes of illness and death in South Dakota, driven by behavioral risks, social conditions, and limited access to preventive care. Disparities are greatest among low-income residents and American Indians, who experience higher rates of risk factors and worse outcomes. According to 2024 South Dakota Vital Statistics, heart disease remains the leading cause of death, followed by cancer, chronic lower respiratory disease, Alzheimer's disease, and stroke.[20]

According to South Dakota's Behavioral Risk Factor Surveillance Survey, tobacco use among adults has fallen from 23% in 2011 to 14% in 2022, though e-cigarette use is rising, especially among American Indians and low-income residents. Alcohol use remains widespread: 19% of adults report binge drinking, including 31% of those ages 18-29. Depression affects 18% of adults and 22% of young adults, both rates have been increasing since 2011.[21]

Obesity rates continue to rise, affecting 37% of adults and 16% of high school students in 2022. Diabetes impacts 9% of adults, increasing sharply with age, while 7% live with COPD, 35% have high blood pressure, and 36% have high cholesterol. Despite strong overall screening rates for breast, cervical, and colorectal cancer, American Indians who live in predominately rural and frontier areas experience much lower screening rates (36% colorectal vs. 69% among Whites).[22]

Beyond chronic disease, according to SD DOH Vital Statistics, South Dakota faces high rates of suicide, overdose, and alcohol-related harm:

- Suicide: Leading cause of death for ages 20-39; American Indian rate 2.9× higher than Whites.
- Overdose: Rising meth, opioid, and fentanyl deaths; American Indian rate 3.5× higher.

- Alcohol-Related Deaths: Third-highest age-adjusted death rate nationally.

These trends highlight the urgent need for coordinated, statewide efforts to build overall capacity (especially in chronic disease management programs), address workforce shortages, and advance behavioral health delivery.[23]

Health Outcomes: Child and Maternal Health

Maternal and child health outcomes in South Dakota are shaped by limited obstetric service availability and geographic isolation. Nearly half of women of reproductive age live in rural counties, yet 60% of short-term acute care hospitals no longer provide obstetric services, leaving more than half the state's counties designated as maternity care deserts.[24] As a result, South Dakota ranks 47th nationally for obstetric service availability, and many women in rural and Tribal communities must travel long distances for care.[25]

The state's maternal mortality rate (45.4 per 100,000 live births) is much higher the national average, with American Indian women accounting for 17% of births but experiencing nearly half of maternal deaths. Similar disparities appear in infant mortality: rates among American Indian infants (10.5 per 1,000) are substantially higher than among White infants (6.1 per 1,000).[26]

These disparities underscore the urgent need for statewide strategies to expand maternity care access and strengthen prenatal and postpartum supports.

Healthcare Access: Distance to Care and Availability of Healthcare Providers

Access to healthcare in South Dakota is more limited in rural areas than in urban regions, even though nearly half of residents live in non-metropolitan areas. Urban areas have more care sites per 10,000 square miles, while rural regions have fewer facilities relative to population. As a result, many rural residents often face long travel times to receive care. Many must travel over

60 minutes for emergency or hospital services, and residents in western South Dakota may travel more than two hours to reach acute care facilities.[27]

Transportation is also a barrier to healthcare access in rural areas. Many counties lack public transit and residents face long travel times and high out-of-pocket costs for emergency transport. Although public and medical transportation services provide millions of rides annually, limited availability, restricted service hours, and regional gaps continue to make accessing care difficult for many residents.[28]

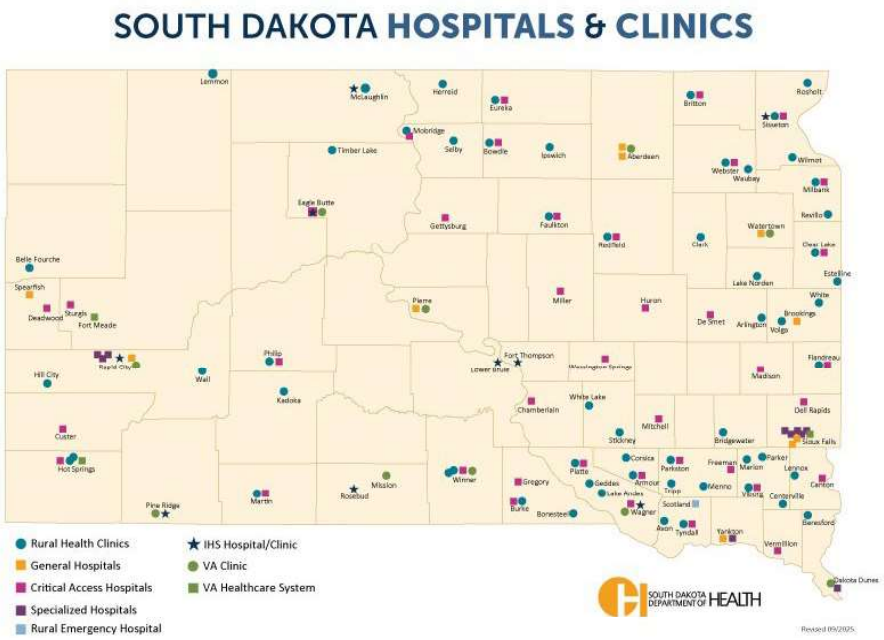
Provider shortages also contribute to challenges. South Dakota faces shortages across all provider types, particularly in rural areas. Healthcare Professional Shortage Areas (HPSAs) are designated based on provider-to-population ratios, poverty levels, and travel distance to care, and are required for eligibility in federal programs such as the National Health Service Corps. The entire state is classified as a mental health HPSA, and large portions are also designated as primary care HPSAs. Shortages are especially acute in the Black Hills and South-Central Plains regions, leaving many rural residents without consistent access to care. Network adequacy assessments indicate that multiple counties lack an adequate number of providers to meet community demand.[29]

Maternity care access is particularly limited with 37 of the state's 66 counties considered maternity care deserts.[30] Recruitment and retention challenges, driven by factors including housing affordability and geographic isolation, contribute to these shortages. South Dakota retains about 57.7% of its physician residents, consistent with national trends, yet one in five providers plan to retire or leave the workforce within five years, half of whom are in rural areas. Rural EMS services face similar struggles with workforce retention.[31]

Operational challenges further strain rural providers, including administrative burdens, complex reimbursement structures, and growing demand from an aging population with chronic conditions. These realities point to the need for investments that strengthen local care delivery, support providers in rural regions, and ensure South Dakotans can access timely, high-quality care.

Healthcare Access: Health Care Facility Numbers and Distribution

Across South Dakota, there are 39 Critical Access Hospitals (CAHs, 25 beds or less), 10 larger hospitals (26+ beds), and 10 specialized hospitals licensed through the SD DOH. The state has 50 general acute-care hospitals, including one Indian Health Services (IHS) hospital not operating as a Tribal 638 organization, and three rural hospitals with fewer than 50 beds.[32]



In 2023, daily censuses in CAHs ranged from 1 to 15, averaging 4.18 patients, while Prospective Payment System hospitals with fewer than 49 beds averaged 10.67 patients per day.[33] South Dakota also has 15 ambulatory-surgery hospitals, 58 Rural Health Clinics (RHCs),

39 Federally Qualified Health Centers (FQHCs), three Veterans Administration hospitals, four IHS hospitals, and four IHS clinics.

Community Health Centers (CHCs): South Dakota's four CHC organizations – Complete Health, Falls Community Health, Horizon Health Care, and Rural Health Care – operate 45 sites statewide, providing primary, preventive, behavioral, and sometimes dental and substance abuse care regardless of patients' ability to pay. In 2023, they served 124,541 patients, primarily in high-need areas.

Federally Qualified Health Centers (FQHCs): South Dakota has 46 FQHCs that meet federal Section 330 requirements or operate as look-alikes. These centers deliver essential primary and dental care to underserved populations in free-standing clinics or co-located community settings.

Rural Health Clinics (RHCs): Fifty-eight RHCs operate in 35 counties and 56 cities, addressing rural physician shortages and expanding non-physician care. They meet CMS requirements, including being in shortage areas, employing nurse practitioners or physician assistants, and providing diagnostic, laboratory, and emergency services.

Critical Access Hospitals (CAHs): South Dakota's 39 CAHs are supported by the Medicare Rural Hospital Flexibility (Flex) Program, which provides 101% reimbursement for Medicare inpatient and outpatient services. Seventy-seven percent are east of the Missouri River, where 70% of the population lives, while western communities face travel times up to 120 miles to reach care. The state mitigates access barriers through referral and transfer agreements, collaborative projects via the Flex Program, and partnerships with Avera Health, Sanford Health, and Monument Health to improve care delivery, quality, and EMS integration.

Certified Community Behavioral Health Clinics (CCBHCs): South Dakota has zero CCBHCs (A. 2. current list of CCBHC entities as of September 1, 2025).

Medicaid Disproportionate Share Hospital (DSH) Payments: In FY2025, 23 hospitals in South Dakota received DSH payment (A. 7. number of hospitals receiving DSH payments).[34]

Healthcare Access: Rural Facility Financial Health

An analysis of South Dakota Critical Access Hospitals (CAHs) from 2020-2025 shows that most facilities have remained in the low- or medium-low financial risk categories. Medium-high risk hospitals remained relatively stable, and no hospitals were classified as high risk in 2023-2025. Notably, the "no data" category rose in 2025 to 18, reflecting reporting gaps.

Critical Access Hospitals in Financial Distress 2020-2025						
Year	2020	2021	2022	2023	2024	2025
Low Risk	12	14	14	25	24	15
Medium-low Risk	15	11	9	8	11	4
Medium-high Risk	8	5	8	5	3	3
High Risk	0	1	1	0	0	0
No Data	5	9	8	2	2	18
Healthcare Cost Report Information System 2024, Quarter 4 Data File (Flex Monitoring Team) updated March 2025.						

Median financial indicators for South Dakota CAHs in 2023 show strong performance compared to national medians. Total margin (5.0%) and operating margin (3.78%) exceeded U.S. averages, liquidity was robust with days cash on hand (144) and a current ratio (4.68), and debt service coverage remained healthy at 4.12. South Dakota hospitals also rely more heavily on Medicare services than the national median, reflecting the rural populations they serve. Staffing and salary levels were in line with national norms.

Median Indicator Values for South Dakota and the United States 2021					
Indicator	**SD**	**US**	**Indicator**	**SD**	**US**
Total Margin (%)	5.00	3.87	Patient Deductions (%)	42.36	47.95
Cash Flow Margin (%)	8.70	6.18	Medicare Inpatient Payer Mix (%)	78.07	58.75
Return on Equity (%)	5.67	6.00	Medicare Outpatient Payer Mix (%)	47.39	29.22
Operating Margin (%)	3.78	1.38	Medicare OP Cost to Charge	36.30	42.15

Current Ratio	4.68	3.00	OP Revenue to Total Revenue	76.54	84.21
Days Cash on Hand	143.64	103.07	Salaries to Net Patient Revenue (%)	44.46	44.01
Days in Net Accounts Receivable	32.74	47.21	Average age of Plant	10.94	12.30
Days in Gross Accts Receivable	48.06	48.92	FTEs/Adjusted Occupied Bed	6.05	4.95
Equity Financing (%)	78.48	66.65	Avg Salary Per FTE	78119	76443
Debt Service Coverage	4.12	4.00	Avg Daily Census Swing SNF	1.28	1.62
Long-Term Debt to Capitalization (%)	16.22	17.88	Avg Daily Census Acute Beds	1.48	2.19
OP Revenues to Total Revenues (%)	76.54	84.21	Number of Included CAHs	39	1324

Healthcare Access: Number of Rural Hospital Closures

In the past three years, three South Dakota hospitals have converted to different facility types: an IHS hospital became Tribally managed in 2022, a Prospective Payment System hospital converted to a CAH in 2023, and a CAH transitioned to a Rural Emergency Hospital in July 2025. The most recent hospital closure in the state occurred in 2010.[35]

Healthcare Access: Utilization Levels/Patient Volumes of Existing Rural Health Facilities

The 2024 Rural Health Strategic Analysis found that utilization of care sites varies by region, rurality, and Tribal classification. Rural and Tribal areas have limited access to outpatient services, leaving residents with fewer care options. As a result, hospital outpatient departments are used more frequently than clinics which can be more costly for patients.

South Dakotans use telehealth and telemedicine to help address access-to-care challenges, but usage remains lower than in peer states. This highlights an opportunity to expand telehealth, particularly in very rural and small rural areas identified in the analysis. To ensure equitable access to outpatient care across South Dakota, targeted investment is needed to enhance telehealth infrastructure, particularly in rural and Tribal communities.[36]

Rural Health Transformation Plan: Goals and Strategies

Rural healthcare in South Dakota is essential and resilient, but persistent challenges exist related to geographic access to care, workforce shortages, financial and social barriers, limited healthcare infrastructure, and pronounced health disparities, particularly among rural and Tribal populations. This situation presents an opportunity to transform how we support rural healthcare delivery by investing in long-term, sustainable capacity-building initiatives that strengthen providers and systems, rather than starting temporary programs that lapse when funding ends.

This Rural Health Transformation Plan prioritizes direct investment in provider capacity over creating new programs. Recognizing that rural providers understand their communities' needs best, this plan offers flexibility for local innovation by supplying practical tools and support necessary to enable providers to deliver high-quality care efficiently and sustainably. Through strategic investments across four core themes, this plan will build capacity that extends beyond this grant period. Connect Technology and Data for a Healthier SD will optimize Electronic Health Record (EHR) systems, fund essential technology and equipment, and develop statewide data infrastructure. Advance the Rural Workforce will address workforce shortages via recruitment incentives, training infrastructure, and workforce expansion. Keep Healthcare Local and Strong focuses on enhancing chronic disease management programs, supporting facility optimization, and reforming payment models. Transform Systems for Sustainability advances behavioral healthcare delivery and emergency medical services.

These targeted investments will enable rural providers to operate more efficiently, extend their reach, reduce administrative burdens, and retain strengthened capacity beyond 2031. Efficiency gains from EHR optimization, telehealth capabilities supported by critical equipment, and the recruitment of clinicians all represent lasting improvements in care delivery.

Enhancements to chronic disease programs, facility optimization, payment model reforms, and expanded behavioral health and emergency services further ensure that these gains are sustainable, meaningful, and tailored to the needs of rural communities.

Together, these initiatives will achieve measurable transformation by creating a resilient and enduring rural healthcare infrastructure that will strengthen communities and serve South Dakotans for decades into the future.

Improving Access

Access to healthcare in rural South Dakota requires both immediate workforce solutions and long-term infrastructure investments that extend provider reach. Our approach addresses access gaps across the full continuum: primary care, specialty services, behavioral health, maternal health, and emergency medical services.

Technology investments will deploy telehealth capabilities, diagnostic equipment, and remote monitoring tools that bring specialty expertise to rural communities to improve health outcomes for patients. Financial incentives through recruitment and retention programs will attract and keep clinicians in rural areas, while our Rural Health Forward training and resource hub will support existing providers with continuing education. Community health worker (CHW) expansion extends clinical team capacity for care coordination and chronic disease support.

Behavioral health access will be transformed through Certified Community Behavioral Health Clinic (CCBHC) implementation, ensuring same-day access and 24/7 crisis response. Access to maternal health services will be improved by assessing and implementing opportunities for coordinated care. EMS system advancement through regional hubs will improve response times, while grants for rural Medicaid providers will help facilities transition to sustainable models that keep services local.

Improving Health Outcomes

Outcome-focused initiatives address South Dakota's leading causes of morbidity and mortality while building systems that prevent disease progression. Strengthening statewide chronic disease management will reduce deaths from heart disease, stroke, and diabetes through early intervention and improved disease control. Care coordination improvements through EHR optimization and health information exchange integration ensure continuous information flow across care settings. CHW extension expands coordination into homes and communities. Value-based payment transformation through Medicaid reform aligns financial incentives with health outcomes rather than volume, rewarding providers for keeping patients healthy. Integrated behavioral health will improve outcomes through comprehensive, coordinated care delivery. The Rural Data Atlas will enable outcome tracking at the community level, allowing providers and health departments to identify gaps, target interventions, and measure impact.

Technology Use

South Dakota will advance the adoption of emerging technologies with careful evaluation of their relevance and effectiveness for rural providers and patients. Technology strategies will prioritize tools that enhance prevention and chronic disease management which are areas where rural residents have historically experienced gaps in care.

Remote patient monitoring for chronic conditions enables real-time data collection and early intervention to prevent severe complications, and EHR optimization ensures existing technology is fully leveraged for clinical decision support and population health management. The plan will support technology-driven solutions ranging from AI diagnostic tools to robotic devices that are evaluated based on demonstrated effectiveness in rural settings, alignment with provider capacity, patient connectivity, implementation costs, and measurable impact. Expansion

of telehealth will extend specialist services into communities that are not able to support specialists locally. The Data Atlas will use community data to support prevention through community-level surveillance and data-driven resource allocation while health information exchange integration will ensure coordinated prevention and chronic disease management across providers. Technology investments will also include funding for training, technical assistance, and implementation support to ensure sustainable adoption and impact.

Strategic Partnerships and Collaboration

Strategic partnerships will drive sustainable improvements in rural health. Regional collaborations funded through rural Medicaid provider grants will allow hospitals and clinics to coordinate services, offer complementary care, and achieve measurable quality gains and strengthened financial stability. Regional innovation hubs will mentor and support smaller facilities through training, technical assistance, and shared services to elevate care quality and access. Integrated data systems, including the Data Atlas, will provide unified access to patient-level information for evidence-based decision-making. Behavioral health networks strengthened through the CCBHC model and regional EMS sites will further enhance coordination, training, and resource sharing.

Workforce

South Dakota's rural workforce shortage requires solutions that address professional isolation, limited continuing education, and financial barriers. Recruitment incentives will provide financial incentives to support rural service commitments, while community health worker expansion will extend clinical team capacity and reduce administrative burden for providers. A training and resource hub will support retention through continuing education and professional development. EMS advancement will expand training for emergency medical

professionals. Finally, telehealth investments through grants allow rural providers to consult specialists remotely, manage complex cases with support, and increase clinical confidence and job satisfaction which further supports retention.

Data-Driven Solutions

The Data Atlas creates a public technology platform with interactive maps, charts, and tables displaying county-level health data, enabling evidence-based decision-making, grant writing, needs assessment, and intervention evaluation. EHR interoperability investments connect rural providers to health information exchange systems, ensuring patient data follows individuals across care settings to prevent duplicative testing and medical errors. Quality improvement analytics through EHR enhancements provide rural providers with dashboards tracking readmissions, infections, wait times, and screening rates. Remote monitoring generates continuous patient data informing clinical decisions and enabling early intervention. Each initiative includes specific, measurable outcomes tracked through data systems to enable continuous program refinement and accountability.

Financial Solvency Strategies

Ensuring long-term financial stability requires payment reform options, operational adjustments, and strategic investments in sustainable service models. Value-based payment options through Medicaid can provide predictable revenue rewarding quality outcomes rather than volume, addressing financial vulnerability from low rural patient volumes while incentivizing preventive care.

Medicaid provider grants will fund financial, accounting, legal, and strategic consulting to help hospitals and clinics assess operations and transition to sustainable models. This may include modifying service offerings, right-sizing facilities, developing regional partnerships, or

transitioning to alternative facility designations. Revenue diversification occurs through expanded Medicaid billing for CHW services, reimbursable care coordination, and remote patient monitoring models.

Infrastructure investments through EHR and technology and equipment grants will enhance operational efficiency, expand service capacity, and enable higher-acuity services locally. By reducing costly facility transfers and capturing more services within rural facilities, these investments improve financial performance. Regional EMS hubs and CCBHC automated reporting systems will reduce administrative burden and improve billing accuracy.

Addressing Root Causes of Rural Hospital Risk

Rural hospitals face a range of connected challenges that put their services and viability at risk. This plan addresses each systematically. Low volume challenges are addressed through value-based payment providing predictable revenue regardless of volume, facility transformation support for right-sizing or regional partnerships, and chronic disease management reducing hospitalizations while maintaining local access.

Quality and patient bypass concerns are addressed through a training and resource hub that supports provider competencies, technology investments that expand local diagnostic and teleconsultation capacity, and care coordination that strengthens outcomes and community trust. Payer mix and reimbursement challenges are addressed through Medicaid payment transformation, community health worker enhancement, chronic disease management initiatives that improve population health, and strategies to diversify revenue.

Workforce shortages limiting service capacity are comprehensively addressed through recruitment and training initiatives. Technology and infrastructure deficits are directly addressed

through investments in EHR, technology, and equipment while the Data Atlas supports strategic planning and quality improvement.

Key Performance Objectives

Connect Technology and Data for a Healthier South Dakota: The objective is to modernize South Dakota's rural healthcare infrastructure through strategic health information technology investments and data-driven decision making. By transitioning facilities from paper-based systems to certified EHR technology, achieving complete integration with the state health information exchange, and establishing a comprehensive Data Atlas, the state will enable real-time clinical decision support, population health management, and evidence-based policy development. These technological foundations will drive improvements in preventive care delivery, chronic disease management, and patient safety while creating the data infrastructure necessary to track health disparities and inform community health strategies across all 66 counties. Each initiative includes clearly defined performance objectives.

Advance the Rural Workforce: The objective is to build and sustain a comprehensive rural healthcare workforce capable of meeting the complex needs of South Dakota's rural, frontier, and Tribal communities. Through targeted recruitment and retention strategies that support expanded training and certification programs, the state will strengthen capacity across multiple disciplines. This multifaceted workforce development approach will ensure communities have access to culturally responsive care that addresses both clinical needs and social determinants of health. Performance objectives are detailed within each individual initiative.

Keep Healthcare Access Local and Strong: The objective is to preserve essential healthcare services in rural communities while improving quality, efficiency, and financial sustainability. By supporting operational improvements, facilitating strategic partnerships, and advancing

value-based payment models, the state will help rural facilities maintain comprehensive service offerings close to home. Simultaneously, investments in primary care transformation, preventive care, and chronic disease management will improve health outcomes and reduce avoidable utilization to decrease unnecessary emergency department visits and hospital readmissions. Each initiative outlines its own specific performance objectives.

Transform Systems for Sustainability: The objective is to create coordinated, regional systems for emergency medical services, behavioral health, and maternal care that ensure timely, integrated, and sustainable access across South Dakota. Through hub-and-spoke models and regional partnerships, the state will establish infrastructure for rapid crisis response, whole-person behavioral health care, and comprehensive maternal support. These transformed systems will reduce fragmentation, improve clinical outcomes through care coordination and follow-up, and build long-term sustainability through shared resources, enhanced technology integration, and workforce development. Specific objectives and performance targets are provided for every initiative.

Proposed Initiatives and Use of Funds

Connect Technology and Data for a Healthier South Dakota

Initiative: Tech and Data Connection for a Healthier South Dakota

Description: This initiative will modernize healthcare delivery across South Dakota through a comprehensive approach to digital health infrastructure and health information exchange. Guided by feedback from system leaders, rural hospitals, and provider associations, it provides flexible funding to healthcare facilities while building statewide infrastructure for sustained success. A key component, the South Dakota Health Data Atlas, will unify siloed health data into a single, accessible platform, allowing communities, providers, and policymakers to make data-driven

decisions that strengthen rural health outcomes. Together, these efforts address both clinical technology needs and essential operational infrastructure including telecommunications, cybersecurity, equipment, and emergency preparedness systems that enable modern healthcare delivery in rural settings.

- **Tier 1 - Foundation Building:** Small practices, Tribal clinics, behavioral health providers, long-term care, and rural clinics will receive funding for EHR implementation, South Dakota Health Link (state's health information exchange) connections, training, and workflow optimization. This tier ensures that providers with limited or no EHR capabilities receive the support needed to establish foundational digital health systems, enabling them to participate in coordinated care and meet modern standards for documentation and quality reporting.
- **Tier 2 - Advanced Integration:** Mid-size facilities can upgrade systems for full interoperability, implement clinical decision support, integrate telehealth, deploy population health tools, and establish robust data analytics. This tier transforms adequate systems into high-performing platforms that improve clinical outcomes, operational efficiency, and care coordination across provider networks.
- **Tier 3 - Regional Innovation Hubs:** Critical Access Hospitals, regional health systems, and large FQHCs can become regional technology leaders by partnering with smaller facilities to accelerate technology adoption. These hubs will provide training, mentorship, technical assistance, and shared services to help elevate care quality and access.
- **Accelerated Health Link Expansion:** Funding will remove barriers to SD Health Link participation, including waived connection fees, local engagement support, technical assistance, upgraded infrastructure, and enhanced interoperability for rural providers.

- **Comprehensive Infrastructure Modernization:** Beyond clinical technology, this initiative recognizes that effective healthcare delivery requires robust operational infrastructure. Facilities can access funding for critical systems and equipment that address the unique challenges of rural healthcare environments.

<table>
<tr><th colspan="3">Eligible Activities</th></tr>
<tr><td>Purchase of certified EHR systems</td><td rowspan="2">Cybersecurity enhancements including encryption, multi-factor authentication, and intrusion detection</td><td rowspan="3">Operational resilience tools to include backup power systems, emergency generators, and business continuity solutions that maintain healthcare access during weather events, power outages, or other disruptions common in rural areas</td></tr>
<tr><td>ePrescribing of controlled substances capabilities</td></tr>
<tr><td rowspan="2">Population health management platforms for chronic disease tracking and preventive care</td><td>Workflow redesign and optimization consultation</td></tr>
<tr><td>Quality measure reporting automation</td></tr>
<tr><td>Clinical decision support systems including drug interaction checking, evidence-based order sets, and predictive algorithms</td><td>Comprehensive training programs for clinicians, nurses, medical assistants, administrative staff, and IT personnel to include change management support</td><td rowspan="3">Advanced care delivery tools to include telehealth equipment and platforms, robotic surgical or diagnostic systems, AI-powered clinical support tools, remote patient monitoring devices, occupancy tracking platforms, and consumer-facing technology that expands access to specialized care without requiring patient travel</td></tr>
<tr><td>Implementation services including vendor project management, system configuration, data migration, and testing</td><td>Health Link connectivity including recruitment, interface development, testing, and go-live support</td></tr>
<tr><td>Patient engagement tools including portals, mobile apps, and secure messaging</td><td>Interface development connecting EHRs to labs, pharmacies, imaging, and other systems</td></tr>
<tr><td>Practice management and revenue cycle systems integrated with clinical EHRs</td><td rowspan="2">Workforce tools to include training programs, technical resources, and implementation support that ensure staff can effectively utilize new technologies and sustain improvements over time</td><td rowspan="2">Technology infrastructure to include servers, network equipment, telecommunications upgrades, cybersecurity solutions, and IT security systems</td></tr>
<tr><td>Ongoing maintenance, licensing, and support contracts (up to 3 years)</td></tr>
<tr><td>Data analytics and quality reporting infrastructure</td><td>Cloud-based EHR infrastructure and hosting services</td><td>Telehealth module fully integrated with EHR workflows</td></tr>
</table>

Grants will be awarded through a streamlined application process that considers facility readiness, community impact, and alignment with statewide health priorities. Applicants must demonstrate how requested funding will improve patient care, expand access, enhance

operational capacity, or strengthen care coordination. Technical assistance will be available throughout the application and implementation process to ensure success, particularly for smaller facilities with limited grant management experience.

This integrated approach recognizes that modern healthcare requires both clinical information systems and the underlying infrastructure to support them. By addressing EHR adoption, health information exchange, and comprehensive technology infrastructure in a coordinated manner, South Dakota will build a sustainable foundation for high-quality, accessible healthcare across all communities regardless of size or geographic location.

- **Rural Data Atlas:** The South Dakota Health Data Atlas will serve as a comprehensive rural health dashboard, integrating data from state agencies and the health information exchange into interactive maps, charts, and tables. By unifying siloed systems into a single, accessible platform, it will support data-driven planning and investment across the rural health system. Hospitals, clinics, Tribal nations, and community partners will be able to analyze trends, identify service gaps, target resources, and measure outcomes using county-level data on key health indicators.

Main Strategic Goal: Technology Innovation

Use of Funds: A, C, D, F, K

Technical Score Factors: B.1., C.1., C.2., F.1, F.2., F.3

Key Stakeholders: Hospitals, Healthcare Systems, CAHs, Ambulatory Clinics, Urgent Care Clinics, FQHCs, RHCs, Post-Acute and Long-Term Care Facilities, Community Mental Health Providers, Home Health Agencies, Hospice, Pharmacies, Optometrists, Dentists, and other ancillary healthcare stakeholders

Outcomes:

1. **EHR Adoption:** Establish baseline EHR functionality in previously unserved facilities

   Metric: Percentage of Tier 1 facilities that transition from paper-based or limited EHR systems to certified EHR technology

   Baseline: Assessment of EHR adoption by facility type within first 180 days (2026)

   Target: 80% of funded Tier 1 facilities implement certified EHR systems by Year 3

2. **Enhanced Preventative Care Delivery:** Use population health tools and automated outreach to increase evidence-based screenings

   Metric: Percentage increase in completed colon cancer, breast cancer, and diabetes screenings through automated patient identification and outreach

   Baseline: Current screening rates by facility (2025)

   Target: 8% increase in completed preventive screenings by Year 3 in funded Tier 2 facilities

3. **Clinical Decision Support:** Reduce adverse events through real-time clinical alerts and evidence-based guidance

   Metric: Percentage reduction in hospital-acquired infections (HAIs) and medication-related adverse events through infection surveillance modules and drug interaction checking

   Baseline: Current HAI and adverse event rates (2025)

   Target: 15% reduction in HAIs and 10% reduction in medication errors by Year 3 in funded Tier 2 facilities

4. **Innovation Diffusion:** Pilot and scale advanced health IT capabilities across regions

Metric: Number of innovative health IT pilots (AI-driven tools, advanced analytics, novel telehealth integrations) implemented and scaled to partner facilities

Baseline: 0 (new program)

Target: Each funded Tier 3 hub launches 2 successful innovation pilots by Year 4, with at least one scaled to 2 partner facilities

5. **Strengthen Public Health Impact:** Increase the number of assessments (city, county, or hospital), state agency plans, initiatives, or reports, or other health-focused strategies that cite or use data from the Data Atlas.

   Metric: Number of resources referencing Data Altas

   Baseline: 0 references

   Target: 30 references by 2029

6. **Improve Population Health Outcomes:** Track key health conditions and disparities across counties.

   Metric: Number of county-level outcome indicators available in Data Atlas

   Baseline: 0 indicators

   Target: 25 indicators by 2029

Impacted Counties: All South Dakota Counties, 46003-46137

Implementation Plan:

Stage	Key Activities	Lead / Responsible Party	Start Date	End Date	Deliverables / Milestones
0	Project Planning	EHR/Health Link: SD DOH + Consultant	Jan 2026	May 2026	Workplan approved, grant program guidance developed, marketing and outreach plan developed
		Data Atlas: SD DOH	Jan 2026	June 2026	Develop governance, technical infrastructure, and host internal stakeholder meetings

1	Project Kick Off	EHR/Health Link: Lead + Consultant	June 2026	Aug 2026	Kick off meeting completed, communications plan implemented
	Initial Go-Live	Data Atlas: Lead + Stakeholders	July 2026	Dec 2026	DOH initiates Data Atlas with limited data and seeks external stakeholder feedback
2	Implement	EHR/Health Link: Lead + Consultant	Aug 2026	June 2030	Release grant guidance documents, provide technical resource virtual presentations, accept applications on set cycles, review and approve applications
	Refine	Data Atlas: Initiative Lead & Team	Jan 2027	June 2027	Stakeholder feedback refines Data Atlas
3	Check Goal	EHR/Health Link: Lead + Consultant	Oct 2027	Nov 2027	Interim metrics report completed; adjustments made based on evaluation data; lessons learned documented
	Expanded go-live	Data Atlas: Team	July 2027	June 2028	Additional data from DSS, DHS, Health Link, and RHT outcomes included in Data Atlas
4	Finalize	EHR/Health Link: Lead + Consultant	June 2030	July 2030	Final outcomes
	Monitor	Data Atlas Team	July 2028	Dec 2029	Load data as it becomes available, monitor use of Data Atlas
5	Evaluate	EHR/Health Link: SD DOH + Consultant	Aug 2030	Dec 2030	Final evaluation completed and sustainability plan submitted, all metrics and deliverables reported
	Implemented	Data Atlas: Team	Jan 2030	Sep 2030	Complete impact evaluations

Estimated Required Funding: $500,000,000 over 5 years

Advance the Rural Workforce

Initiative: Building a Sustainable Rural Healthcare Workforce

Description: This initiative will strengthen South Dakota's rural healthcare workforce through a comprehensive, incentive-based program that attracts, develops, and retains professionals across critical roles and care settings. By combining targeted recruitment incentives with education-based retention supports, the program ensures sustainable access to quality care in rural and frontier communities. Recruitment incentives will draw new healthcare professionals to high-need rural areas through competitive sign-on bonuses, relocation assistance, and rural service stipends. Retention efforts will support current healthcare workers in advancing their skills and

careers through tuition assistance, paid clinical release time, on-site or hybrid training, and leadership or mentorship opportunities. Together, these strategies build a stable, skilled, and sustainable workforce to serve rural South Dakotans for years to come.

Specific activities include:

- **Recruitment Incentives:** Offer tiered sign-on bonuses, relocation assistance, and rural service stipends based on role and location. These incentives will help remove barriers to relocation and make rural healthcare positions more competitive in attracting highly skilled professionals. Participants will be required to sign five-year commitments.
- **Retention Supports:** Provide current rural healthcare workforce with direct funding for education, certification, or leadership training tied to five-year rural service commitments.
- **Education Partnerships:** Collaborate with technical colleges and universities to expand accessible rural training pathways to include apprenticeship opportunities.

The application process for both recruitment and retention incentives will be streamlined to minimize administrative burden on healthcare providers and applicants. Clear, transparent eligibility criteria and requirements will be established upfront to ensure fairness and efficiency. To protect the state's investment and ensure program integrity, participants who fail to fulfill their five-year service commitment will be subject to prorated repayment obligations.

Main Strategic Goal: Workforce Development

Use of Funds: A, E, C

Technical Score Factors: D.1

Key Stakeholders: Licensed Healthcare Professionals, Rural Healthcare Facilities, Tribal Health Partners, Educational Institutions

Outcomes:

1. **Rural Healthcare Workforce Recruitment:** Increase the number of healthcare professionals practicing in rural and frontier communities through targeted recruitment incentives.

   Metric: Number of healthcare professionals recruited to rural communities

   Baseline: N/A (new program)

   Target: 500 professionals recruited by 2030

2. **Rural Workforce Retention:** Strengthen the stability of the rural healthcare workforce through long-term service commitments and education-based retention supports.

   Metric: Percentage of healthcare professionals retained in rural communities five years after receiving incentives

   Baseline: N/A (new program)

   Target: 90% retention rate five years post-incentive

3. **Healthcare Education Advancement:** Expand education and career advancement opportunities for healthcare professionals serving rural communities.

   Metric: Number of professionals completing education or professional development programs supported through the initiative

   Baseline: N/A (new program)

   Target: 200 professionals by 2030

4. **Improved Patient Access to Care:** Increase availability of care closer to home by expanding and stabilizing the rural healthcare workforce.

   Metric: % of Medicaid beneficiaries accessing primary care within 30 miles of home

   Baseline: Established in Year 1 using claims data (2026)

Target: Increase from baseline by 15% by 2023

Impacted Counties: All South Dakota Counties, 46003-46137, except for Minnehaha (46099) and Pennington (46103)

Stage	Key Activities	Lead / Responsible Party	Start Date	End Date	Deliverables / Milestones
0	Project Planning	Initiative Lead	Jan 2026	Mar 2026	Workplan approved, program goals defined, program guidelines established
1	Kickoff	Lead + Team	June 2026	Aug 2026	Staff assigned, contractor secured, kickoff meeting completed, roles/responsibilities finalized
2	Implement	Lead + Team	Sep 2026	June 2030	Activities launched: recruitment incentives; retention through long-term service commitments and education-based supports.
3	Midpoint Check	Lead + Team	Oct 2027	Nov 2027	Metrics report/adjustments: Interim metrics report completed; adjustments made based on evaluation data; lessons learned documented
4	Finalize Goal	Lead + Team	June 2030	July 2030	Final outcomes defined; review metric, baseline and target data for each outcome
5	Evaluation	Lead + Team	Aug 2030	Dec 2030	Evaluation, lessons learned, sustainability, reporting.

Estimated Required Funding: $62,500,000 over 5 years

Initiative: Expand and Strengthen Rural Community Health Worker Workforce

Description: This initiative will expand community health workers (CHW) and community health representatives (CHR) through training, technical assistance, and capacity building, while strengthening the workforce through sustainable reimbursement, stakeholder collaboration, and professional development. It will focus on five core activities designed to increase access to health services, grow the rural workforce, and enhance organizational capacity, education, and technical support for CHWs and CHRs.

Rural communities in South Dakota face limited access to care and follow-up services due to social determinants of health. CHWs and CHRs serve as trusted bridges between these communities and the healthcare system, helping individuals navigate care, manage chronic

conditions, connect with social services, and address social needs. These roles are especially critical in rural and frontier areas, where access is limited and trusted local relationships are essential. Specific activities include:

- **Financial Sustainability & Reimbursement Support:** Support long-term financial sustainability by assisting organizations with Medicaid claims and billing processes, establishing Medicare billing pathways for CHWs/CHRs, and supporting the integration of CHWs into organizational structures to ensure durable funding and reimbursement.
- **Integration & Awareness Building:** Enhance provider awareness of CHW/CHR roles and advance evidence-based programs for chronic disease and injury prevention. CHWs will be integrated into rural settings to expand reach and improve care coordination.
- **Technical Assistance for Program Development & Expansion:** Assist organizations in establishing and expanding CHW programs.
- **Workforce Recruitment & Retention:** Develop strategies to recruit CHWs in rural communities, create career pathways and advancement opportunities, and maintain peer learning networks and communities of practice to support retention.
- **Training, Certification, & Professional Development:** Offer cross-training and scholarship opportunities for EMS professionals, medical assistants, patient access staff, Tribal health workers, and other personnel.

Main Strategic Goal: Sustainable Access

Use of Funds: A, D, E, G

Technical Score Factors: B.1. B.2., C.1., C.2., D.3.

Key Stakeholders: Community Health Worker Collaborative of South Dakota, Lake Area Technical College, Southeast Technical College, CHW and CHR Programs

Outcomes:

1. **Expanded Workforce:** Expand CHW workforce, provide training that equips them to improve access to care and address social drivers of health in rural SD.

   Metric: Total number of individuals trained as CHWs

   Baseline: 340 individuals trained as of November 2025

   Target: Train a total of 500 individuals as CHWs by 2030

2. **Increase Certification:** Increase the number of Certified CHWs and CHRs

   Metric: Number of Certified CHWs and CHRs

   Baseline: 180 certified CHWs and CHRs as of November 2025

   Target: Certify 300 CHWs and CHRs by 2030

3. **Create New CHW Programs:** Support new CHW/CHR programs in South Dakota

   Metric: Number of CHW and CHR programs enrolled and serving Medicaid patients

   Baseline: 22 programs in November 2025

   Target: Assist 25 new programs in enrolling and serving Medicaid patients by 2029

4. **Support More Medicaid Recipients:** Expand access to CHW/CHR services for Medicaid recipients

   Metric: Number of unique Medicaid recipients receiving CHW/CHR services

   Baseline: 1,250 recipients supported in 2025

   Target: Increase to 1,750 unique Medicaid recipients by October 2029:

Impacted counties: All South Dakota Counties, 46003-46137

Stage	Key Activities	Lead / Responsible Party	Start Date	End Date	Deliverables / Milestones
0	Planning	Initiative Lead	Jan 2026	Mar 2026	Workplan approved, contractor solicited, project goals defined

1	Initial Work	Lead + Team	June 2026	Aug 2026	Staff assigned, contractor secured, training organizations secured, roles/responsibilities finalized, outreach to stakeholders begins
2	Implement	Lead, Team + Contractor	Aug 2026	Oct 2030	Outreach and expansion, implementation support, Medicaid enrollment assistance, CHW training, and quarterly and annual reporting
3	Midpoint Check	Lead, Team + Contractor	Oct 2027	Nov 2027	Report review, outreach, implementation assessment, documentation of lessons learned, and launch of sustainability efforts.
4	Goal & Objective Finalization	Lead, Team + Contractor	June 2030	Oct 2030	Outcomes defined, expansion targets set, CHWs trained/certified, Medicaid engagement achieved.
5	Evaluation	Lead, Team + Contractor	Aug 2030	Dec 2030	Evaluation, lessons learned, sustainability, reporting.

Estimated Required Funding: $3,535,176 over 5 years

Initiative: Rural Health Forward: Training and Resource Hub

Description: This initiative will establish Rural Health Forward, a resource and training hub designed to close gaps in education, training, and professional development between urban and rural healthcare providers. Designed for rural use but accessible to all, the hub will serve physicians, advanced practice providers, nurses, CHWs/CHRs, EMS professionals, doulas, and other frontline healthcare staff across South Dakota.

The hub will provide access to high-quality, evidence-based continuing education, training, and resources. It will feature on-demand learning modules, regional training events, and simulation-based experiences focused on key topics such as maternal and child health, behavioral health, emergency care, telehealth, and chronic disease prevention.

This initiative will strengthen South Dakota's rural healthcare workforce, improve care quality, and ensure that every community benefits from well-trained, well-supported professionals. A request for proposal (RFP) would be released by the SD DOH to allow a university, association, or other central coordinating group to operate the hub.

Specific activities include:

- **Platform Development:** Design and launch a statewide digital platform hosting evidence-based training modules, resources, and best practices.
- **Training and Education:** Deliver virtual and in-person training opportunities, including simulation experiences and CE/CME-accredited courses.
- **Stakeholder Engagement:** Partner with universities, health systems, and professional associations to guide content and ensure statewide relevance.
- **Evaluation and Quality Improvement:** Track utilization, training outcomes, and workforce impacts to guide continuous improvement.
- **Sustainability Planning:** Develop long-term governance and funding strategies to maintain and grow the hub beyond initial implementation.

Main Strategic Goal: Workforce Development

Use of Funds: A, D, E

Technical Score Factors: B.1, B.2, C.2

Key Stakeholders: CAHs, Independent and Community Clinics, FQHCs, RHCs, Long-Term Care and Home Health Agencies, State Universities and Medical Schools, Technical Colleges

Outcomes:

1. **Provider Training Participation**: Expand access to training for healthcare professionals across disciplines.

   Metric: Number of providers trained

   Baseline: 0 providers trained

   Target: At least 1,000 providers trained statewide by Year 3.

2. **Geographic Reach:** Ensure equitable access to training for providers in rural, frontier, and Tribal communities.

   Metric: % of rural, frontier, and Tribal counties with at least one participating provider.

   Baseline: 0%

   Target: Providers from at least 80% of rural/Tribal counties access resources by Year 3.

3. **Knowledge and Skill Improvement:** Improve clinical knowledge and application of evidence-based practices.

   Metric: Increase in participant knowledge or skill confidence based on pre-/post-training assessments.

   Baseline: Established through first training cohort (Year 1).

   Target: Demonstrate at least a 20% improvement in post-training assessment scores by Year 3.

4. **Workforce Retention and Impact:** Strengthen long-term workforce stability and provider retention in rural and underserved areas.

   Metric: Percentage of trained providers remaining in South Dakota's healthcare workforce after 12 months.

   Baseline: To be established using Year 1 tracking data.

   Target: ≥80% of trained providers remain in the workforce after one year; ≥60% continue to practice in rural or frontier areas.

Impacted Counties: All South Dakota Counties, 46003-46137

Implementation Plan:

Stage	Key Activities	Lead / Responsible Party	Start Date	End Date	Deliverables / Milestones
0	Planning	Initiative Lead	Jan 2026	Mar 2026	Workplan approved, project goals defined, RFP process initiated.

1	Initial Work	Lead	Apr 2026	June 2026	Staff assigned, contractor secured, kickoff meeting completed
2	Implement	Lead +Team	June 2026	June 2030	Stakeholder ID, training needs assessment, curriculum/platform development, CE/CME accreditation, statewide training, quarterly reporting
3	Midpoint Check	Lead	Oct 2027	Nov 2027	Interim reporting, adjustments, lessons learned, sustainability review, partnership development.
4	Goal & Objective Finalization	Lead + Stakeholders	June 2030	July 2030	Final outcomes defined, targets for education program and resource hub achieved.
5	Evaluation	Lead	Aug 2030	Dec 2030	Evaluation, lessons learned, sustainability, reporting.

Estimated Required Funding: $4,730,000 over 5 years

Keep Healthcare Access Local and Strong

Initiative: Medicaid Primary Accountable Care Transformation

Description: This initiative will implement an alternative payment model that provides flexible, capitated payments to rural primary care practices, incentivizing both providers and patients for quality outcomes while promoting shared accountability for cost and utilization.

Specific activities include:

- **Model Design & Development:** Develop payment methodology with phased options bridging fee-for-service to partial capitation, define quality measures, and establish practice transformation requirements.
- **Provider Infrastructure Support:** Offer transformation grants for care coordination, care managers, population health tools, and technology enhancements.
- **Quality Payment System:** Deploy a vendor-supported platform for real-time performance dashboards, HEDIS tracking, and year-end bonus calculations.
- **Data Analytics Infrastructure:** Implement population health tools to identify high-risk patients, track care gaps, and enable reporting and data exchange.

- **Payer Alignment Coordination:** Align payment methodologies across Medicare, commercial insurers, and Tribal health programs.
- **Practice Support & Training:** Provide technical assistance on care coordination, chronic disease management, behavioral health integration, and value-based operations.

The model strengthens rural primary care sustainability by ensuring predictable revenue that rewards quality and enables practices to maintain comprehensive services.

Main Strategic Goal: Innovative Care

Use of Funds: I, A, B, C

Technical Score Factors: E.1, E.2, B.1, B.2, E.2, F.1

Key Stakeholders: Medicaid-Enrolled Primary Care Clinics, RHCs, FHQCs, Tribal Partners, Medicaid Recipients

Outcomes:

1. **Increased Quality of Care:** Improved quality of patient care, as measured by in five primary-care centric HEDIS measures.

   Metric: HEDIS-based primary care quality measures

   Baseline: South Dakota Medicaid rates by measure (2024 data).

   Target:

   - By December 2028: Achieve a statistically significant improvement above baseline in each selected HEDIS measure at the clinic/community level.
   - By December 2030: Sustain improvements and demonstrate continued year-over-year gains in HEDIS measures across clinics, with performance compared to like facilities.

2. **Reduce Emergency Department Visits:** Decrease unnecessary emergency department utilization.

   Metric: ED visits per 1,000 member-months for ambulatory care sensitive conditions (ACSCs)

   Baseline: South Dakota Medicaid average (2024 data).

   Target:

   - By December 2028: Achieve a statistically significant reduction in unnecessary ED visits at the clinic/community level.
   - By December 2030: Maintain or further reduce unnecessary utilization, with year-over-year improvement.

3. **Improve Sustainability of Primary Care for Clinicians:** Amplify efforts to recruit/retain primary care physicians to rural/frontier locations.

   Metric: Provider burnout rate

   Baseline: National burnout rate of 43.2% (AMA, 2024); South Dakota baseline to be established via survey.

   Target: By December 2028: Reduce clinician burnout and administrative stress to at least one standard deviation below the national average.

4. **Transform South Dakota Primary Care Landscape:** Engage with stakeholder payors for alignment work

   Metric: Number of payers formally aligned on payment methodology

   Baseline: 1 (Medicaid only).

   Target: By December 2030: 4 payers

Impacted Counties: All South Dakota Counties, 46003-46137

Implementation Plan

Stage	Key Activities	Lead / Responsible Party	Start Date	End Date	Deliverables / Milestones
0	Planning	Initiative Lead	Jan 2026	Apr 2026	Workplan approved, goals defined, stakeholder engagement plan completed, RFI/RFP needs identified.
1	Initial Work	Lead	May 2026	July 2026	Staff assigned, kickoff meeting held, roles finalized, RFP completed, infrastructure funding process established.
2	Implement	Lead + Team	May 2026	Sep 2027	Vendors selected, model created, quality reporting process implemented, bridge payments for FQHC/RHCs enacted.
3	Midpoint Check	Lead	Oct 2027	Oct 2027	Case management staff hired and trained, SPA/admin changes completed, quality metrics set, lessons documented, payor alignment initiated.
4	Finalize Goal	Lead + Stakeholders	Nov 2027	Dec 2029	Final outcomes defined, model launched, payor alignment on core tenets, annual best-practices gathering held.
5	Evaluate	Lead	Jan 2030	Sep 2030	Quality and utilization data analyzed, results inform budgeting/legislation, all metrics and deliverables reported

Estimated Required Funding: $62,610,000 over 5 years

Initiative: Medicaid Rural Health Access and Quality Grants

Description: This initiative will establish Rural Health Access and Quality Grants to help rural hospitals and clinics assess and transition their service delivery models to ensure long-term access to essential healthcare. These grants will help sustain vital rural healthcare services and promote quality in clinical and operational delivery across South Dakota. Funding will support professional services such as financial, legal, and organizational change management, as well as regional assessments and partnerships that strengthen coordination and sustainability. Grants will be awarded through a competitive RFP process. Provider proposals must describe how funds will be used to maintain or expand healthcare access and improve operational performance.

Specific allowable activities include:

- **Strategic Partnerships:** Planning and developing regional partnerships or affiliations to expand specialty and maternal health access. Funds may support legal or accounting services, technical consulting, shared infrastructure, and hub-and-spoke models for specialized care.
- **Service Line Expansion:** Conducting feasibility assessments, securing technical and contracting support, and making infrastructure upgrades to expand/realign service lines.
- **Operational Efficiency:** Engaging consultants to improve staffing models, train existing personnel, and enhance revenue cycle management to reduce waste and strengthen financial performance.

Main Strategic Goal: Sustainable Access

Use of Funds: D, F, G, H, J, K

Technical Score Factors: A.3, A.7, B.1, C.1, F.1, F.2

Key stakeholders: Urban Tertiary Hospitals and Health Systems, Academic Medical Centers, Rural Hospitals, CAHs, Rural Emergency Hospitals, RHCs, FQHCs, Community Mental Health Centers, IHS/Tribal Facilities, Clinicians

Outcomes:

1. **Healthcare Access Preservation:** Ensuring essential services remain available locally

   Metric: Percentage of essential service lines maintained or expanded through grant-funded facilities (to include through telehealth and transportation coordination)

   Baseline: Number of services lines offered pre-grant (2025)

   Target: 100% of pre-existing essential services maintained; >10% of facilities expand service offerings

2. **Strategic Partnerships:** Expanding specialized care access through collaboration

   Metric: Number of new regional partnerships or affiliations established

   Baseline: 0 (new initiative)

   Target: At least one meaningful partnership per funded proposal for strategic partnerships

3. **Operational Efficiency:** Supporting sustainability through streamlined operations

   Metric: Financial performance improvement

   Baseline: Operating margin, days cash on hand, cost per adjusted patient day (2025)

   Target: 15% improvement in operating margin OR achieve positive operating margin

4. **Community Health Impact:** Improving population health to reduce crisis-driven care

   Metric: Medicaid health outcomes in grant-recipient service areas

   Baseline: Medicaid and CHIP Quality Core Set Data

   Target: 15% improvement in child and adolescent annual prevention visits; 10% improvement in chronic disease control measures

Impacted Counties: All South Dakota Counties, 46003-46137

Implementation Plan:

Stage	Key Activities	Lead / Responsible Party	Start Date	End Date	Deliverables / Milestones
0	RFP Prep	Initiative Lead	Jan 2026	Feb 2026	Draft RFP, obtain approval, form evaluation team, develop provider contracts and reporting templates.
1	RFP Execute	Lead	Mar 2026	July 2026	Issue RFP, review proposals, finalize awards, obtain signed provider contracts.
2	Fund + Monitor	Lead	Aug 2026	Jun 2028	Disperse funds, collect and review bi-annual provider progress reports.
3	2nd RFP Cycle	Lead	Jun 2028	Dec 2028	Review previous grants and reports, issue second RFP, review proposals, finalize awards, obtain contracts.

4	2nd Fund + Monitor	Lead	Jan 2028	July 2030	Disperse funds, collect and review bi-annual provider progress reports.
5	Evaluate	Lead	Aug 2030	Sep 2030	Data analysis of metrics. All deliverables reported.

Estimated Required Funding: $125,000,000 over 5 years

Initiative: Strengthening Chronic Disease Management

Description: This initiative strengthens statewide chronic disease management through four key strategies: targeted rural funding, expanded self-management programs, enhanced caregiver support, and provider training.

Specific activities include:

- **Targeted Rural Funding:** Rural hospitals, clinics, pharmacies, and schools will receive funding to implement evidence-based interventions tailored to local needs. Eligible activities include care coordination, remote patient monitoring, use of CHWs to address barriers, and screening for social drivers of health. These efforts complement and expand the Medicaid Health Home program by supporting infrastructure growth and encouraging new provider participation.
- **Chronic Disease Self-Management:** Evidence-based programs will be expanded to help individuals manage symptoms, improve daily functioning, and reduce healthcare costs. Expansion includes increasing program capacity and training more organizations to ensure sustainability and reach.
- **Caregiver Support:** Caregivers, a largely unrecognized workforce, will gain additional resources through peer support groups, coordinated resources, expanded provider training, and increased respite care availability.

- **Provider Training:** Targeted training will ensure fidelity in implementing interventions, covering topics such as remote monitoring and caregiver coordination, fostering provider engagement and sustainable impact.

The initiative also includes a pilot within the Medicaid Health Home program to test whether enhanced quality incentive payments improve health outcomes and drive further program improvements.

Main Strategic Goal: Make Rural America Healthy Again

Use of Funds: A, C, D, E, F, I, K

Technical Score Factors: B.1, B.2, C.1, F.1

Key Stakeholders: Healthcare providers in South Dakota including, but not limited to, Rural Hospitals, RHCs, FQHCs, Primary Care Clinics and Physician Practices, Community Pharmacies, Home Health Agencies, Chronic Disease Self-Management Providers, Schools

Outcomes:

1. **Reduce Hospital Readmissions:** Reduce 30-day readmission rates for patients with chronic health conditions in rural hospitals.

   Metric: 30-day readmission rate for chronic condition patients

   Baseline: To be established through the funding application process (data provided by participating hospitals)

   Target: Annual reduction in readmission rates, as reported by funded entities, with specific targets set once baseline data is collected

2. **Remote Patient Monitoring – Blood Pressure Control:** Increase the number of participants in remote patient monitoring programs achieving controlled blood pressure (<140/90), with current medication adherence and no medication changes needed.

Metric: Number of patients with controlled blood pressure

Baseline: To be established through initial program reporting by funded entities

Target: 1,000 participants with controlled blood pressure by 2030, monitored annually through funded entity reports

3. **Chronic Disease Self-Management Workshops:** Increase participation in certified chronic disease self-management workshops.

   Metric: Number of individuals completing a certified workshop

   Baseline: To be established through initial reporting by the statewide coordinating entity

   Target: 750 participants annually by 2030, monitored annually through reports from the coordinating entity

4. **Medicaid Health Home Quality Incentive Performance:** Improve outcomes on Medicaid Health Home Quality Incentive Payment metrics.

   Metric: Number of metrics (of 7) showing improved performance

   Baseline: CY 2025 performance on seven quality metrics: depression follow-up plan documented, active person-centered care plan, BMI in control, mammogram up to date, colonoscopy up to date, blood pressure in control, and appointment compliance

   Target: Improvement in at least 3 of 7 metrics by 2030, measured annually through Medicaid Health Home reporting

Impacted Counties: All South Dakota Counties, 46003-46137

Implementation Plan:

Stage	Key Activities	Lead / Responsible Party	Start Date	End Date	Deliverables / Milestones
0	Planning	Initiative Lead: SD DOH	Jan 2026	Mar 2026	Workplan, goals, stakeholder plan completed.
1	Staffing	Lead	June 2026	Aug 2026	Staff assigned, contractor secured, kickoff meeting held, roles finalized.

2	Launch	Lead + Team	Aug 2026	June 2030	EBI funding released, programs and supports implemented, provider trainings, quarterly reports.
3	Midpoint Check	Lead	Oct 2027	Nov 2027	Interim metrics report completed, adjustments made based on evaluation data, lessons learned documented.
4	Outcomes	Lead + Stakeholders	June 2030	July 2030	Targets met for chronic disease management, self-management, and caregiver support.
5	Evaluation	Initiative Lead	Aug 2030	Dec 2030	Final evaluation, lessons learned, sustainability plan submitted, all metrics reported.

Estimated Required Funding: $45,079,000 over 5 years

Initiative: **Regional Maternal and Infant Health Hubs**

Description: This initiative aims to reduce maternal and infant health disparities and improve access to high-quality care in rural and Tribal areas in South Dakota by establishing regional hubs. These hubs focus on both clinical care and broader care coordination, supported by spoke sites that integrate community social-support networks.

Specific activities include:

1. **Assessment, Planning, and Policy Alignment**: Conduct a maternal health gap, policy, and funding analysis to identify service shortages, regulatory and payment barriers, and workforce needs. Complete a landscape analysis of social services, home-visiting programs, and community-based supports for mothers and infants. Map existing maternal care providers, define care coordination pathways, and develop an ideal care coordination model.
2. **Clinical Transformation - Hub and Spoke Model:** Informed by the assessments, three healthcare entities will receive funding to design and launch regional maternal health hubs linked to local “spoke” sites. This will be a hybrid OB-Nest-style model combining in-person, telehealth, and remote monitoring prenatal and postpartum care. Funding can

be used to develop telehealth and data infrastructure, provide training and technical assistance to hub and spoke staff, and pilot, refine, and scale hub operations.

3. **Social Support Care Coordination:** Integrate social and clinical care to address non-medical barriers affecting maternal and infant health outcomes by establishing and testing a patient navigation model with hubs and spokes. Define collaboration between different members of the care team. Strengthen referral pathways for housing, behavioral health, transportation, nutrition, and home visiting services. Build data-sharing and communication systems to link social and clinical information.
4. **Community and Tribal Doula Support:** Fund and support community and Tribal organizations to develop and sustain doula programs. Integrate doulas into hub care teams.

Main Strategic Goal: Make Rural America Healthy Again

Use of Funds: A, D, E, F, G, I, K

Technical Score Factors: B.1, B.2, C.1, D.1, F.1, F.2,

Key stakeholders: Healthcare Providers including, but not limited to, Rural Hospitals, RHCs, FQHCs, Primary Care Clinics and Physician Practices, Integrated Health Systems, Indian/Tribal Health Services, Community Organizations

Outcomes:

1. **Prenatal Care Initiation:** Increase percentage of women receiving prenatal care in the first trimester

   Metric: Prenatal care visit during the first trimester (% among participating women in OB hubs)

Baseline: To be established through the funding application process (data provided by participating hospitals and clinics)

Target: 80.5% of pregnant women, to align with Healthy People 2030 goal

2. **OB Hybrid Hub and Spoke Implementation**: Increase number of pregnant and postpartum women served through the hybrid hub and spoke model

   Metric: Number of women receiving hybrid OB care

   Baseline: To be established through initial program reporting by funded entities

   Target: To be established by hub and spoke sites in their application for funding.

3. **Care Coordination and Referrals**: Increase percent of women who receive referrals to address behavioral health, housing, nutrition, and other social needs.

   Metric: Percentage of women in OB hybrid model receiving a referral for social/behavioral health needs

   Baseline: To be established through initial program reporting by funded entities.

   Target: 80% of women who had a positive social determinant of health screening receive at least one referral

4. **Doula Workforce Expansion:** Increase number of doulas in the state

   Metric: Number of trained, certified, and Medicaid verified doulas statewide

   Baseline: To be established through initial reporting through funded entity

   Target: Increase from baseline by 25% each year

Impacted Counties: All South Dakota Counties, 46003-46137

Implementation Plan:

Stage	Key Activities	Lead / Responsible Party	Start Date	End Date	Deliverables/Milestones
0	Planning	Initiative Lead: SD DOH	Jan 2026	Mar 2026	Workplan approved, goals set, engagement plan done, RFP initiated.

1	Staffing	Lead	April 2026	June 2026	Staff assigned, contractor secured, kickoff held.
2	Implementation	Lead + Team	June 2026	June 2030	Gap analysis done, pilot hub funding awarded and launched, doula training funded, quarterly metrics reported.
3	Midpoint Check	Lead	Oct 2027	Nov 2027	Interim report completed, adjustments made, lessons documented, sustainability plan started.
4	Outcomes	Lead + Stakeholders	June 2030	July 2030	Final outcomes defined, maternal and infant hub targets achieved.
5	Evaluation	Initiative Lead	Aug 2030	Dec 2030	Final evaluation completed, lessons learned, and sustainability plan submitted, all metrics reported.

Estimated required funding: $24,000,000 over 5 years

Transform Systems for Sustainability

Initiative: Integrated Behavioral Health through CCBHC & Collaborative Care

Description: This initiative will implement the Certified Community Behavioral Health Clinic (CCBHC) model statewide, ensuring comprehensive, coordinated care with same-day access, 24/7 crisis response, integrated physical and behavioral health services, and evidence-based care for special populations including veterans and perinatal populations. This initiative will also expand the Collaborative Care Model from three pilot sites to additional primary care locations statewide, integrating mental health into primary care through teams of physicians, behavioral health case managers, and psychiatric consultants. This evidence-based model improves access and quality of care for rural and frontier patients closer to home. Specific activities include:

- **Provider Capacity Building:** Support behavioral health and primary care providers in meeting CCBHC and Collaborative Care standards, including same-day access, case management, peer support, and integrated screening.

- **Crisis Services Expansion:** Establish one Mobile Crisis Team and one crisis stabilization facility per region to reduce ER use and jail holds.
- **Payment System Transformation:** Implement a Behavioral Health PPS with outcome-based incentives and provider technical assistance.
- **IT Infrastructure Development:** Create a statewide, multi-functional EHR/IT system to standardize data collection, monitor outcomes in real time, and streamline payment processes. The system will interface with provider EHRs and state Medicaid systems to support quality improvement and performance tracking.
- **Telehealth Infrastructure Enhancement:** Expand telehealth capabilities to improve access in rural and frontier areas.
- **Workforce Development**: Implement recruitment and retention strategies, training programs, and supports for both licensed professionals and paraprofessionals such as peer support specialists, CHWs, care coordinators.
- **Technical Assistance and Oversight:** Provide contractual support for grant management, CCBHC coordination, PPS implementation, and population health platforms, including care coordination, referral tracking, and analytics tools.
- **Collaborative Care Billing Codes:** Ensure coverage and implementation of Collaborative Care Model billing codes for both Medicaid and commercial insurance.

Main Strategic Goal: Make Rural America Health Again

Use of Funds: B, D, E, F, G, H

Technical Score Factors: A.1, A.2, A.3, A.4, A.5, A.6, B.1, B.2, B.4, C.1, D.1, D.2, E.1, F.1, F.2

Key Stakeholders: Behavioral Health stakeholders in South Dakota including but not limited to: Community Mental Health Centers, Substance Use Disorder Programs, Helpline Center/988, Inpatient Psychiatric Hospitals, Short-Term Crisis Stabilization Centers, RHCS, Rural Hospitals, State Office of Rural Health, Council of Community Behavioral Health, Indian/Tribal Health Services, and other ancillary behavioral healthcare stakeholders later identified.

Outcomes:

1. **CCBHC Regional Coverage:** Implement at least one CCBHC in each of South Dakota's Behavioral Health Regions.

   Metric: Operational CCBHCs per region

   Baseline: 0 CCBHCs (January 2026)

   Target: At least 2 by 2027, with full coverage of 1 per region by 2030.

2. **Timely Access to Behavioral Health Care:** Patients receive urgent care within 24 hours and follow-up within 7 days post-hospitalization or crisis.

   Metric: 24-Hour Access, 7-Day Follow-Up

   Baseline: No baseline data (new)

   Target: By December 2027: 60% of same-day access standards met and 75% of 7-day follow-ups completed and documented across all certified CCBHCs.

3. **Integrated Clinical Improvement:** Patients with co-occurring behavioral and physical health conditions receive integrated care, promoting symptom reduction and improved medication adherence.

   Metric: 6-month symptoms and medication improvement

   Baseline: No baseline data

   Target:

- By December 2026: Collect six months of baseline data to establish benchmarks.
- Achieve a 10% improvement over baseline.

4. **Timely Intervention:** Patients with newly identified mental health concerns in primary care receive prompt, team-based interventions to reduce treatment delays and support early symptom management.

   Metric: Average days from identification to first treatment intervention

   Baseline: No baseline data

   Target:

   - By December 2026: Collect six months of baseline data to establish benchmarks.
   - Achieve a 75% reduction in average days to first treatment compared to baseline.

Impacted Counties: All South Dakota Counties, 46003-46137

Stage	Key Activities	Lead / Responsible Party	Start Date	End Date	Deliverables / Milestones
0	Planning	Initiative Lead: SD DSS	Jan 202	June 2026	Workplan approved, goals defined, CCBHC framework and regional strategy completed, stakeholder engagement plan done, infrastructure and data system updates begun
1	Staffing	Lead + Team	July 2026	Dec 2026	Staff assigned, vendor secured, kickoff held, baseline data collected, benchmarks set, provider training started, provisional providers identified
2	Develop	Lead + Team	Jan 2027	June 2030	Ongoing system buildout, data collection system implemented, PPS methodology prepared, provider training continued.
3	Launch	Lead + Team	Jan 2029	June 2029	First CCBHCs operational, Collaborative Care expanded, data tracked, benchmarks achieved, adjustments made as needed.
4	Evaluate	Lead, Team + Stakeholders	June 2029	Dec 2030	Comprehensive evaluation completed, outcome targets assessed, barriers/successes reviewed, strategic adjustments made, certification and expansion accelerated, systems interconnected.

5	Sustain	Lead + Team	Oct 2030	Dec 2030	Final evaluation of all outcomes, 5-year data analyzed, sustainability and financial planning completed, efficiency and provider satisfaction assessed, lessons learned documented, findings shared, ongoing quality improvement planned.

Estimated Required Funding: $56,357,877over 5 years

Initiative: Enhancing Sustainable Emergency Medical Services

Description: This initiative will create a modern, connected, and sustainable Emergency Medical Services (EMS) system across South Dakota, ensuring timely, high-quality emergency care for all residents, including those in rural, Tribal, and frontier communities. By incentivizing establishment regional EMS hubs, integrating advanced technology, and expanding workforce development, this initiative addresses critical gaps in response times, staffing, equipment, and operational efficiency.

This initiative will also implement coordinated coverage models and telemedicine integration to improve patient outcomes, strengthen hospital partnerships, and enhance real-time data collection and sharing. These evidence-based strategies ensure residents receive lifesaving care closer to home, regardless of location.

Specific activities include:

- **Regional Hub Development:** Incentivize establishment of strategically located EMS hubs to optimize coverage, reduce response times, and coordinate advanced life support.
- **Workforce Capacity Building:** Support EMS providers through career development, simulation-based training, retention strategies, and certification programs.
- **Technology Integration:** Implement real-time data systems, telemedicine platforms, and hospital interfaces to enhance patient care and operational coordination.

- **Operational Efficiency and Cost Management:** Reduce duplication, pool resources, and streamline EMS operations to lower costs while maintaining high-quality service.
- **Technical Assistance and Oversight:** Provide support for EMS coordination, data collection, and performance tracking.

Main strategic goals: Sustainable Access

Use of funds: E, G, H

Technical Score Factors: C.2

Key Stakeholders: EMS Agencies and Associations, City and County Officials, Law Enforcement and First Responders, Healthcare Providers and Telemedicine Partners, Educators and Technical Colleges, Community Leaders in Rural and Frontier Regions

Outcomes:

1. **EMS Regional Coverage:** Establish regional EMS hubs to ensure coordinated, timely emergency response and advanced life support coverage across South Dakota

   Metric: Operational regional EMS hubs per designated region

   Baseline: 0 hubs (new)

   Target: At least 1 hub per region by 2027, with full statewide coverage by 2030
2. **Enhance EMS Data Integration & Technology Use:** Achieve seamless integration of EMS electronic patient care records with the state's health information exchange.

   Metric: Percentage of EMS agencies integrated with the State HIE

   Baseline: 0% integration (January 2026)

   Target: 100% integration in 12 months
3. **Improve EMS Response Times:** Reduce delays in emergency response.

   Metric: Percentage of 911 calls with response times exceeding 15 minutes

Baseline: 20% of calls (January 2026)

Target: Less than 10% of calls within 36 months

4. **Grow and Train the EMS Workforce:** Expand recruitment, certification, and training.

   Metric: Increase in certified EMTs/EMRs

   Baseline: Current workforce (January 2026)

   Target: 15% increase statewide within 24 months

Impacted Counties: All South Dakota Counties, 46003-46137

Implementation Plan:

Stage	Key Activities	Lead / Responsible Party	Start Date	End Date	Deliverables / Milestones
0	Planning	Initiative Lead: SD DOH	Jan 2026	Apr 2026	Workplan approved, project goals defined, stakeholder engagement plan completed, regional assessment planning approved.
1	Staff	Lead	June 2026	Aug 2026	Staff assigned, contractor secured, kickoff meeting completed
2	Implement	Lead	Aug 2026	June 2030	Launch of regional EMS assessment, identification of hub sites, integrate communications and telemedicine systems, workforce and staffing pool development, and coordination of dispatch systems.
3	Midpoint Check	Lead	Oct 2027	Nov 2027	Interim metrics report completed; adjustments made based on evaluation data; lessons learned documented
4	Finalize Goal	Lead	June 2030	July 2030	Final outcomes defined, targets for EMS hubs, training and workforce development
5	Evaluation	Lead	Aug 2030	Dec 2030	Final evaluation completed and sustainability plan submitted, all metrics and deliverables reported

Estimated Required Funding: $64,000,000 over 5 years

Implementation Plan

The SD DOH will lead designated initiatives, with the South Dakota Department of Social Services (SD DSS) taking the lead on initiatives aligned with their expertise. Overall plan

ownership resides with the SD DOH Office of Rural Health, which will oversee progress, coordinate activities, and ensure alignment with statewide rural health goals. Consultants will support the Office of Rural Health by administering and managing most initiatives, providing technical assistance, monitoring, and reporting. Each initiative will have a dedicated team, DOH-led or DSS-led, responsible for execution and reporting. Progress will be tracked against defined milestones and performance metrics, with consultants and initiative teams submitting regular updates to the Office of Rural Health.

Stakeholder Engagement

South Dakota launched this effort with comprehensive stakeholder engagement, including individual meetings with the South Dakota Association of Healthcare Organizations, the state's three major hospital systems, the Great Plains Tribal Leaders Health Board, and several provider associations. Listening sessions were also conducted in rural communities statewide and written feedback was solicited through a Request for Information. This level of engagement will continue throughout the five-year initiative, involving community health centers, hospitals, primary care providers, Tribal health organizations, patients, caregivers, advocacy groups, and community partners.

All engagement will be guided by principles of transparency, collaboration, responsiveness, and consistency to ensure diverse perspectives are represented. Stakeholders will participate through bi-annual briefings to review progress, address challenges, and gather structured input. Annual listening sessions will be held to align priorities and inform strategic adjustments. Ongoing communication via written reports and updates will be complemented by interactive consultations including surveys, focus groups, and advisory conversations as needed.

The SD DOH Office of Rural Health will coordinate engagement efforts, synthesize

stakeholder input, and communicate outcomes, while initiative leads provide regular updates, identify engagement needs, and implement feedback. Consultants will support logistics, track input, and ensure timely follow-up. All engagement activities will be documented and used to inform mid-course adjustments. Effectiveness will be measured through participation rates, stakeholder satisfaction, and the extent to which feedback shapes implementation, with engagement strategies evolving based on lessons learned and changing needs.

Sustainability Plan

South Dakota's plan is designed for long-term impact through strategic one-time investments that build enduring infrastructure and capacity. Each initiative uses non-recurring funding to establish systems, tools, and capabilities that will continue functioning well beyond the grant period. The sustainability approach focuses on three core strategies. First, one-time funds will build essential technology infrastructure and platforms that require minimal ongoing investment to maintain. Second, funding will support comprehensive staff training and recruitment efforts that create lasting workforce capacity and expertise. Third, initiatives will establish self-sustaining resources such as training hubs and resource libraries that continue serving communities through regular utilization after initial development.

These investments transform existing systems and strengthen foundational capabilities. Technology platforms will be integrated into routine operations, trained staff will remain embedded in their organizations, and newly established care delivery models will be sustained through standard billing and reimbursement mechanisms. Community health centers, hospitals, and other partner organizations will incorporate new tools and approaches into their standard practice, ensuring improvements persist as part of their operational framework.

The state will monitor sustainability indicators throughout implementation, tracking

adoption rates, utilization patterns, and integration into existing workflows. By the end of the funding period, all initiatives will have clear operational ownership, defined maintenance responsibilities, and demonstrated pathways for continued function without additional grant support. This approach ensures that temporary funding produces permanent improvements in South Dakota's rural health infrastructure.

State Policy Factors

South Dakota is committed to improving rural healthcare access through targeted policy actions.

B.2. Health and Lifestyle: South Dakota discontinued the Presidential Fitness Test when it was eliminated federally in 2013, but is eager to reinstate the test when new federal guidelines are released.

B.3. SNAP Waiver: South Dakota is not currently pursuing a SNAP waiver due to the costs and complexities of implementing a state-specific waiver but is monitoring the Healthy SNAP Act of 2025 and will adopt federal reforms when implemented.

B.4. Nutrition Continuing Medical Education (CME): South Dakota will offer optional supplemental CME in nutrition to healthcare professionals to increase the state's capacity to address nutrition-related health disparities as part of South Dakota’s Rural Health Forward Training and Resource Hub.

C.3. Certificate of Need (CON): South Dakota has no Certificate of Need (CON) laws regulating healthcare facilities. The state fully repealed its CON statute (SDCL 34-7A) in 1988.

D. 2. Licensure Compacts: South Dakota is a member of multiple licensure compacts, including:

- Physician: Interstate Medical Licensure Compact (IMLC) for physicians,

- Nurse: Nurse Licensure Compact (NLC) for nurses.
- Emergency Medical Services (EMS): United States EMS Compact for Emergency Medical Services personnel
- Psychology and Behavioral Health Professionals: Board of Psychology, Board of Social Workers, Board of Counselor Examiners.
- Physician Assistant (PA): South Dakota's PA Association has expressed interest in introducing legislation to adopt the compact within the next 2-3 years, and the South Dakota commits to supporting this effort.

D.3. Scope of Practice: South Dakota supports scope of practice policies that enable providers to practice at the top of their license and training. Current status of professions:

- Physician Assistants (PAs): Full scope of practice
- Nurse Practitioners (NPs): Full scope of practice
- Pharmacists: South Dakota asks CMS to re-consider the score for pharmacists' scope of practice, arguing the state deserves at least a 6 equating to 50 points for this technical scoring factor. Innovations in Pharmacy identifies six categories of healthcare practice that expand access to healthcare through pharmacists, which include participating in collaborative practice agreements.[37] South Dakota Codified Law 36-11-19.1(6) allows collaborative practice agreements, also referred to as protocols. In rural healthcare, this coordination as a team is vital to provide the highest quality of care to the patient. The Cicero report awards no points for utilizing collaborative practice agreements with prescribers. The Cicero report also fails to consider the telepharmacy innovation in place in South Dakota since 2007, which allows pharmacy access to rural areas where staffing is limited and can be overseen by pharmacists via audiovisual technology.

- Dental Hygienists: Semi-restricted scope of practice. Allowable tasks include supervision of dental assistants, provision of sealants, direct access to prophylaxis, and general local anesthesia. Unallowable tasks include dental hygiene diagnosis, prescriptive authority, direct Medicaid reimbursement, and dental hygiene treatment planning.

E.3. Short-Term, Limited-Duration Insurance: South Dakota's regulations for short-term limited-duration insurance are in line with federal guidelines, with current limits set at less than 12 months (364 days max) with renewals and extensions. The total duration cannot exceed 36 months.

F.1. Remote Care Services: South Dakota has strong reimbursement policies for telehealth services, including live video and remote patient monitoring, which are reimbursed by Medicaid. The state will continue to enhance its remote care infrastructure through this plan. Current policies include Medicaid payment for live video services, store-and-forward for radiology and tele dentistry, and remote patient monitoring (RPM). South Dakota also maintains a telehealth license or registration process tied to Medicaid enrollment but does not have an in-state licensing exception.

State Policy Actions Conclusion

South Dakota remains committed to strengthening rural health and largely aligns with federal policy priorities. The state will continue to stay aligned while pursuing initiatives that address the unique needs of rural and frontier communities.

Cybersecurity Plan

This CMS funding opportunity requires a cybersecurity plan only if a project involves ongoing access to HHS systems and handling of PII or PHI from HHS. South Dakota does not receive information from HHS and is not proposing initiatives that meet these criteria and has

not included a formal cybersecurity in this application. South Dakota does maintain robust cybersecurity protections through the Bureau of Information and Telecommunications and is fully prepared to comply with CMS cybersecurity requirements if future initiatives require access to HHS systems or PII/PHI.

Endnotes

[1] HRSA Federal Office of Rural Health Policy. *Rural Health Designations* (2025); U.S. Department of Agriculture. *Frontier and Remote (FAR) Area Codes* (2024).

[2] Guidehouse. (2024, July 26). *Strategic Analysis of South Dakota's Rural Healthcare Programs: Data Analysis Summary.* South Dakota Department of Health, Office of Rural Health.

[3] South Dakota Association of Healthcare Organizations (SDAHO). *Hospital Financial Condition Report.* (2024).

[4] Guidehouse. (2024, July 26). *Strategic Analysis of South Dakota's Rural Healthcare Programs: Data Analysis Summary.*

South Dakota Department of Health, Office of Rural Health; Centers for Disease Control and Prevention (CDC). *Transportation Barriers to Health Care in Rural Communities.* (2023).

[5] From 2020-2023, the state gained over 32,000 residents, a 9.6% increase, slightly faster than the national average. Rural and Tribal communities have a higher proportion of residents aged 65+, which increases the demand for chronic disease management, long-term care, and specialty services. Utilization data shows that rural and Tribal populations rely heavily on hospital outpatient departments, while urban residents more often use urgent care or ambulatory surgical centers. Telehealth has the potential to offset demand pressures, but utilization remains below peer states, especially in very rural and Tribal areas.

[6] Guidehouse. *Strategic Analysis of South Dakota's Rural Healthcare Programs: Data Analysis Summary.* (2024).

[7] HRSA Federal Office of Rural Health Policy. *Rural Health Designations* (2025).

[8] U.S. Department of Agriculture. *Frontier and Remote (FAR) Area Codes* (2024).

[9] U.S. Census Bureau. *QuickFacts: South Dakota.* (2024).

[10] Rural Health Information Hub. *Frontier Counties by Population Density (2024).*

[11] U.S. Department of Agriculture, Economic Research Service. *Rural-Urban Commuting Area (RUCA) Codes Documentation.* (2020).

[12] USDA, 2010 Frontier and Remote (FAR) Area Codes https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes/documentation

[13] U.S. Census Bureau. *QuickFacts: South Dakota.* (2024).

[14] U.S. Census Bureau. (2023). *Persistent poverty in the United States: 2023 edition* (ACS-51) https://www.census.gov/content/dam/Census/library/publications/2023/acs/acs-51%20persistent%20poverty.pdf

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[15] South Dakota Department of Labor Workforce Report: https://dlr.sd.gov/lmic/publications/labor_market_reports/workforce_report_2024.pdf

[16] Stats America, U.S Department of Economic Administration: https://www.statsamerica.org/sip/rank_list.aspx

[17] Labor Market Information Center, Economic Snapshot, South Dakota Department of Labor https://dlr.sd.gov/lmic/economic_snapshot.aspx

[18] Labor Market Information Center, South Dakota Employment Status of the Population: 25 Years and Older by Educational Attainment, South Dakota Department of Labor

[19] Behavioral Risk Factor Surveillance System (BRFSS), 2022

[20] South Dakota Department of Health Vital Statistics, 2023

[21] Behavioral Risk Factor Surveillance System (BRFSS), 2022

[22] South Dakota Department of Health Vital Statistics, 2023

[23] South Dakota Department of Health, 2023

[24] South Dakota Department of Health, Office of MCH Data Analytics & Insights. (2025a). *Analysis of reproductive-age women by rural–urban county classification in South Dakota* [Unpublished internal analysis]. Pierre, SD.

[25] Kozhimannil, K. B., Interrante, J. D., Carroll, C., Sheffield, E. C., Fritz, A. H., McGregor, A. J., & Handley, S. C. (2025). Obstetric care access declined in rural and urban hospitals across US states, 2010–22. *Health Affairs, 44*(7), 806–811. https://doi.org/10.1377/hlthaff.2024.01552

[26] Provisional SD data from 2021-2023. The SD rate is unreliable due to a small number of cases and should be considered with caution. MMRC has not completed review of 2023 cases. Historically, 85% of reviewed cases were found to be preventable. 2021-2023 US Data Source: National Vital Statistics Reports, Volume 74, Number 1, March 18, 2025, Births: Final Data for 2023

[27] South Dakota Department of Transportation. *2024 Intercity Bus and Transit Needs Report.*

[28] Guidehouse. *Strategic Analysis of South Dakota's Rural Healthcare Programs: Data Analysis Summary.* (2024)

[29] Guidehouse. *Strategic Analysis of South Dakota's Rural Healthcare Programs: Data Analysis Summary.* (2024).

[30] Stoneburner, A., Lucas, R., Fontenot, J., Brigance, C., Jones, E., & DeMaria, A. L. (2024). *Nowhere to go: Maternity care deserts across the US* (Report No. 4). March of Dimes. https://www.marchofdimes.org/maternity-care-deserts-report.

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[31] Guidehouse. *Strategic Analysis of South Dakota's Rural Healthcare Programs: Data Analysis Summary.* (2024).

[32] South Dakota Department of Health Licensure as of 10/29/2025: https://www.sdhls.org/verify/

[33] Critical Access Hospitals in Financial Distress 2020-2025. Information based off Healthcare Cost Report Information System 2024 Quarter 4 Data File (Flex Monitoring Team) updated March 2025.

[34] South Dakota Department of Social Services, 2025

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