INTEGRATED HIV PREVENTION AND CARE PLAN/ STATEWIDE COORDINATED STATEMENT OF NEED

2022 – 2026

Conducted under the auspices of the South Dakota Department of Health, Ryan White Part B and HIV Prevention Division

Submitted on

Insert Letter(s) of Concurrence

November 30, 2022

Carla Alexander-Pender

Federal Project Officer

Program Development and Implementation Branch/DHP

CDC

1600 Clifton Rd

Atlanta, GA 30333

CAPT Kathleen Edelman

Public Health Analyst

HIV/AIDS Bureau

Health Services and Resources Administration

5600 Fishers Lane

Rockville, MD 20857

Mrs. Alexander-Pender and CAPT Edelman:

Thank you for the opportunity to present the State of South Dakota's 2022-2026 Integrated HIV Prevention and Care Plan to the Centers for Disease and Control and Prevention and to the Health Resources and Services Administration.

I have reviewed the plan and find the state goals and objectives presented within aligned with local goals as well as the coordinated goals of the National HIV/AIDS Strategic Plan and the Ending the HIV Epidemic Initiative. The State's plan reflects timely and input solicited from consumer and provider stakeholders throughout the State.

The Division of Family and Community Health of the South Dakota Department of Health provides concurrence and supports submission and implementation of the State's 2022-2026 integrated plan.

Sincerely,

Beth Dokken

Beth Dokken

Division Director

Family and Community Health

November 30, 2022

Carla Alexander-Pender
Federal Project Officer
Program Development and Implementation Branch/DHP
CDC
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5600 Fishers Lane
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Mrs. Alexander-Pender and CAPT Edelman:

The South Dakota HIV Prevention Planning Group (PPG) has reviewed and concurs with the state's 2022-2026 Integrated HIV Prevention and Care Plan and finds it to be responsive to the priorities identified by the PPG and its goals align with the National HIV/AIDS Strategy.

We look forward to supporting the state's plan to reduce the spread of HIV/AIDS in South Dakota.

Sincerely,

DocuSigned by:
12/7/2022
BA10EC2DF7A8479
Seth Bieber, South Dakota Community Co-Chair

DocuSigned by:
12/7/2022
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I. EXECUTIVE SUMMARY

The South Dakota FY2022 to FY2026 Integrated HIV Prevention and Care Plan is designed to ensure resources and activities are focused and align with the goals of the National HIV/AIDS Strategy (NHAS) and the Ending the HIV Epidemic (EHE) initiative in the United States. The operational goals of South Dakota's 5-year Integrated Plan are to: Eliminate duplication of activities, expend state and federal resources, and ensure all organizations in South Dakota that are involved in HIV care and prevention are collaborating based on a single blueprint to meet EHE goals. The South Dakota Integrated Plan intends to build upon interventions identified in the previous Plan that are relevant to: a) current demographic data and trends; b) current co-occurring conditions; and c) the NHAS and EHE initiative.

The South Dakota 2022-2026 Integrated Plan reflects the contrast of demographic data from the previous plan to current demographic data in order to identify trends and new concerns to be included in this 5-year strategic plan. The evaluation of the goals and objectives from the previous plan with planning partners and community focus groups assisted in the refinement and inclusion of new goals and objectives in the 2022-2026 Plan. Existing program materials are being revised to support the 5-Year Integrated Plan and include a Resource guide and the Ryan White Part B Manual. The Manual now includes a Telehealth/Telemedicine Guide that both care and prevention providers can use with emphasis on populations of focus, based upon new surveillance data and qualitative immigration data.

The information used to refine and design the next 5-Year Integrated Plan include: the South Dakota 2022 HIV Prevention Plan; information obtained from a 2022 Strengths, Weaknesses, Opportunities, Threat (SWOT) assessment conducted with the South Dakota HIV Prevention and Planning Group (PPG); provider and client surveys; virtual Townhall focus group sessions conducted; and information from PPG meetings. Additional information for the 5-Year Plan includes material obtained from up-to-date research regarding previously unknown challenges and evidence-based strategies to achieve NHAS, EHE, and local determined strategies.

Section III outlines the requirements of the Statewide Coordinated Statement of Need (SCSN), fulfilling the epidemiologic overview, HIV care continuum, financial and human resources inventory, and data access, sources, and systems. Section IV fulfills the assessment of current needs, gaps, and barriers of the SCSN.

Alignment with the HIV National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021-2025 and the updated HIV strategy will be key to the success of each activity. The South Dakota 5-year HIV Prevention and Care Plan mirrors the pillars identified in the EHE:

- Pillar 1: Diagnose all people with HIV as early as possible
- Pillar 2: Treat people with HIV rapidly and effectively to reach sustained viral suppression
- Pillar 3: Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)
- Pillar 4: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them

Each of the South Dakota's goals match those of the EHE goals and relate to the NHAS goals as they are very similar to those of the EHE pillars.

A. The Approach

The South Dakota Ryan White HIV/AIDS Program (RWHAP) Part B Program in conjunction with the Prevention Program commissioned a consultant firm to assist in the evaluation of the previous plan and to help refine and design the next 5-year strategic plan with its partners. The approach to evaluation of the previous plan was outlined with both programs in an effort to determine how all objectives and goals in the previous plan noted successes and challenges. Both programs, in partnership with the PPG, hosted meetings to discuss the approach in evaluation of the previous plan and how the information gathered would assist the State in designing the next 5-year Plan. Outcome data was used to assess the effectiveness of the activities that were implemented for each objective and goal in the previous plan. In addition, the team reassessed the goals and objectives/strategies noted to determine the Plan's alignment with NHAS and EHE goals. The evaluation of the previous plan was imperative to determine the extent to which the previous plan goals and objectives/strategies would inform the new Integrated Plan for South Dakota.

To assist in developing goals and objectives for the new Integrated Plan, the PPG received technical assistance on developing SMART (Specific, Measurable, Obtainable, Relevant, and Time-bound) objectives that will allow for the collection of data to evaluate the effectiveness of the strategies. In the evaluation process it was determined a new needs assessment would be conducted to provide more up-to-date consumer input since the 2014 assessment. To address a more preventative inclusion, South Dakota used an innovative approach that included providers who are not RWHAP Part B/C subrecipients or HIV Prevention contractors. The intent of including non-funded providers was to gain insight into what type of collaboration for client needs are present so that the new plan is more effective in meeting NHAS/EHE goals. The PPG also received technical assistance regarding data reporting from community stakeholders regarding the progress of goals which allows timely goal revision and more effective resource allocation/conservation.

As noted previously, A SWOT analysis was performed that generated new objectives and confirmed some previous ones; one example was the importance of provider and client education in meeting new objectives. The SWOT analysis was conducted with consumer involvement, provider input, and was hosted on-site during a PPG planned strategic meeting. Two statewide Townhall meetings were conducted as an additional recruitment activity to promote discussion in the evaluation of current perceived challenges and needs from the provider, consumer, and community views. A provider survey was developed with the RWHAP and Prevention programs to gather additional qualitative information to support the strategies proposed in this plan and promote buy-in from partners. In addition, a consumer survey was drafted and promoted in the revision of the Integrated Plan process to include consumer feedback and determine additional resources and services needed to achieve viral suppression.

The use of HRSA's HIV Resources Inventory Compiler aided the approach in both evaluation of current resources and in determining additional outreach opportunities to build capacity in the State. The South Dakota Department of Health (SDDOH) only receives RWHAP Part B funds, therefore knowledge of external resources in South Dakota will help with resource conservation and adherence to payer of last resort as per HRSA HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) 21-

02. Knowledge of external resources via the inventory compiler will assist in better coordination of activities among organizations with similar goals and objectives in the new Integrated Plan. The addition of the U=U campaign for HIV prevention in the new Plan will add value of the concept of viral suppression of people living with HIV (PLWH) as a platform for HIV Prevention. The campaign offers inclusion in outreach to clients and the message to reinforce undetectable means the virus cannot be transmitted. This campaign helps validate that viral suppression is important not only for the client's health but also the role of being virally suppressed in protecting partners and the community.

B. Documents Submitted:

Documents used to meet submission requirements:

1. South Dakota 2016-2021 Integrated Plan: Evaluation of the Objectives and Goals, along with activities noted
2. 2022 HIV Prevention Plan
3. SWOT analysis results
4. NCAI Policy Research Center (2018). Research Policy Update: The Opioid Epidemic: Definitions, Data, and Solutions. National Congress of American Indians, March 2018
5. New demographic data
6. Consumer survey results
7. Provider survey results
8. Townhall – Provider and Consumer focus group results
9. Resource Guide

II. Community Engagement and Planning Process

A. Entities Involved

The 2022-2026 SDDOH Integrated Plan is the result of hours of participation, input, and effort by members of the RWHAP Part B Advisory Council, the PPG, funded and non-funded providers for HIV treatment care and prevention, case management agencies, consumers, and community members. The RWHAP Part B and Part C case managers were vital in providing access to PLWH to promote the consumer survey and consumer Townhall planning activities to gain further insight into current service needs, gaps, and barriers to care and/or access to care that limit viral suppression.

The Statewide HIV Prevention Planning Group (PPG) provided data to testing and key points of entry for PLWH, as well as their participation and involvement in the SWOT analysis conducted to evaluate the successes of the previous plan. Housing Opportunities for People Living with AIDS (HOPWA) representatives, as part of the PPG meetings, provided information that would assist PLWH with housing needs, emergency financial assistance, and provided updated materials for case managers to incorporate as part of the education provided to consumers. The medical community offered updates to the capacity issues related to substance use services and discussed advancements with telehealth/telemedicine, as well as efforts with some agencies to provide consumers with cell phones to alert them of upcoming appointments.

B. Role of the RWHAP Part A Planning Council/Planning Body

South Dakota only receives RWHAP Part B funding to include AIDS Drug Assistance Program (ADAP), and Centers for Disease Control and Prevention (CDC) Prevention funding. Additional funded resources include HOPWA, RWHAP Part C, and Community Health Centers in the local communities.

Entities included in the planning process are typically members of the South Dakota HIV Prevention and Planning Group. The following list provides detail on the specific agency and their role in the community:

1. Great Plains Tribal Chairmen's Health Board: Agency provides Native Americans support services and clinical services at the Oyate Health Center for mental health, primary care, dental care, physical therapy, and vision care; located in Rapid City, SD -- not a contracted provider. Receives Substance Abuse and Mental Health Services Administration (SAMHSA) funding for substance use prevention, mental health services and substance use disorder treatment.
2. Planned Parenthood: Provides HIV services, women's primary care, women's health services, breast cancer screening, and family planning services to men and women; located in Sioux Falls, SD -- not a contracted provider. Receives private donation funds, and Planned Parenthood Action Funds.
3. Volunteers of America Northern Rockies: Provides HIV prevention services, mental health services, veterans services, substance use treatment and community health services; located in Rapid City, SD. Currently a State of South Dakota Department of Health Prevention and Ryan White Part B subrecipient; CDC funds.

4. Falls Community Health: A Federally Qualified Health Center (FQHC) that provides primary care, dental care, mental health services, family planning services, HIV prevention, PrEP, and HIV care and case management; Located in Sioux Falls, SD. This agency is funded by RWHAP Part C and is a SDDOH Prevention Program sub-recipient -- RWHAP Part C and CDC funds.
5. Dakota Area Education and Training Center: A partner agency of the Mountain West AIDS Education Training Center (MWAETC).
6. Heartland Health Resource Center: HIV prevention subrecipient and provides HIV testing, support groups, transportation, health insurance premium assistance, and assists with ADAP applications; is located in Sioux Falls, SD; subrecipient for RWHAP Part B funds.
7. Episcopal Migration Ministries: Non-profit faith-based organization that works with the Office of Refugee Resettlement (ORR). Migration services provides intensive case management services aimed at assisting clients to achieve self-sufficiency; services are provided to minor individuals (under 18 years old), single-parent households, elderly people, LGBT clients, and HIV-positive clients; Receives federal funds from the ORR.

C. Role of Planning Bodies and Other Entities

South Dakota is a RWHAP Part B and CDC Prevention Program recipient. Two planning bodies work in collaboration with all activities to include Prevention Planning, HIV Care Continuum Planning, and the 5-year Integrated Plan. South Dakota does not receive funding for Ending the HIV Epidemic or other nationwide initiatives such as Fast Track Cities. Despite not having these additional funded programs, South Dakota continues to stay apprised with such initiatives so as to gain knowledge in best practices, expand partnerships with successful programs, and integrate successful initiatives as applicable.

The RW Part B Advisory Council includes representatives from health care providers, community organizations, Medicaid, county welfare, housing, HIV Prevention, RWHAP Part B, STD program, Community Health Centers, RWHAP Part C, HOPWA, and those infected and affected by HIV. The Part B Advisory Council discusses program areas to fund, services to provide, and funding allocations.

The HIV PPG work with community members to design a state prevention plan that best represents the prevention needs of communities at risk for or already infected with HIV. The PPG seek the participation of every community affected by HIV which include rural and urban residents; women at risk; people living with HIV; African Americans; Native Americans; and injection drug users. Planning group members and participants include department staff, community service providers, staff from statewide community-based organizations, and other concerned citizens.

D. Collaboration with RWHAP Parts

HIV Prevention Planning Group: A collaborative process through the State of South Dakota Department of Health (Prevention, STD, and RWHAP), works with community members from the entire state of South Dakota to ensure that organization members are working together to end the HIV epidemic. PPG members represent healthcare organizations, social services, community members and persons living with HIV. The PPG meets four times a year (either in person or virtually) in various locations.

The work of the PPG includes revision of the State HIV Prevention Plan to ensure that the plan includes strategies to address: Persons identified as populations of focus (Native Americans, African Americans and MSM); stigma; substance use disorder; housing; transportation; and access to care. The key stakeholders for the PPG include Ryan White Part B, Part C and CDC Prevention contractors which helps ensure that organizations that are funded by HRSA and the CDC are working together. Currently the PPG members are divided into three groups focused on the HIV Care Continuum with the responsibility of identification, implementation, and coordination of projects to move South Dakota to meeting the NHAS and EHE goals.

RWHAP Part A: South Dakota does not receive Part A funding.

RWHAP Part B: The PPG includes a member representative of Heartland Health, funded through RWHAP Part B, to provide medical and non-medical case management, health insurance assistance, early intervention services, and other allowable client services based on local needs assessments. This member participates in the HIV Care Continuum work group focused on linking persons diagnosed with HIV to care and treatment. Heartland Health is located in the Southeast part of South Dakota where 59% of the concentration of PLWH in the State are located and where 75% of enrolled Ryan White Part B clients reside.

RWHAP Part C: Falls Community Health Clinic is located in the City of Sioux Falls Health Department clinic and is a HIV care provider funded by Ryan White Part C. A representative of the Falls Community Health Clinic participates in a HIV Care Continuum workgroup focusing on persons diagnosed with HIV.

RWHAP Part D: South Dakota does not receive Part D funding.

RWHAP Part F: The AIDS Education Training Center for this region is the Mountain West AETC (MWAETC) and offers several programs to assist HIV care providers to develop capacity and expertise in HIV care. HIV Project ECHO®, practice transformation via evidence-based coaching and strategies, preceptorships for nurses, doctors, case managers and pharmacists are just a few of the programs available. The AETC also supports interprofessional education to enhance the practice of clinicians who will work in HIV care. The MWAETC has nine satellite AETC's in ten different states. South Dakota is supported directly by the Dakotas AETC (DAETC), serving North and South Dakota.

The DAETC office is located in Sioux Falls, South Dakota, and the representative is a PPG member who also participates in the workgroup for persons diagnosed with HIV. As of May 9, 2022, the Director of the HIV ECHO® Program that is operated out of the flagship site for the MWAETC agreed to open their services to South Dakota partners to participate in their HIV ECHO®. This agreement for collaboration is significant because many ECHO® sites only allow providers from their own state to participate in ECHO® programs. Participation in the University of Washington HIV ECHO® program, offered in a collaborative environment, could be an opportunity for growth in the number of HIV healthcare providers practicing in South Dakota, provide orientation support for current providers new to HIV care, and assist with educational opportunities to support healthcare provider staff in gaining experience serving HIV patients and/or clients.

E. Engagement of People with HIV

The South Dakota HIV/AIDS Prevention Program and the Ryan White Part B Office continually elicit feedback from PLWH and providers of services to PLWH to inform the planning of services, strategies and activities needed to decrease service gaps, barriers and needs, and to achieve optimal success in viral load suppression and capacity building. The following describes the ways that PLWH and were engaged in the design of the 2022-2026 HIV Integrated Prevention and Care Plan.

2022 SDDOH Consumer and Provider Needs Assessment Surveys

In 2022, with input from a diverse representation of PPG contributors, two needs assessment surveys were developed and conducted state-wide to support the goals of the NHAS/EHE: 1) The SDDOH Consumer Needs Assessment for PLWH and 2) the SDDOH Provider Needs Assessment for providers of services to PLWH. The surveys were offered through SurveyMonkey® during the months of July and August. The 2022 needs assessment surveys supplemented and updated data received from the State's last comprehensive needs assessment conducted in 2014. Consumer and provider needs also are assessed through continual input via agency surveys, advisory council meetings, and stakeholder feedback.

SDDOH Consumer Needs Assessment Survey

The consumer survey was designed to solicit feedback from PLWH who are in care, newly diagnosed, and out of care. The survey included questions from the 2014 survey to ensure the availability of comparison data, and to provide a broad picture of client needs ranging from HIV testing, STI testing, and mental health assessment/diagnosis.

In addition, new questions were included, derived from preliminary data presented in an April 2022 meeting of the PPG, current literature on barriers to HIV care, and other issues unique to the state of South Dakota.

New areas of inquiry in the 2022 assessment included the following subjects:

- Native American population: National data on HIV in Native Americans demonstrates that Native Americans are disproportionately affected by HIV and have lower viral suppression rates. The 2021 data indicates that Native Americans frequently reside in regions lacking HIV care and prevention providers. To address this inequity, data was needed that describes the experiences of South Dakota's Native American population in the current system of HIV and with general medical care.
- Gender data: Gender data was considered important to planning for future interventions in the State of South Dakota, however neither the current demographic data for PLWH in South Dakota nor the available national data provides information on transgender clients.
- Transportation: The surveys included questions relevant to transportation, including the distance consumers travel to obtain HIV medical care and the methods of transportation used. Transportation was noted in literature and in the previous plan as a barrier to care. In South Dakota's current system, HIV care providers are located at opposite ends of the state, making data regarding transportation challenges particularly relevant.
- Telemedicine/Telehealth: As a follow-up to the previous plan regarding the use of telehealth, more in-depth questions about consumer experiences were included in the survey to assess

telehealth utilization and internet access. Telehealth was viewed as important to overcoming travel barriers and otherwise providing enhanced access to care.

- Complementary medicine: Research shows the potential for unexpected drug-to-drug interactions between supplements and antiretroviral medications, decreasing the likelihood of medication adherence. In addition, information about the types and utilization of tribal healing practices in South Dakota's American Indian/Alaska Native population could assist providers in understanding and communicating respect for the individual's belief system and adjusting their approach to care accordingly.

SDDOH Provider Needs Assessment Survey

The provider survey was designed to solicit data from HIV medical care providers, case managers, and other providers of services to PLWH. Subject matter included in this survey focused on consumer needs, services, and barriers from the providers' perspective, including STI screening, challenges to the provision of behavioral health and substance use assistance. Questions, where relevant, mirrored the consumer survey (e.g., telehealth, transportation barriers, complementary medicine). Survey questions were derived from feedback during the April 2022 meeting of the PPG, current literature on barriers to HIV care, and issues unique to the state of South Dakota.

Virtual Town Halls-Focus Groups

In addition to the quantitative needs assessment surveys, two virtual Town Halls were held on June 29, 2022:

1) Health Professionals and Stakeholders Session and

2) Consumer and Community Session.

Each session offered a brief visual data presentation to convey where priority populations reside as it relates to where they receive care. To emphasize a status neutral approach, data was also given to show where South Dakotans may receive testing, PrEP, and be linked to care if found positive. Robust discussion was held among both groups to elicit opinions and concerns focused on both **care** and **prevention**. The comprehensive overview can be found in **Appendix B**.

Both sessions were open to anyone in the community, which also encompassed persons living with HIV and others who wanted to be a part of the process for creating the Integrated Plan. Challenges identified during these meetings that will be addressed in the Plan's objectives are:

- Perception that there is a lack of substance abuse treatment options, specifically for in-patient
- Lack of PrEP education, awareness, and support among clinicians and/or health institutions leading to fewer providers willing or able to prescribe PrEP.
- Inability to establish needle exchange programs due to jurisdictional legislation
- Physical distance to available care providers in rural South Dakota
- Inconsistent appointment attendance
- Client utilization of available local transportation options

Priority Setting and Resource Allocations

In addition to participation in the PPG, all Ryan White Part B clients are invited to attend the South Dakota Ryan White Part B/ADAP Advisory Council meeting, with in-person and virtual options

available. For those clients that may not be able to attend, the RW Office encourages clients to submit comments, concerns, or questions to the program manager before the meeting. The RW Part B Advisory Council includes representatives who are living with or affected by HIV. The entire council is invited to take an active role in the development and implementation of Part B funding. The Part B Advisory Council reviews year-end data and discusses program areas to fund, services to provide, and funding allocations. This process is also known as the Priority Setting and Resource Allocations (PSRA). The Department of Health then follows the Advisory Council's recommendations unless forbidden by federal guidelines.

Development of goals and objectives

The task of developing the goals and objectives is the responsibility of members from the PPG, Advisory Council, and the SDDOH. Members of the community, including PLWH, either serve on these committees or act in a capacity to advise them. PLWH are involved by providing their expert opinion and experience, which inform the development or revision of Integrated Plan strategies to ensure relevance and effectiveness. When monitoring and evaluating the strategies, their feedback guides proposed changes for the greatest impact on achieving desired outcomes.

F. PRIORITIES

During the planning and community engagement process of the Integrated Plan, priorities were determined as a result of three methodologies described below.

Comparison of previous Integrated Plan Data and Needs Assessment with current Data and Needs Assessment.

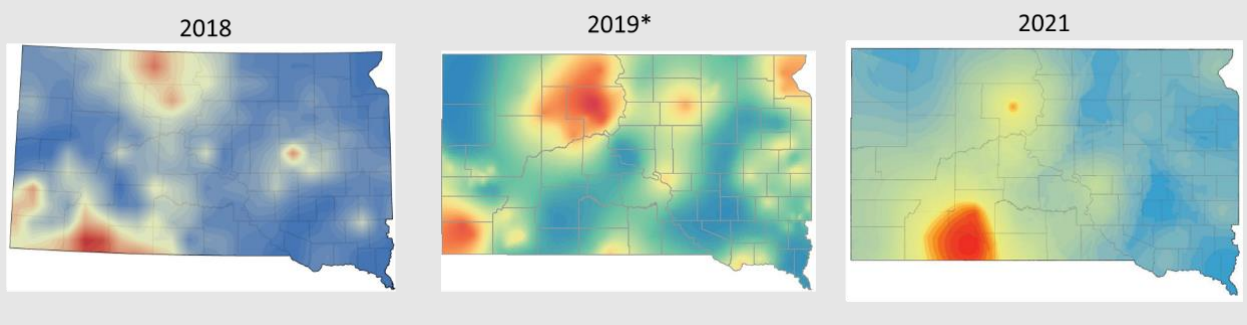
It was essential to know how the identified needs from the 2022 Needs Assessment compared to that of the 2014 Needs Assessment in order to a) identify focus areas that require more attention if they are continual needs, b) identify new areas of focus that were not identified in the 2014 assessment, and c) capture practices implemented in the 2016 Integrated Plan that have had successful outcomes that can be expanded. Surveillance data identified populations most affected by HIV as males, Black/African Americans, American Indian/Alaska Natives, individuals who are foreign-born, individuals aged 24-65 years, and individuals living in the southeastern and western regions of the state, as described in the 2016 Integrated Plan. This data also identified behavioral risk factors among those most affected by HIV including high risk heterosexual contact, men who have sex with men, and injection drug use. Those who engaged in injection drug use resided primarily in the southeastern and western regions of the state.

Surveillance data as of December 2021 shows that the following populations continue to be most affected by HIV: males, Black/African Americans, American Indian/Alaska Natives, individuals who are foreign born, and individuals aged 25-39 years. This data also shows that high risk heterosexual contact, men who have sex with men, and injection drug use remain behavioral risk factors among those most affected by HIV in South Dakota.

HIV-positive individuals who achieve and maintain an undetectable or suppressed viral load (<200 copies/mL) are unable to transmit HIV to an uninfected person. Figure 1 displays the viral suppression of PLWH in South Dakota. The 2019 and 2020 heat maps reflected the same geographic images; therefore only 2019 is shown here. Areas in red indicate where a higher proportion of non-

virally suppressed individuals reside, whereas areas in blue indicate where a higher proportion of virally suppressed individuals reside.

Figure 1. Viral suppression map, South Dakota, 2018-2021.



Areas in red indicate where a higher proportion of non-virally suppressed individuals reside, whereas areas in blue indicate where a higher proportion of virally suppressed individuals reside.
Source: https://doh.sd.gov/diseases/infectious/HIV-AIDS/Prevention.aspx.

SWOT analysis

During the quarterly meeting of the PPG in April 2022, consultants from Health Access, LLC guided discussions with attendees in conducting a SWOT analysis to determine perceived strengths, weaknesses, opportunities, and threats related to both HIV Prevention and Care in South Dakota. The complete responses from the discussion can be found in **Appendix B**.

A few areas of importance that will be incorporated in the objectives per each category are:

Care

- Strengths: South Dakota HIV data is comprehensive; efficient linkage to care; Ryan White Part B case management agencies are located on both the East and West side of the state offering services to clients statewide.
- Weaknesses: More HIV care providers are needed; long driving distances to get to HIV services; HIV stigma; lack of staff time and culturally competent case managers.
- Opportunities: Many grants available; telemedicine is available; there is strategic planning between RW, HIV Prevention, and STI/STD programs.
- Threats: Lack of thorough follow-up; political climate; lack of concern by HIV care providers; lack of substance use disorder (SUD) treatment services.

Prevention

- Strengths: Many advertisements to address stigma; HIV testing is provided at no cost; PrEP is available; HIV Testing is active; partner services for clients who have tested positive.
- Weaknesses: Lack of HIV prevention providers on Native American reservations; not working with minorities; lack of condom distribution sites; cannot educate in schools; not enough outreach at public events.
- Opportunities: Many education partners exist; statewide internet access; Mobile HIV/STI testing unit; can partner with AETC for education.
- Threats: Conservative state politics; Stigma; Lack of privacy in accessing health services in rural settings; male vs female valuation; Cultural influence and conflicting education for immigrant/refugee populations.

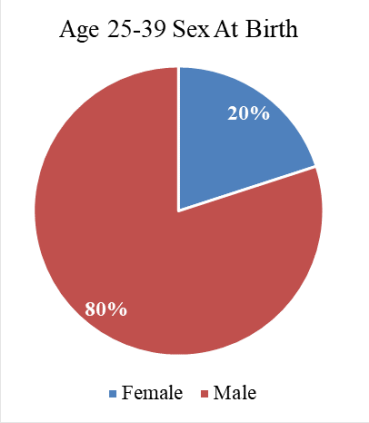
G. Analysis of Consumer Survey Responses for Priority Populations

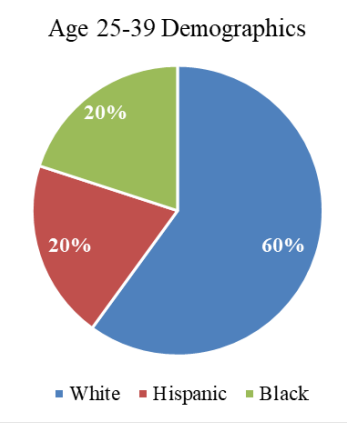
Below is an analysis of the survey responses per **demographic** priority population:

Cohort: age 25-39 years

The following graphs and tables show the outcomes from the consumer needs assessment for the cohort ages 25-39. Approximately 12% (n=5) of all consumer respondents are aged 25-39 years. All identified as heterosexual.

Figure 2. Demographic characteristics of individuals interviewed for consumer needs assessment.





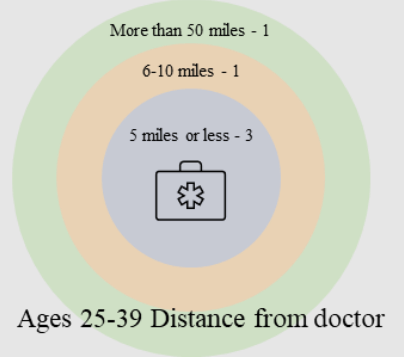


Table 1. Aged 25-39 Years Needs Assessment Results		
What would make it easier for you to get tested for HIV/STIs, or test more often? (Top responses) n=5		
Faster results	More free testing locations/clinics	
Telehealth testing	Testing available at medical care provider/doctor's office	
Vouchers for free tests	Testing available at hospital/emergency room	
Number of respondents who have been tested for Hepatitis B in the past 12 months		4
Number of respondents who tested positive for an STI		1
I tested positive for HIV in the past 12 months		2
I tested positive for HIV more than 12 months ago		3
If you did not get tested for STIs or ever delayed getting tested, what were your reasons? (n=1)		
Did not think I was at risk for getting an STI	Fear of positive diagnosis	Fear of what other people might think (stigma)
Concerned about being judged by medical care provider	Concerned about confidentiality	Concerned about cost of test
No health insurance	Did not know where to get tested	No reliable transportation to testing site
As a person living with HIV, what are your most important needs? (Top responses) n=5		
HIV medications (5)	Health insurance (4)	
HIV medical care provider (3)	Dental care (3)	Financial assistance (3)
What are the top services you use to stay in care for your HIV? (Top responses) n=5		
HIV medications (5)	HIV medical care provider (4)	
Dental care (3)	Health insurance (3)	
What are services that you need but are hard to get? (Top responses) n=5		
HIV medications (2)	Dental care (2)	Financial assistance (2)
What are services that you need that you cannot get? (Top responses) n=5		

HIV medications (1)	Housing assistance (1)	
Food assistance (1)	Financial assistance (1)	
When is the last time you attended an appointment with your HIV medical care provider or received HIV lab work (CD4 or viral load test)? n=5		
During the past 12 months	5	
Have you been diagnosed by a mental health provider with a mental health condition? n=5		
No, I am not in need of mental health services		3
No, but I think I am in need of mental health services		1
Yes, but I am not receiving care		1
Have you been diagnosed by a mental health provider with a substance use disorder? n=5		
No, I am not in need of substance use services		5
In the past year, have you used any of the following substances without a prescription from a medical or mental health provider? n=5		
Alcohol (4)	Marijuana (1)	
Tobacco (cigarettes, vape, chewing) (3)	Prescription pain killers / opiates (1)	
I have personal internet (Wi-Fi) at my home, on my own device (computer, phone, tablet) and am familiar with different forms of apps to video chat/conference	5	
Would you be comfortable seeing your medical care provider or case manager using telehealth/telemedicine?	Yes	3

Cohort: Black/African Americans

The following graphs and tables show the outcomes from the consumer needs assessment for the cohort Black/African American. Approximately 12% (n=5) of the total respondents fall in this demographic. Four identified as heterosexual and one preferred not to disclose.

Figure 3. Demographic characteristics of Black/African Americans interviewed for consumer needs assessment.

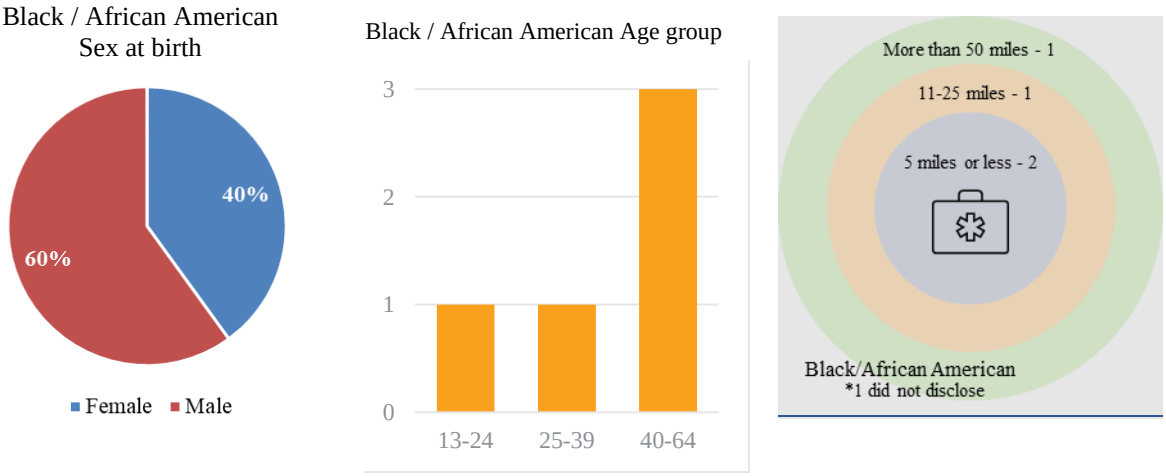


Table 2. Black/African American Needs Assessment Results		
What would make it easier for you to get tested for HIV/STIs, or test more often? (Top responses) n=3		
HIV and STI testing available at the same time (1)	Faster results (1)	More discrete testing location (1)
More free testing locations/clinics (1)	Transportation to testing location (1)	Closer distance to testing location (1)

HIV testing at health fairs (1)	At home test kits (1)	At home test kits (1)
Vouchers for free tests (1)	Testing available at hospital/emergency room (1)	

Number of respondents who have been tested for Hepatitis B in the past 12 months	0
Number of respondents who tested positive for an STI	1
I tested positive for HIV in the past 12 months	1
I tested positive for HIV more than 12 months ago	2

If you did not get tested for STIs or ever delayed getting tested, what were your reasons? n=3		
Did not have symptoms of an STI (1)	Did not think I was at risk for getting an STI (1)	Fear of positive diagnosis (1)
Fear of what other people might think (stigma) (1)	Concerned about being judged by medical care provider (1)	Concerned about confidentiality (1)
Concerned about cost of test (1)	No health insurance (1)	Did not know where to get tested (1)
N/A (1)	No reliable transportation to testing site (1)	

Have you tested for HIV in the past 12 months? n=5	Yes	4
	No	1

What was the main reason you decided to get tested? n=5		
Felt sick (2)	No reason (1)	I get tested regularly (1)

If you did not get tested for HIV or ever delayed getting tested, what were your reasons? n=3	
Did not have symptoms of HIV	Did not think I was at risk for getting HIV
As a person living with HIV, what are your most important needs? (Top responses) n=3	
HIV medications (3)	HIV medical care provider (2)
Case Management (2)	Dental care (2)
Food assistance (2)	Financial assistance (2)
Health insurance (2)	Medical Nutrition Therapy/Dietician services (2)
What are the top services you use to stay in care for your HIV? (Top responses) n=3	
HIV medications (3)	HIV medical care provider (2)
Dental care (2)	
What are services that you need but are hard to get? (Top responses) n=3	
Counseling/Mental health treatment (1)	Financial assistance (1)
Health insurance (1)	None (1)
What are services that you need that you cannot get? (Top responses) n=3	

Financial assistance (1)	Health insurance (1)	None (1)

When is the last time you attended an appointment with your HIV medical care provider or received HIV lab work (CD4 or viral load test)? n=3	
During the past 12 months	3
Have you been diagnosed by a mental health provider with a mental health condition? n=3	
No, but I think I am in need of mental health services	1
Not sure	1
No, I am not in need of mental health services	1
Have you been diagnosed by a mental health provider with a substance use disorder? n=3	
No, I am not in need of substance use services	3

In the past year, have you used any of the following substances without a prescription from a medical or mental health provider? n=3		
Tobacco (cigarettes, vape, chewing) (1)	Alcohol (1)	Prescription pain killers / opiates (1)

I have personal internet (Wi-Fi) at my home, on my own device (computer, phone, tablet) and am familiar with different forms of apps to video chat/conference n=3	2

Don't know how to use Internet n=3	1	
Would you be comfortable seeing your medical care provider or case manager using telehealth/telemedicine? N=3	Yes	1
	No	1
	Don't know how to use Internet	1

Cohort: American Indians/Alaskan Natives

The following graphs and tables show the outcomes from the consumer needs assessment for the cohort American Indians/Native Americans. Approximately 14% (n=6) of all respondents fall in this demographic.

Figure 4. Demographic characteristics of American Indians interviewed for consumer needs.

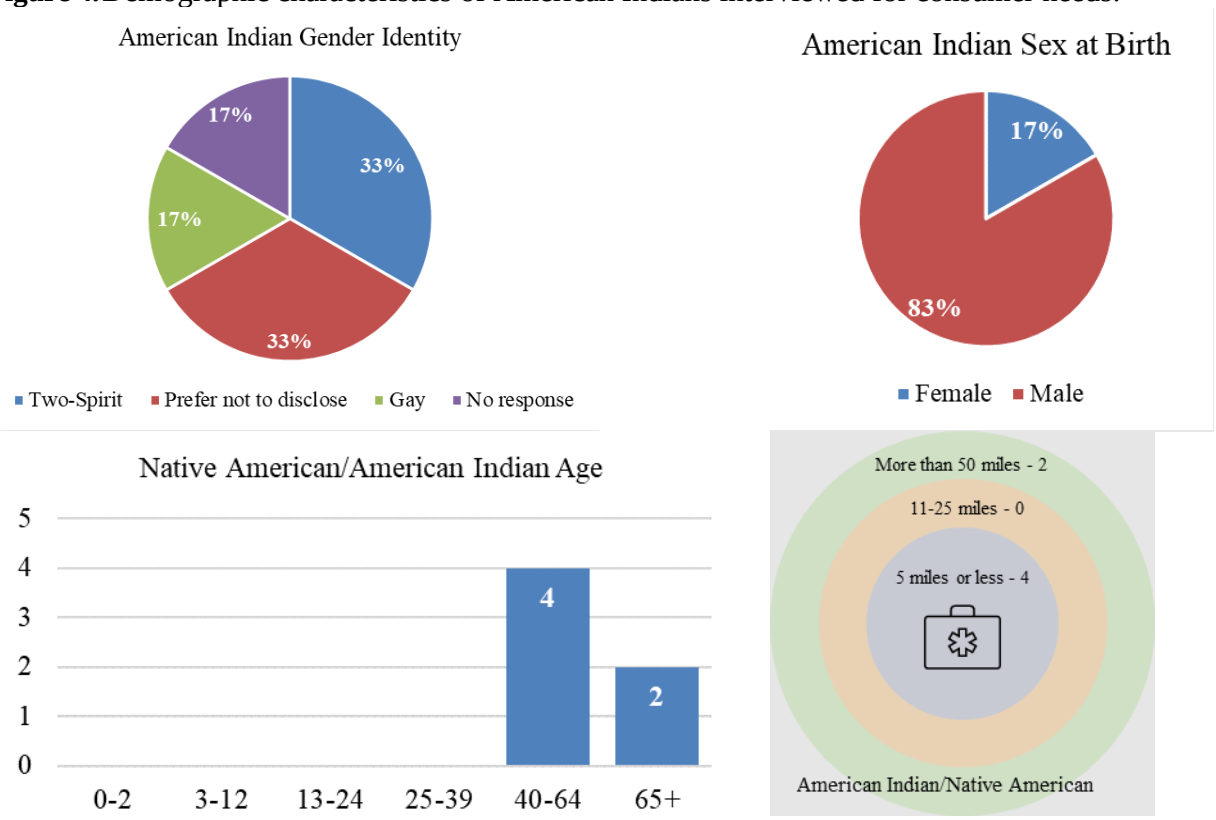


Table 3. American Indian/Alaska Native Needs Assessment Results			
What would make it easier for you to get tested for HIV/STIs, or test more often? (Top responses) n=4			
HIV and STI testing available at the same time (4)	Closer distance to testing location (4)	More discrete testing location (4)	
More free testing locations/clinics (4)	Transportation to testing location (4)	Testing available at medical care provider/doctor's office (4)	
Testing available at hospital/emergency room (4)	Texts or other automatic reminders (3)	Vouchers for free tests (3)	
HIV testing at health fairs (4)	Mobile testing (4)	Faster results (4)	At home test kits (4)

Number of respondents who have been tested for Hepatitis B in the past 12 months n=3			3
Number of respondents who tested positive for an STI n=3			0
I tested positive for HIV in the past 12 months n=6			1
I tested positive for HIV more than 12 months ago n=6			5
What was the main reason you decided to get tested? n=4			
I get tested regularly (2)	Gym membership (1)	Sex with someone who has HIV (1)	
If you did not get tested for HIV or ever delayed getting tested, what were your reasons? n=4			
Don't know (1)	N/A (4)		
As a person living with HIV, what are your most important needs? (Top responses) n=6			
HIV medical care provider (4)	HIV medications (4)		
Case Management (2)	Counseling/Mental health treatment (2)		
Support groups (2)	Dental care (2)		
Housing assistance (2)	Financial assistance (2)		
What are the top services you use to stay in care for your HIV? (Top responses) n=6			
HIV medications (5)	Case Management (5)		
Food assistance (3)	HIV medical care provider (3)	Housing assistance (3)	
What are services that you need but are hard to get? (Top responses) n=6			
HIV medical care provider (1)	Transportation to HIV care (1)		
Support groups (1)	Food assistance (1)		
Financial assistance (1)	None (1)		
What are services that you need that you cannot get? (Top responses) n=6			
Support groups (1)	Food assistance (1)		
Financial assistance (1)	None (3)		
When is the last time you attended an appointment with your HIV medical care provider or received HIV lab work (CD4 or viral load test)? n=6			
During the past 12 months	6		
Have you been diagnosed by a mental health provider with a mental health condition? n=6			
Yes, and I am receiving care			1
Not sure			1
No, I am not in need of mental health services			4
Have you been diagnosed by a mental health provider with a substance use disorder? n=6			
No, I am not in need of substance use services			5
Not sure			1
In the past year, have you used any of the following substances without a prescription from a medical or mental health provider? n=6			
Tobacco (cigarettes, vape, chewing) (3)	Alcohol (2)		
Amphetamines / methamphetamines (1)	Prescription pain killers / opiates (1)		
I have personal internet (Wi-Fi) at my home, on my own device (computer, phone, tablet) and am familiar with different forms of apps to video chat/conference n=6			6
Would you be comfortable seeing your medical care provider or case manager using telehealth/telemedicine? n=6		Yes	1
		No	4
		Don't know	1

The following is a brief analysis of the survey responses per **behavioral demographics** priority population:

Cohort: Men Who Have Sex With Men

The following graphs and tables show the outcomes from the consumer needs assessment for the cohort men who have sex with men (MSM) to include those who identify as two-spirit. Approximately 16% (n=7) of the total respondents fall in this demographic.

Figure 5. Demographic characteristics of men who have sex with men interviewed for consumer needs

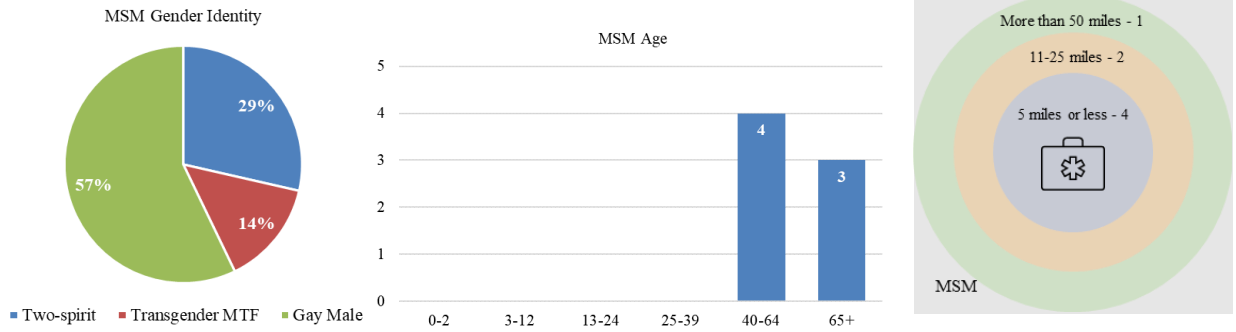


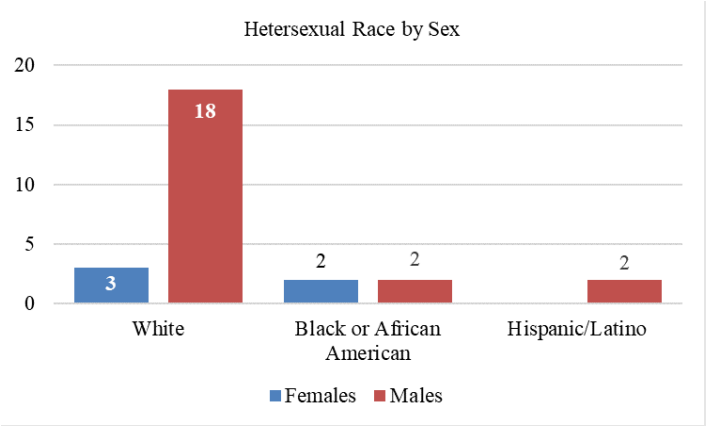
Table 4. MSM Needs Assessment Results					
Have you tested for HIV in the past 12 months? n=7				Not sure	1
				Yes	3
				No	3
What was the main reason you decided to get tested? n=7					
I get tested regularly (3)			N/A (4)		
Already tested positive and on meds (1)			I already have HIV (1)		
What would make it easier for you to get tested for HIV/STIs, or test more often? (Top responses) n=6					
HIV and STI testing available at the same time (5)		More free testing locations/clinics (5)		Closer distance to testing location (5)	
Mobile testing (5)	At home test kits (5)		Vouchers for free tests (4)		Faster results (4)
Testing available at medical care provider/doctor's office (5)		Texts or other automatic reminders (4)		Transportation to testing location (4)	
Testing available at hospital/emergency room (4)		More discrete testing location (4)		Telehealth testing (4)	
Number of respondents who have been tested for Hepatitis B in the past 12 months n=7				4	
Number of respondents who tested positive for an STI n=7				0	
I tested positive for HIV in the past 12 months n=7				1	
I tested positive for HIV more than 12 months ago n=7				6	
What was the main reason you decided to get tested? n=3					
I get tested regularly (3)					
If you did not get tested for HIV or ever delayed getting tested, what were your reasons? n=3					
N/A (3)					

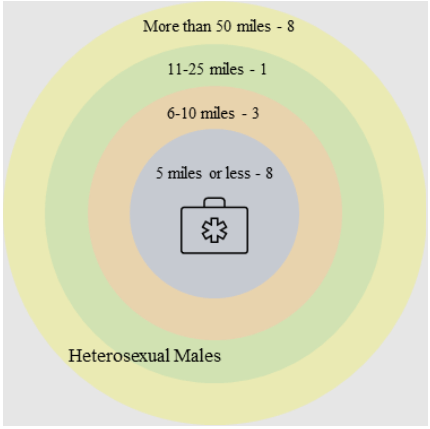
As a person living with HIV, what are your most important needs? (Top responses) n=7			
HIV medical care provider (6)		HIV medications (6)	
Case Management (3)		Housing assistance (3)	
What are the top services you use to stay in care for your HIV? (Top responses) n=7			
HIV medications (6)		HIV medical care provider (5)	
Case Management (5)	Housing assistance (4)		Food assistance (4)
What are services that you need but are hard to get? (Top responses) n=7			
Transportation to HIV care (1)		Food assistance (1)	
Financial assistance (1)		Health insurance (1)	
What are services that you need that you cannot get? (Top responses) n=7			
Financial assistance (2)		Food assistance (2)	
When is the last time you attended an appointment with your HIV medical care provider or received HIV lab work (CD4 or viral load test)? n=7			
During the past 12 months		7	
Have you been diagnosed by a mental health provider with a mental health condition? n=7			
Yes, and I am receiving care	2	No, I am not in need of mental health services	5
Have you been diagnosed by a mental health provider with a substance use disorder? n=7			
No, I am not in need of substance use services			7
In the past year, have you used any of the following substances without a prescription from a medical or mental health provider? n=7			
Alcohol (2)	Tobacco (cigarettes, vape, chewing) (1)		Marijuana (1)
I have personal internet (Wi-Fi) at my home, on my own device (computer, phone, tablet) and am familiar with different forms of apps to video chat/conference n=7			7
Would you be comfortable seeing your medical care provider or case manager using telehealth/telemedicine? n=7		Yes	2
		No	5

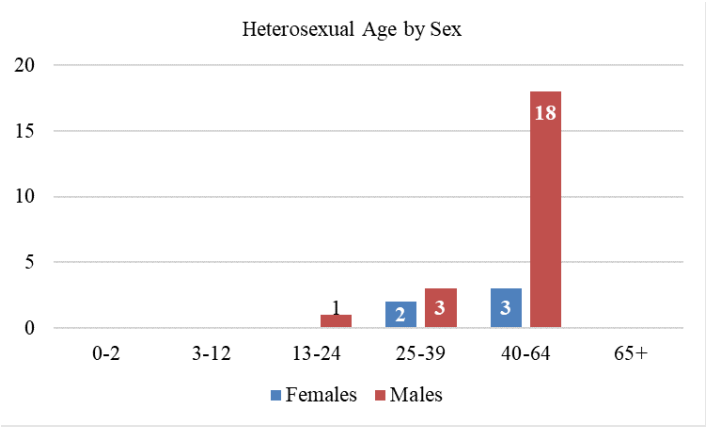
Cohort: Heterosexual (by sex at birth):

The following graphs and tables show the outcomes from the consumer needs assessment for the cohort heterosexual. For this cohort, only those who indicated specifically they are cisgender or heterosexual were included.

Figure 6. Demographic characteristics of heterosexuals interviewed for consumer needs







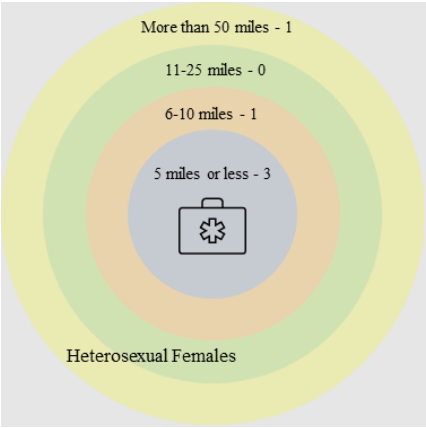


Table 5. Heterosexual Needs Assessment Results							
Have you tested for HIV in the past 12 months? (Females n=5; Males n=22)							
Yes	F: 1 | M: 13	No	F: 4 | M: 8	Not sure	F: 0 | M: 1		
What was the main reason you decided to get tested?							
Females (n=5)	Felt sick (1)						
Males (n=22)							
Felt sick (1)	I get tested regularly (9)			Sex with someone who might have HIV (1)			
No reason (1)	HIV positive testing viral load (1)			I'm undetectable and get tested regularly… (1)			
If you did not get tested for HIV or ever delayed getting tested, what were your reasons?							
Females (n=5)	N/A (1)						
	Already have (1)						
Males (n=10)							
Did not have symptoms of HIV (2)	Did not think I was at risk for getting HIV (2)			Fear of what other people might think (stigma) (1)			
No health insurance (1)		Already positive (8)					
What would make it easier for you to get tested for HIV/STIs, or test more often? (Top responses) (Females n=2; Males n=19)							
Faster results	F: 2 | M: 11	More discrete testing location	F: 2 | M: 10				
Mobile testing	F: 2 | M: 6	HIV testing at health fairs	F: 2 | M: 6				
At home test kits	F: 2 | M: 11	Telehealth testing	F: 2 | M: 5				
HIV and STI testing available at the same time	F: 2 | M: 13	Testing available at medical care provider/doctor's office	F: 2 | M: 14				
Testing available at hospital/emergency room	F: 2 | M: 9	Testing available at places where I socialize	F: 2 | M: 4				
Texts or other automatic reminders	F: 2 | M: 7	Closer distance to testing location	F: 2 | M: 8				
More free testing locations/clinics	F: 2 | M: 13	Transportation to testing location	F: 2 | M: 8				
Vouchers for free tests	F: 2 | M: 9						
Number of respondents who have been tested for _____ in the past 12 months (Females n=3; Males n=20)							
Gonorrhea	F: 3 | M: 6	Chlamydia	F: 3 | M: 8				
Syphilis	F: 2 | M: 9	Hepatitis B (HBV or Hep B)	F: 2 | M: 8				

Hepatitis C (HCV or Hep C)	F: 2 | M: 6	Sexually transmitted infection, but I don't remember the type	F: 3 | M: 4
No, I have not been tested for any of these		F: 3 | M: 7	
If tested, number of respondents who tested positive for an STI		No	F: 2/3 | M: 11/14
		Yes	F: 1/3 | M: 3/14
I tested positive for HIV in the past 12 months		F: 1/4 | M: 2/20	
I tested positive for HIV more than 12 months ago		F: 3/4 | M: 18/20	
As a person living with HIV, what are your most important needs? (Top responses)			
Females (n=4)			
HIV medications (4)		Dental care (4)	
Health insurance (3)	HIV medical care provider (3)	Financial assistance (3)	
Males (n=20)			
HIV medications (19)		HIV medical care provider (16)	
Dental care (13)		Health insurance (12)	
What are the top services you use to stay in care for your HIV? (Top responses)			
Females (n=4)			
HIV medications (4)	Dental care (3)	HIV medical care provider (3)	
Males (n=20)			
HIV medications (19)		HIV medical care provider (16)	
Dental care (14)		Health insurance (12)	
What are services that you need but are hard to get? (Top responses)			
Females (n=4)			
Counseling/Mental health treatment (1)	Dental care (1)	Concern about how HIV is going to affect my future career. Stigmatization and rejection. (1)	
Food assistance (1)	Traditional/Native healing (1)	Housing assistance (1)	
Males (n=20)			
Dental care (9)	Financial assistance (8)	Food assistance (5)	
What are services that you need that you cannot get? (Top responses)			
Females (n=4)			
Dental care (1)		Housing assistance (1)	
Food assistance (1)		Traditional/Native healing (1)	
Males (n=20)			
Financial assistance (5)		Dental care (4)	
Housing assistance (4)		Food assistance (4)	
When is the last time you attended an appointment with your HIV medical care provider or received HIV lab work (CD4 or viral load test)? (Females n=5; Males n=20)			
During the past 12 months		F: 5 | M: 20	
Have you been diagnosed by a mental health provider with a mental health condition? (Females n=5; Males n=22)			
Yes, and I am receiving care			F: 1 | M: 8
Yes, but I am not receiving care			F: 1 | M: 2
No, but I think I am in need of mental health services			F: 1 | M: 1
No, I am not in need of mental health services			F: 2 | M: 10
Have you been diagnosed by a mental health provider with a substance use disorder?			
No, I am not in need of substance use services			F: 5 | M: 19
No, but I think I am in need of substance use services			F: 0 | M: 1
Yes, and I am receiving care			F: 0 | M: 2

In the past year, have you used any of the following substances without a prescription from a medical or mental health provider? (Females n=5; Males n=22)			
Alcohol	F: 2 | M: 16	Tobacco	F: 3 | M: 10
Prescription pain killers / opiates	F: 1 | M: 1	Marijuana	F: 1 | M: 8
Amphetamines / methamphetamines	F: 2 | M: 2	Cocaine	F: 1 | M: 1
I have personal internet (Wi-Fi) at my home, on my own device (computer, phone, tablet) and am familiar with different forms of apps to video chat/conference			F: 4 | M: 20
I do not have internet (Wi-Fi) access			F: 1 | M: 1
I use someone else's internet (Wi-Fi) outside of my home, on my own device (computer, phone, tablet)			F: 0 | M: 1
Don't know how to use Internet			F: 0 | M: 1
Would you be comfortable seeing your medical care provider or case manager using telehealth/telemedicine?	Yes		F: 2 | M: 16
	No		F: 2 | M: 5
	Don't know		F: 1 | M: 1

H. Updates to Other Strategic Plans Used

How SD will use annual needs assessment data to adjust priorities.

The South Dakota Prevention and Care Programs used information from two client focus groups in Rapid City, South Dakota to help prioritize work and form objectives. One client focus group was made of 2 female clients and 4 male clients; the second focus group was made up of two persons: 1 male client living with HIV and his affected partner. A total of 8 clients provided information to the State to assist in the development of priorities. The male to female client mix was 25% female and 75% male which was reflective of the overall gender mix for the State when the 2016-2021 Integrated Plan was written. For 2022, an annual needs assessment will not be possible and instead the PPG planned to combine the results (qualitative data) from the Prevention and Care Strengths, Weaknesses, Opportunities, and Threats (SWOT) assessment along with provider and client focus groups that were conducted in June/July 2022 as the annual needs assessment. In order to determine client and program needs, the PPG used current stratified data to identify needs for priority populations. Additional stratification will be looked at using zip code data as well as available demographic data to identify locations in the state where there is more need for focused prevention and care activities. The Prevention and Care SWOT was conducted during the April 2022 PPG meeting and included client input.

During the April 2022 PPG meeting, Health Access explained to the PPG that moving forward they will need to collect data regarding the outcomes of objectives so that the PPG can adjust. The PPG received technical assistance on how to select strategies that will generate measurable data to allow for simpler evaluation. Moving forward the PPG will be evaluating data (demographic, surveillance, and performance data) to assess priorities and allocations. The PPG also received technical assistance on the value of reporting data to stakeholders for transparency but also so that stakeholders can be made aware of the effectiveness of interventions and provide input when available data demonstrate that a goal or objective is not being met.

How SD incorporates ongoing feedback from PLWH and stakeholders

Beginning in 2022, SD will include additional avenues through which qualitative feedback can be elicited from HIV service providers and disseminated to PPG members and other stakeholders to more effectively address perceived gaps in HIV prevention and care. Additionally, SD will continue to elicit consumer feedback through established methods such as PPG meetings, Advisory Council, surveys, and continual client input through case management allowing SD to be aware of and responsive to the expressed needs of PLWH. Prevention staff will continue to collaborate with providers and key stakeholders in areas where individuals are disproportionately affected by HIV to ensure that necessary resources and support is available.

Changes to the plan as a result of updates, assessments, and community input.

Local objectives were reevaluated for the 2022-2026 Integrated Plan and strategies have been updated to align with NHAS strategies and reflect the need for additional jurisdictional capacity building, education, etc.

Changes made to the planning process as a result of evaluating the planning process.

The only noted change to the planning process was to develop a comprehensive evaluation tool for the PPG to review the goals and objectives of the Integrated Plan at each meeting for the next 5-years.

III. Contributing Data Sets and Assessments

A. Data Sharing and Use

South Dakota Department of Health (SDDOH) collects statewide HIV surveillance data using MAVEN and eHARS. HIV Surveillance collects, analyzes, interprets, and disseminates data for prevalence and incidence for the most recent completed calendar year (e.g., data dissemination of 2020 is provided in 2021). SDDOH Epidemiologic Profile of HIV, 1985-2019, published in September 2021 was used as a baseline for data for the Integrated Plan. Demographic data specific to Ryan White Part B clients was used to be able to identify PLWH retention and viral suppression in the HIV Care Continuum. Stratifying data based on specific demographics such as Native American men who have sex with men (MSM), Black/African American MSM, MSM aged 13-24 years, and sex at birth helps to narrow the emphasis for which populations of focus with continued health disparities that this Plan needs to address. Maps that use surveillance data to illustrate HIV incidence by county and viral suppression rates as a proportion provide a snapshot of areas where HIV transmission rate and disease burden are highest. Geographic data heat maps with overlay maps locating current medical care locations as well as Native American reservation boundaries also helped to understand where HIV care "deserts" may exist. Additionally, data collected from the HIV Prevention Plan was also used to strategize collaborative efforts between HIV Prevention and Care that would make the biggest impact.

B. Epidemiologic Snapshot

Before speaking on the epidemiologic information of PLWH who reside in South Dakota, it is important to understand the geographic characteristics of the state. South Dakota is considered a frontier area. "Frontier areas are the most remote and sparsely populated places along the rural-urban continuum, with residents far from healthcare, schools, grocery stores, and other necessities."[1] The state's entire geographic boundary is 77,116 square miles, with over 12 percent of that being Native American reservation or trust land. The majority of South Dakota's population lives in Sioux Falls and Rapid City[2] which are located on opposite ends of the southern part of the state. Due to this geographic makeup South Dakota is also considered a rural state. A rural state is defined as "all population, housing, and territory not included within an urbanized area or urban cluster[3]".

Information in this plan was derived from the SDDOH Epidemiologic Profile of HIV and the 2021 Surveillance Report. As of December 31, 2021, a total of 728 people with HIV and/or CDC-defined AIDS was known to be living in South Dakota. Late testers are individuals who are diagnosed with AIDS within 12 months of their initial HIV diagnosis. Of those individuals diagnosed from 2012-2021, in South Dakota, 39.5% were considered "late testers." The average number of cases reported per year since 2015 is 32.4 with an incidence of 3.6 per 100,000 population and a prevalence of 18

[1] https://www.ruralhealthinfo.org/topics/frontier
[2] https://www.southdakota-demographics.com/cities_by_population
[3] https://www2.census.gov/geo/pdfs/reference/ua/Defining_Rural.pdf

per 100,000 population. This rate puts South Dakota among one of the lowest incidence states in the nation. The demographic characteristics of South Dakotans living with HIV/AIDS (as of December 31, 2021) are described in Figures 7-14.

Demographic characteristics of South Dakotans living with HIV/AIDS

BLACK/AFRICAN AMERICANS make up only 2.0% of South Dakota's population, but account for 24% of SD HIV/AIDS cases.

AMERICAN INDIANS/ALASKAN NATIVES make up only 9% of South Dakota's population[1], but account for 20% of SD HIV/AIDS cases.

HISPANICS OR LATINOS make up only 4.4% of South Dakota's population[1], but account for 9% of SD HIV/AIDS cases.

Figure 7. Race

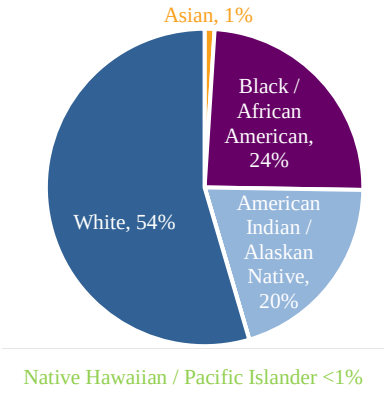


Figure 8. Age groups

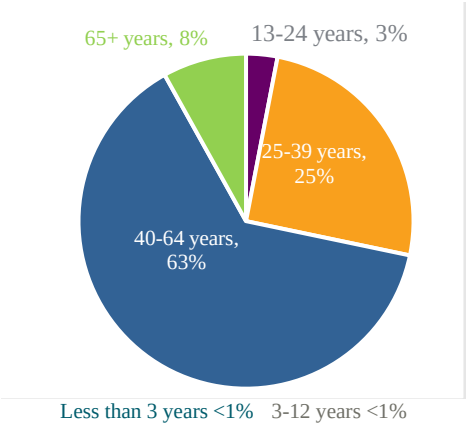


Figure 9. Ethnicity

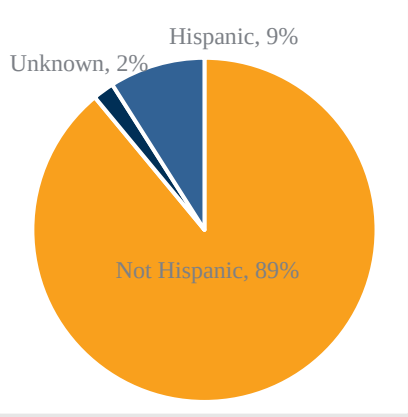


Figure 10. Gender

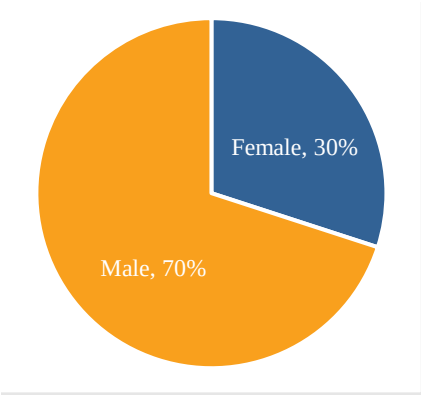
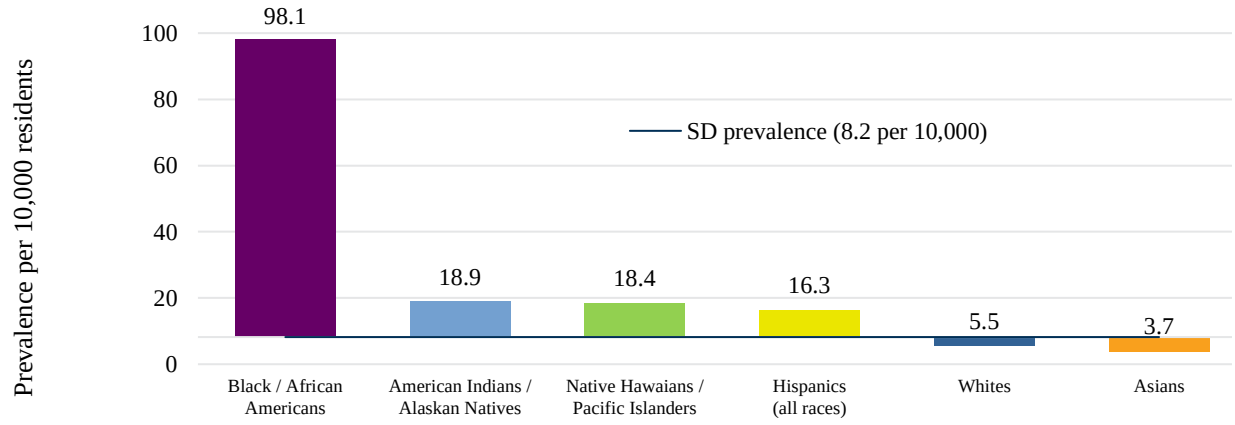


Figure 11. Racial and Ethnic Disparities



Based on 2020 SD population estimates from the US Census Bureau

Figures 12-14 show the three-year trend for HIV/AIDS prevalence in South Dakota by Race, Gender, and Age.

Figure 12. Trending for HIV/AIDS prevalence by race – South Dakota, 2018-2020.

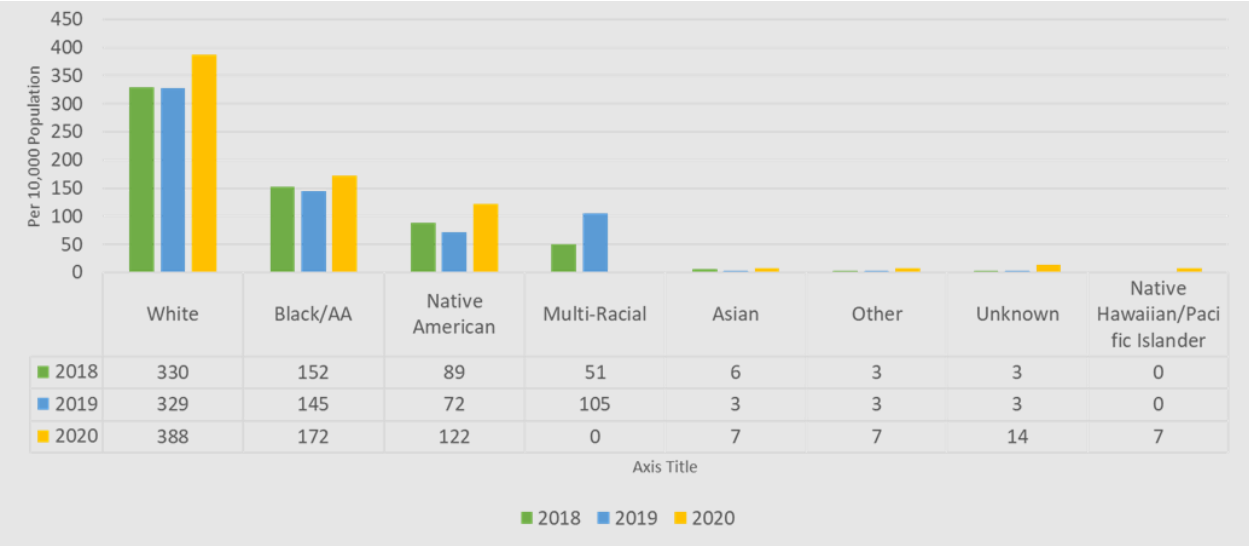
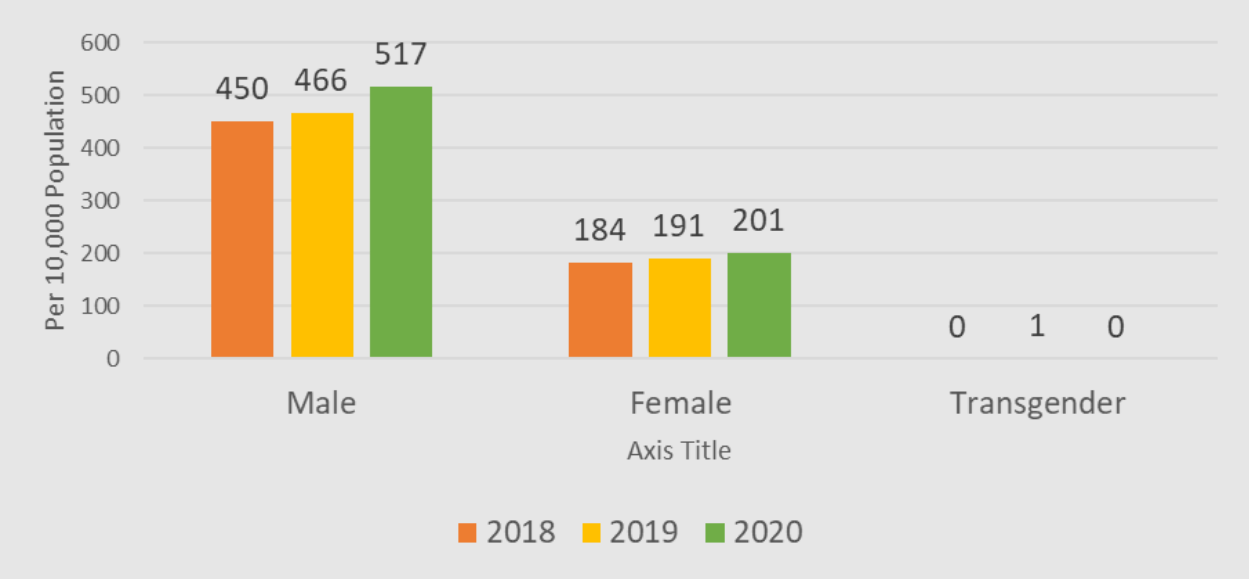


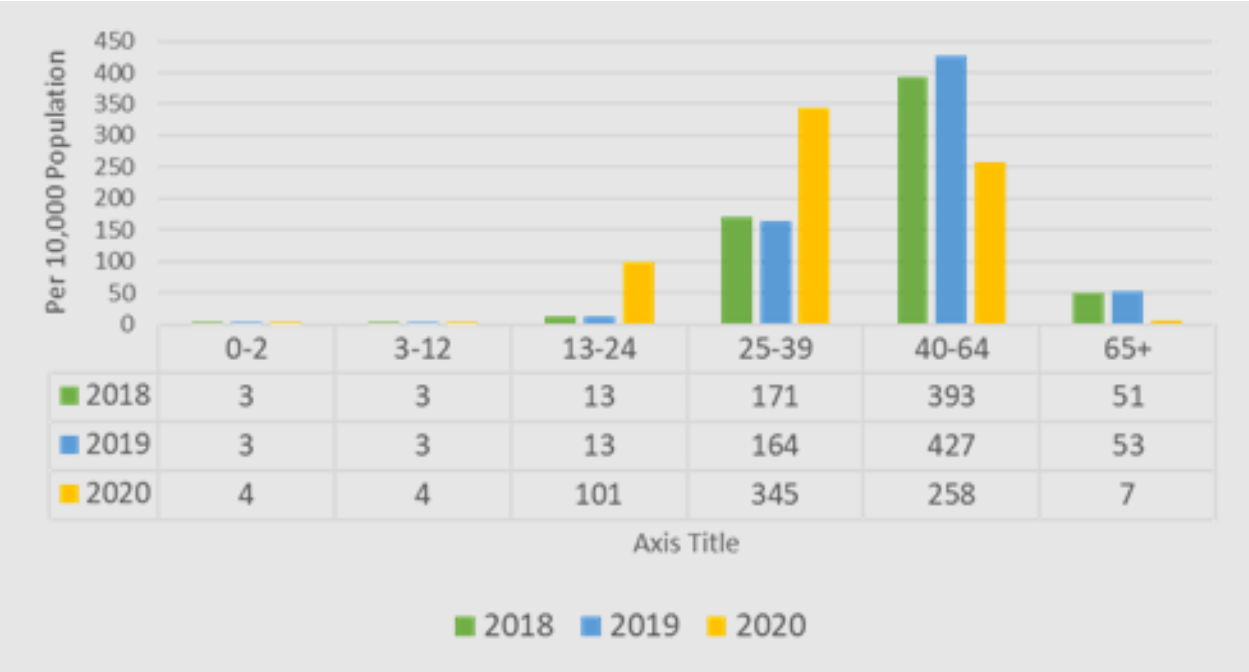
Figure 13. Trending for HIV/AIDS prevalence by gender – South Dakota, 2018-2020



The impact of the HIV on specific race and ethnicities in South Dakota is evident by the data shown. In 2020, Black/African Americans comprise 3% of the total South Dakota population. Despite having a low census number, compared to their White counter parts, for every one White PLWH, there are 13 Black/African American PLWH. Per AIDSVU.org, 2019 data showed the rate of Black females living with an HIV diagnosis is 73.7 times that of White females living with HIV in the state of South Dakota.[4]

[4] https://aidsvu.org/local-data/united-states/midwest/south-dakota/

Figure 14. Trending for HIV/AIDS prevalence by age – South Dakota, 2018-2020



Native Americans comprise 11% of South Dakota's total population yet for every one White PLWH, there are 2.3 Native American PLWH. Hispanic ethnicity data is remarkably similar to rates among American Indian/Alaska Natives as their ratio to White PLWH is 2.1 to 1.

Figure 15. HIV Care Continuum

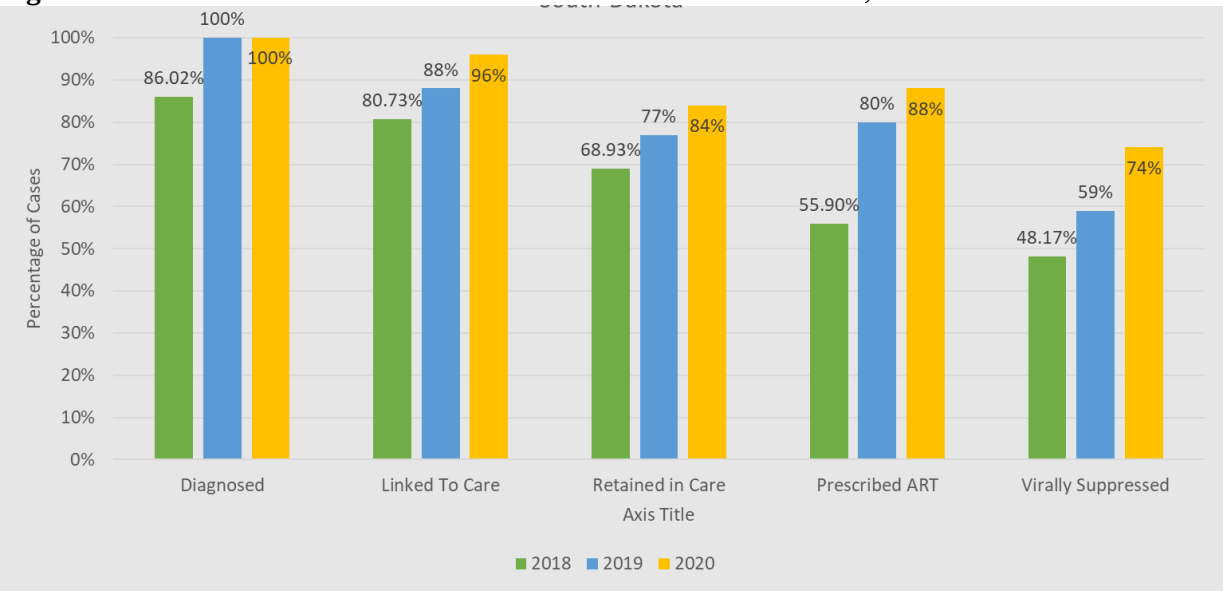
As outlined in this figure, the HIV care continuum is a public health model that outlines the steps or stages that people with HIV go through from diagnosis to achieving and maintaining viral suppression (a very low or undetectable amount of HIV in the body) through care and treatment[5]. The steps are:

- Diagnosis of HIV infection
- Linkage to HIV medical care
- Receipt of HIV medical care
- Retention in medical care

[5] https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum

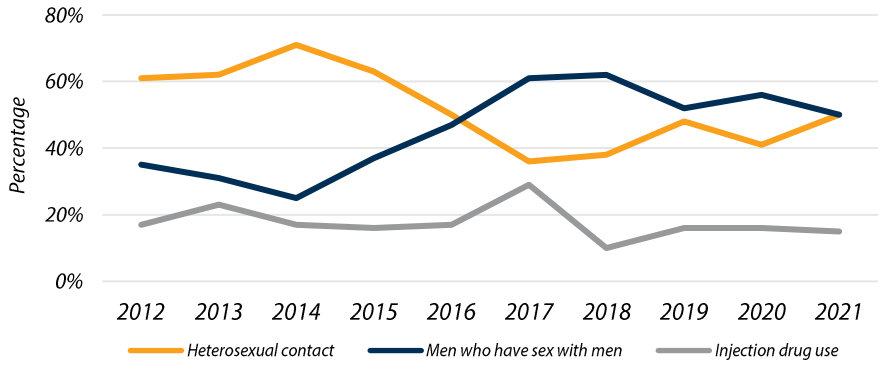
- Achievement and maintenance of viral suppression

Figure 16. Trend of HIV Care Continuum of all PLWH. South Dakota, 2018-2020.



Note: Prior to 2019, South Dakota calculated PLWH assuming ~13% of individuals who have HIV are unaware of their status. After 2019, "Diagnosed" PLWH includes only those with an HIV diagnosis.

Figure 17. Injection Drug Use (IDU), now Persons Who Inject Drugs (PWID)



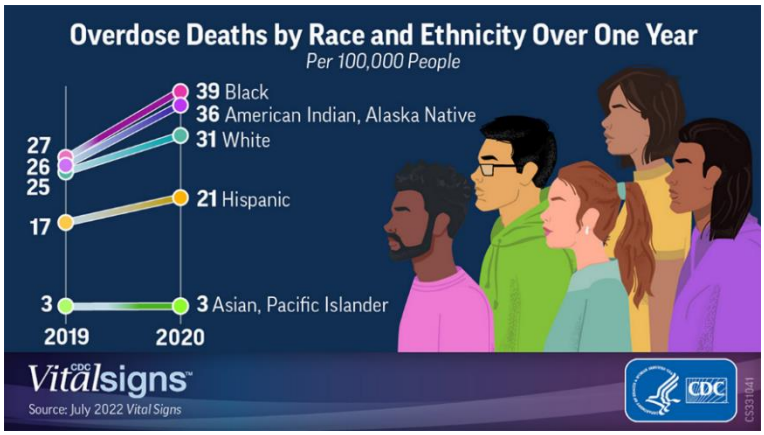
Certain behaviors also hold an increased burden of risk of transmitting HIV. Intravenous drug use is a common means of HIV transmission in the United States[6]. Most recently published by CDC, by the end of 2018, people who inject drugs accounted for 10% of the total HIV diagnosis in the United States. In comparison, in 2021, 15% of South Dakotans diagnosed with HIV reported injection drug use.

In the recently published article from CDC, "in 2020, overdose death rates… increased 44 percent for Black people and 39 percent for American Indian and Alaska Native (AI/AN) people compared with 2019."[7] Of specific concern was that "opioid overdose rates in 2020 were higher in areas with higher availability of opioid treatment programs… particularly among Black and AI/AN."

[6] Source: CDC. HIV infection risk, prevention, and testing behaviors among persons who inject drugs–National HIV Behavioral Surveillance: injection drug use – 23 U.S. Cities, 2018

[7] https://www.cdc.gov/media/releases/2022/s0719-overdose-rates-vs.html

In South Dakota, the three-year rates for opioid related deaths by year from 2018 to 2020 was 27, 37, and 43 respectively. According to the Kaiser Family Foundation analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, there was not sufficient data identifying race other than White until 2020. Per the below table[8], there were 65% White, Non-Hispanic Opioid overdose Deaths in South Dakota. There were 26% in the "other" category which includes Asian or Pacific Islander and American Indian or Alaska Native.



Location	White, Non-Hispanic	Black, Non-Hispanic	Hispanic	Other
South Dakota	65%	NSD	NSD	26%

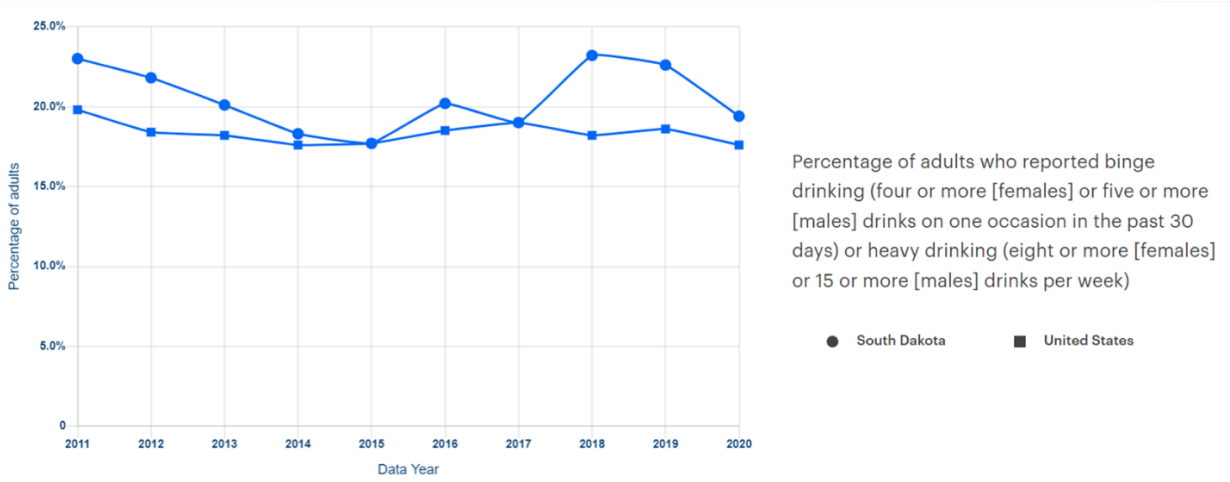
Alcohol and Tobacco Use

There is also concern regarding an increased risk of exposure to HIV among those who utilize coping mechanisms such as alcohol, tobacco, and recreational drug use. South Dakotan rates for each of these is on average higher than that of the United States overall population. Cigarette use prevalence for American Indian adults in South Dakota for 2019 was 42.3%; more than 2 times the rate of other adult populations[9]. In 2019, 11.6% of South Dakota American Indian middle school students reported current use of any type of tobacco products, compared to 0.7% of White students. As the graph below demonstrates, the percentage of adults who reported binge drinking or report heavy drinking is approximately 19% while the overall population of the U.S. is about 17%.

PLWH who report alcohol dependency, recreational drug use, or currently smoke are at an increased risk of antiretroviral treatment non-adherence and viral non-suppression, independent of demographic and socioeconomic factors.

[8] https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/
[9] https://befreesd.com/about-us/priority-populations/american-indians/

Figure 18. Trend: excessive Drinking. South Dakota *versus* United States, 2011-2020.



Source: CDC Behavioral risk Factor Surveillance System.

Refugee Population

The percentage of South Dakotans who were diagnosed with HIV while living outside of the U.S. as citizens of different nations in 2019 was about 10%. Of particular concern are those individuals who were born in Africa and/or South American nations, an identified area where HIV is highly prevalent. Since 2007, the number of HIV positive individuals who were diagnosed in another state or country has increased substantially. Notably, the annual allowance for refugees in the United States has also changed which affects these numbers. "The annual ceiling set for FY2020 was 18,000. The original ceiling set for FY2021 was 15,000, the lowest level on record, but was increased to 62,500 on May 3, 2021[10]." The current threshold for 2022 is 125,000. South Dakota welcomed 52 refugees in 2021, compared to 439 in 2016, according to the Lutheran Social Services' annual report on resettlement. More than half of the people resettling in the state came from the Democratic Republic of Congo in Central Africa[11].

As outlined in the article "Are Opportunities Being Missed? Burden of HIV, STI, and TB, and Unawareness of HIV among African Migrants," individuals who are separated from partners while migrating to another country and sense solitude and isolation may engage in risky sexual practices, are exposed to sexual and gender-based violence, and if they already have an infectious disease, they are at risk of acquiring other infectious diseases[12]. Preliminary data for South Dakota could not be drilled down to verify if these high-risk practices were being experienced by local refugees as no respondents affirmed to being a refugee. However, given the acceptable ceiling increase for refugee population, this is an area worthy of attention and continual observation.

C. HIV Prevention, Care, and Treatment Resource Inventory

Inventory Narrative

[10] https://www.migrationpolicy.org/programs/data-hub/charts/us-annual-refugee-resettlement-ceilings-and-number-refugees-admitted-united
[11] https://www.usnews.com/news/best-states/south-dakota/articles/2022-01-10/refugee-resettlement-in-south-dakota-declining
[12] Dias S, Gama A, Tavares AM, et al. Are Opportunities Being Missed? Burden of HIV, STI and TB, and Unawareness of HIV among African Migrants. Int J Environ Res Public Health. 2019;16(15):2710. Published 2019 Jul 30. doi:10.3390/ijerph16152710 Environmental Research and Public Health. 2019; 16(15):2710. https://doi.org/10.3390/ijerph16152710; https://www.mdpi.com/1660-4601/16/15/2710/htm

SDDOH receives funding to provide PLWH with HIV primary care and ART from the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP) through Part B and ADAP funds. SDDOH also receives HIV Prevention funding from the Centers for Disease Prevention and Control (CDC). Additional RWHAP funding through Part C is available in the state through a local community health center. See **Appendix D** for *abbreviated* details on which agencies receive those funds and a brief description of their capacity. South Dakota also benefits from RWHAP Part F program funding through access to the Community Healthcare Association of the Dakotas (CHAD) and collaboration with the Mountain West AIDS Education Training Center (MWAETC). Services available through the Part F program include provider education with continuing education credits (CEUs), participation in ECHO® forums, HIV prevention medical provider coaching, and HIV clinician technical assistance. SDDOH does not directly receive any funding for HOPWA in FY2021.

Other resources include the Great Plains Area Indian Health Service Office in Aberdeen, SD, which works in conjunction with its 19 Indian Health Service Units and tribal-managed Service Units to provide health care to approximately 130,000 Native Americans located in North Dakota, South Dakota, Nebraska, and Iowa. The SDDOH routinely coordinates with the service office in support of strategic planning, data and information sharing, and technical assistance. Members from local service units have participated in the PPG and SDDOH disease intervention specialists provide additional support and resources to local service units.as requested.

The Great Plains Tribal Chairmen's Health Board has a Behavioral Health Department that services 5 tribes in South Dakota for mental health and offers 10 locations with services for substance abuse and counseling for addiction. The South Dakota Department of Social Services Division of Behavioral Health has three prevention resource centers that provides regional support for prevention resource materials or support.

Strategy for Coordinating the Provision of Substance Use Prevention and Treatment Services

Per guidance of the Substance Abuse and Mental Health Services Administration (SAMHSA), the lack of services for substance use disorder is known to have a negative effect on retention in care, attainment of viral suppression, and immune system reconstitution for HIV-diagnosed individuals. To expand coordination of current substance use disorder (SUD) prevention and treatment resources/services, a two-pronged approach was employed. The first step was for the SDDOH to hold a Town Hall meeting with providers involved in HIV care, prevention specialists, and healthcare organizations not involved in HIV care. A primary outcome from this meeting is the ongoing need for awareness among providers of services available from each other. In some instances, case management agencies involved in HIV care and prevention knew about SUD resources, but other providers have not always worked with SUD providers or known of services available. Based on questions posed during the meeting regarding HIV prevention and care, the responses and feedback indicate an opportunity to decrease knowledge gaps related to substance use treatment facilities, group resources, etc.

The second step in the coordination of SUD care and prevention services among HIV care and prevention providers was to conduct a Resource Inventory as required in the guidelines for completing the Integrated Plan. The inventory assessment process was initiated by determining which agencies or organizations in South Dakota are funded by SAMHSA. During the research, it

was determined the South Dakota Department of Social Services (DSS) is a major recipient for mental health and SUD treatment/prevention from SAMHSA. DSS funds several programs for SUD treatment and prevention and maintains a list of SUD treatment providers (last updated 2021* and for SUD prevention providers*). As part of the work on the inventory, the DSS Behavioral Health Services, Mental Health Prevention Program Strategic Plan was reviewed and indicated alignment with several strategies for this section: identify populations to receive services (Resource Inventory), conduct an inventory of mental health services, and develop processes to facilitate linkage to services and treatment (Resource Inventory and provider education of resources). The SAMHSA locator was also an effective resource for identifying mental health and SUD resources and identified several resources for SUD treatment and prevention. Unfortunately, most SUD prevention funds are targeted at school-age children which can limit access to SUD prevention services for adult PLWH.

The strategy for coordination of SUD care and prevention services for PLWH also may involve identifying effective SUD providers or agencies for the individual. This may include recognition of SUD providers with experience and/or education in providing services to PLWH as well as expanding opportunities for SUD providers to engage in professional development working with PLWH. As noted during a state-wide Consumer Town Hall meeting, not all mental health providers in South Dakota have experience with the unique needs of PLWH. Stigma may be experienced by PLWH resulting in clients feeling unwelcomed or misunderstood and less likely to seek agency services. As per SAMHSA's advisory on Treating Substance Use Disorders Among People with HIV[13]OBJ.

While the results from the Provider/Consumer Town Halls and surveys identified needs for SUD treatment/prevention resources and lack of knowledge about those resources in the community, the strategy moving forward appears to include two components: 1) review which of the existing providers have experience providing services for PLWH, and identify those agencies that want to provide services for PLWH but need additional training with care and treatment guidelines for PLWH; and 2) share among those providers who currently provide HIV care and prevention a list of SUD treatment and prevention providers who either have experience in providing care for PLWH or want to provide care but will need training or close collaboration with HIV care providers to ensure clients receive effective SUD services. Since the primary recipient for SAMHSA is another State agency, coordination and collaboration with the HIV Prevention and Care programs should be incorporated into the plan for coordination of care.

To ensure a comprehensive jurisdictional strategy, coordination of services for American Indians living with HIV or at risk for HIV are embedded in the plan as American Indians have unique challenges when compared to the general population. To determine which of the 22 responding agencies that work with American Indians, the survey included questions about the funding the agency receives to provide services. Approximately 18% of the respondents, or four agencies, responded that they receive funding from the Indian Health Service (IHS). Using IHS funding as the definitive marker that an agency provides services to American Indians, the agencies can be broken down into which agencies provide direct services and which provide preventions services. Three of the four agencies that receive IHS funds or 75% of the agencies provide medical care and the fourth

[13] Substance Abuse and Mental Health Services Administration (SAMHSA). Prevention and Treatment of HIV Among People Living with Substance Use and/or Mental Disorders. Publication No. PEP20-06-03-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020.

agency provides HIV Prevention Services. The table below, **South Dakota Agency, Services, and Service Area,** summarizes the services that are provided and the area of South Dakota they service. Note that not all services that were provided in the survey are actually provided by the agency. Additional services in blue text were not noted in the survey but were found by looking at the agency's website.

Table 6. South Dakota Agency, Services, and Service Area

Agency	Service(s) Provided	Funding	HIV Care	Service Area
Federally Qualified Health Center	Primary care, substance use disorder (SUD) services & screening,	IHS, HRSA	No	Minnehaha County
Primary Care ID	Primary care, case management, podiatry, dental care	IHS, Ryan White Part B	Yes	Pennington County
Primary Care Provider-Family Medicine Residency	Primary care, SUD screening, services via telemedicine, diabetes, women's health & counseling	IHS, Ryan White Part B, C, Veterans Administration	Yes	Pennington County
HIV Prevention Provider	Prevention services, case management services, SUD screening, services via telehealth	IHS, Ryan White Part B, C, CDC	No	Minnehaha County

All four agencies provide screening for STI's to include HIV but they are located in the two major urban centers in South Dakota (Rapid City and Sioux Falls). Since the sites are at the eastern most and western most geographic regions of South Dakota, the distance American Indians may have to traverse could affect their ability to know their HIV status as none of the providers currently offer at-home STI/HIV testing. While two of the three medical providers that see American Indians provide HIV care, an opportunity exists to expand the availability of HIV care in Minnehaha County via practice transformation projects supported by the MWAETC.

How Services Will Maximize the Quality of Health and Support Services Available to Persons at Risk for or with HIV

Two of the four responding agencies that provide services to American Indians have an opportunity to expand access to prevention services, case management, HIV care, primary care and counseling as both have the capacity to deliver services via telemedicine and telehealth which can reduce some of the burden of having to commute to either Rapid City or Sioux Falls for HIV care and prevention services. According to a 2021 report from the American Indian Policy Institute, just 46.5% of the population on tribal lands have broadband service that would support visual and audio streaming for a telehealth/telemedicine[14]. While broadband access can be a barrier for access to care in South Dakota, the South Dakota Medicaid program does allow the use of audio only for behavioral health and for medical appointments for office visits, which can act as a bridge until broadband access is expanded on reservations in South Dakota.

[14] American Indian Policy Institute. (2021). Comment on current infrastructure in Indian Country. Retrieved from: https://docs.house.gov/meetings/II/II24/20210421/112468/HHRG-117-II24-Wstate-MorrisT-20210421.pdf

Based on the 2022 survey of consumer needs, the top five most important needs for PLWH are: HIV medications, access to HIV medical care, dental care, health insurance and financial assistance. These services are available to American Indians through the agencies listed in the table above. However, since the provider survey was statewide, the concentration of these services was indicated to be provided at two locations which happen to be at either end of the state. This presents a challenge for PLWH living in the Northeast, Central or Northwest parts of South Dakota to access these services. Expansion of services to other parts of the State or to existing IHS providers will help improve access for all South Dakota residents regardless of their location.

The revised resource inventory provides more information about services available to American Indian PLWH or those at risk for HIV. The inventory can be filtered to look for specific service providers and provisions such as those that offer prevention and testing or SUD prevention. Another way the expanded inventory will help clients maximize the quality of health and support services is that the inventory is set up to allow clients and/or case managers to easily search for available services such as dental as it is not limited to provider names. Provisions such as dental services can be filtered out from provider information to eliminate the perception that the service is unavailable.

Additionally, one of the major services needed by clients at risk for HIV or living with HIV is mental health services for the general population and American Indians. DSS has significant programs offered across the State for mental health treatment, access to mental health medications, SUD, and SUD prevention. In the provider survey one of the lead reasons for why clients do not access mental health services is the cost. DSS provides services to clients without insurance so it appears that in order to maximize client access to these services, educating service providers about the mental health programs in the State should increase linkage to care for persons who in the past may have not accessed mental health services due to cost[15].

Strengths and Gaps of the Resource Inventory

General evaluation of resource inventory:

Gaps:

Most services are located in 3 parts of the more urban parts of the state requiring great distances to drive to seek prevention and care services for some PLWH. Viral suppression rates are lower in rural areas where services can be sparse or not present at all. There is an apparent lack of coordination between the HIV Care and Prevention with American Indian Service Organizations. There are very few contracted providers for HIV Care and Prevention. Federally Qualified Health Centers are not a part of the overall mix of healthcare providers nor are partners.

Strengths:

- Since it is in an Excel format the inventory can be sorted to find resources to meet a specific EHE measure or topic related to HIV care or telehealth. For example, if a user wanted to find substance use disorder prevention resources the inventory can be sorted and only that list of resource or providers would be available.
- It is designed to be sorted based on zip code or region of the state.

[15] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://dss.sd.gov/docs/behavioralhealth/providers/Financial_Eligibility_FAQ.pdf

- The 2022 inventory now has a considerable number of resources for mental health services (which were noted in the 2016 plan as an issue) and SUD treatment/prevention resources for the general population and American Indians.
- The 2022 inventory now includes built-in locators for persons looking for a specific vendor from mental health services to finding a community health center with dental services.
- During the PPG meeting, members noted that pregnant women with HIV often defer HIV care or STI testing because of the concern that if they test positive for illegal substances the mother would be reported to child and family services. The 2022 inventory has an additional strength of providing information on where a pregnant woman with children can receive treatment for SUD and remain in care as their SUD can be treated in settings that also provides housing for the family.
- The 2022 inventory is set up to address issues noted in the 2016 Integrated Plan and can in the future be used by subrecipients to focus on specific NHAS/EHE objectives/strategies. The ability to sort based on a NHAS/EHE objective/strategy will allow for subsequent reporting to the PPG, the CDC, and HRSA; an example would be which resources were used for linkage to care or to treat HIV.

Capacity building

The last resource inventory was released in 2016 and did not include resources that were mentioned in the 2016 assessment and feedback from the SWOT performed with the PPG. A major part of the capacity building is for all the partners to have access to the inventory but also add and modify the resource inventory as resources are no longer current and add novel resources. The SDDOH, while it provided many of the resources, does not have the capacity to update the inventory and this responsibility should be assigned to partner agencies and the PPG.

Underutilization

Based on responses from clients and providers regarding needed services it is quite possible that the resource inventory was developed but underutilized. For the resource inventory to achieve the goals of the integrated plan it will need to become a living document updated minimally on an annual basis with access provided to new staff (subrecipients and partner agencies).

Approaches and Partnerships

The approach to building the 2022 resource inventory was to include resources that are found in the literature to lead to increased retention and viral suppression via a literature search. The next step was to look at the gaps noted in the 2016 inventory and assess what was done regarding plans to implement interventions in the 2016 Integrated Plan. For example, telehealth was noted as an intervention but there was no action on this strategy. Telehealth resources for providers and clients were added to the 2022 inventory in order to minimize disruptions in care and increase access for those who do not live close to their medical provider.

To make the prevention and care inventory more effective, it was modeled after the Target HIV HRSA Resource Inventory Tool. The HRSA Inventory Tool is searchable and can be sorted for specific resources and identify resources/strategies to help meet a specific NHAS/EHE measure.

The guidance in this section regarding SUD and prevention contributed to the expanded 2022 tool, especially for mental health and SUD services, a major factor in retention in care for PLWH and

priority populations. Integration of mental health services into the 2022 inventory will strengthen HIV prevention and care outcomes. The increased amount of mental health resources could prompt HIV care providers to screen for many types of co-occurring mental illness given available references for client referrals. Since many of the PPG members are also community resource staff, several of the PPG members were added to the resource inventory. By reviewing the PPG member webpages additional services provided by PPG members were found that could help meet Integrated Plan goals. Some PPG members did not have any resources noted in the previous inventory. For example, the following organizations and/or services were not listed but will be added to the 2022 resource inventory: Planned Parenthood of South Dakota, PrEP, contraceptive services, women's health services and Great Plains Tribal Council. Approximately 63% (38 of 60) resources/providers in the 2022 inventory are new partners; all ongoing partners were updated.

Finally, since the goal is to create one community of practice, SDDOH decided it would be beneficial to combine most of the 2022 Prevention Resource Inventory with the Care Inventory to create a Master Resource Inventory for providers of care to PLWH. This promotes the status neutral model of care for at risk and those found positive for HIV.

D. Needs Assessment

As previously mentioned, the SDDOH RWHAP program contracted with Health Access, LLC to assist with conducting a thorough needs assessment for the state. In order to collect both quantitative and qualitative data, the team conducted the SWOT analysis, virtual Town Hall meetings for both providers and consumers, and finally a survey via SurveyMonkey during the months of July and August. It was important that multiple avenues of needs assessments be completed to gather rich and supportive content that would assist in developing the goals and objectives of this Integrated HIV Care and Prevention Plan. These different practices also allowed the consultant to evaluate what proposed activities could truly be accomplished with the current resources available to South Dakota.

1. Status Neutral Services for At-Risk and Newly Diagnosed

The SDDOH will use the status neutral approach in order to address all community members wholistically. To do this they will continue to combat the HIV epidemic through care for those who are already diagnosed as positive and prevention support for those at risk of getting HIV in the state of South Dakota. The assessments created had key questions and direction allowing for response to both the prevention and care aspect of HIV for those at risk and newly diagnosed. For the purpose of the Integrated HIV Prevention and Care Plan, there were three assessments used to help identify other ways to support the current work that is being conducted to address gaps where the Integrated Plan can complement the Prevention Plan activities.

2. At Risk Population Needs to Stay HIV Negative:

Data exists that shows locations for PrEP access, and the HIV Prevention Plan intends to bolster prevention efforts to find other avenues to promote education that will address stigma and make prevention services more accessible. Social marketing and increased awareness for existing programs is one of the effective strategies that the HIV Prevention Plan will support.

The SWOT analysis helped to jump-start discussions on where the state currently stands with regard to at-risk populations. Specific areas identified as "weaknesses" were: sexual health education to youth and parents; lack of PrEP prescribers; websites that do not hold content of referring agencies;

AETC training opportunities; continued stigma; cultural competency among case managers; and mobile testing unit availability.

The Town Hall for providers was a qualitative dialogue with those in the field to discover and/or confirm areas of weakness that the Integrated Plan could assist with. A few responses that were specific to at-risk populations included: perceived lack of substance abuse treatment options; lack of awareness of PrEP; education for providers regarding prescription of PrEP to HIV negative clients.

The survey of the providers and consumers was a comprehensive quantitative analysis. Findings regarding providing testing for STIs (to include HIV testing) and at-home testing or mobile testing are noted in the below table.

Table 7. Provider vs Consumer STI Testing Results		
PROVIDER n=22		
Does your organization provide testing services for STIs (including HIV)?	Yes	19
	No	3
If yes, does your organization provide at-home STI testing? *additional feedback below	Yes	1
	No	17
	Don't know	1
We conduct at home testing with our mobile unit upon a clients request. *We are prepared to assist with this. Waiting on state for tests and program guidance.*		
Providers also suggested they need more PrEP Providers and 60 second HIV testing kits.		
COMMUNITY n=34		
Which of these would make it easier for you to get tested for HIV, or test more often?		
More free testing locations/clinics	24	
At home test kits	21	
Mobile testing	16	

The results show providers indicated they provide STI testing, however, at-home STI testing was not utilized. Community members stated a higher chance of testing if these services, including mobile testing, were offered more.

Partner notification services help to identify and locate sexual or drug injection partners to inform them of their risk for HIV and to provide them with testing, counseling, and referrals for other services.[16] The Disease Intervention Specialists (DIS) of the prevention program provide partner notification services for anyone who tests positive for HIV in South Dakota. Notification of partners is an important piece to prevention and is possible through an encrypted website or anonymous mobile app. The following table shows the outcomes of the respondents from the consumer needs assessment survey regarding partner services.

Table 8. Consumer Partner Notification Services Results n=43		
Are you aware of partner notification services?	Yes	25
	No/Not Sure	15

[16] https://www.cdc.gov/hiv/clinicians/screening/partner-notification-services.html

		No response	3
If you ever tested positive for an STI, did someone from the Health Department contact you to discuss notifying the person(s) you had sex with about possible exposure?	Yes, I was contacted	15	
	No, I was not contacted	4	
	I have not tested positive for an STI	15	
	Don't know/No response	9	
Would you be willing to use an anonymous mobile app or secure encrypted website to notify your sex partner(s) about possible STI or HIV exposure?		Yes	13
		No	12
		Don't Know	14
		No response	4

More than 50% of the respondents were aware of partner notification services; however, of those who had tested, only 15 reported they were contacted. Additionally, only 30% indicated they would be willing to use an anonymous mobile app to notify sex partners about possible STI or HIV exposure.

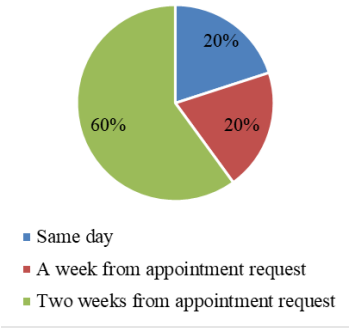
3. Services HIV Positive Persons Need to Rapidly Link to HIV Care:

From all the needs assessments conducted, several themes were recurring:

Long distance to access medical services – providers and consumers alike noted that clients rely on pre-scheduled transportation options such as Lyft or mobile vans offered by the agency. Despite having these options available, due to needing to schedule multiple appointments in the same day to optimize time, the appointments are still missed or cancelled.

One of the questions on the provider survey was how long it typically takes a client to be seen by a medical provider or receive lab services at the organization for newly diagnosed persons. The pie chart to the right shows the outcomes for the 5 respondents who deliver these services.

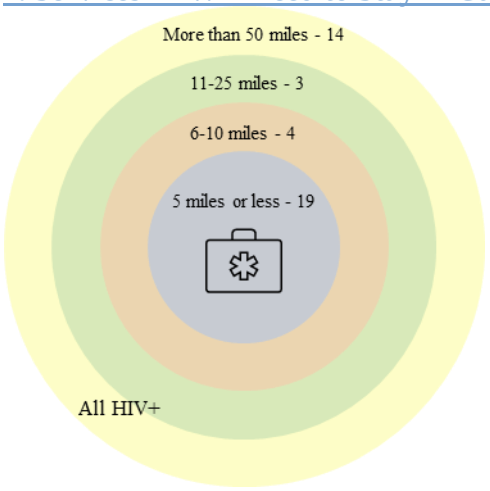
Figure 19. Newly diagnosed – time to first appointment



When asked for suggestions of changes in the HIV system of care to make it easier for clients to access services, a few respondents mentioned warm handoffs to RW providers and DIS staff; easier referral system; using Rapid ART without requirement of enrollment into Ryan White; and educating primary care providers on HIV so clients can access HIV care from any provider.

Additionally, providers articulated in the Town Hall the limited Infectious Disease providers available, which was echoed by consumers as well in the Townhall and through the SWOT analysis. One of the main choices selected by providers in the question on what they see as the biggest challenge that clients face to receiving comprehensive HIV care was clients routinely missing appointments (27%) and clients having trouble getting to their offices (22%). Case managers responded to the same question and indicated clients routinely missing appointments as being the primary challenge (54%).

4. Services PLWH Need to Stay in Care and Achieve Viral Suppression



As previously mentioned, South Dakota is a rural state with a majority of HIV care services located in the more populated major cities which lie on opposite ends of the state. Therefore, transportation was voiced in all the assessments as a leading issue to accessing medical care. Of 40 HIV positive respondents in the needs assessment survey, 14, or 35%, stated they had to drive more than 50 miles to access their medical provider. Only one mentioned currently utilizing telehealth for their care visits.

The SWOT analysis discovered the following areas of particular importance with regard to helping HIV positive individuals to stay in care and achieve viral suppression: Medications are effectively getting to clients and their ADAP program is successful; many clients experience co-morbidities, namely substance abuse and/or mental health issues that must be addressed first; and the need for thorough follow up from providers.

Clients that may have been out of care and are returning into care also have particular challenges that the Integrated Plan may be able to address. In the provider survey, of the 12 applicable respondents, 25% stated clients could be seen the same day, 66% stated a week from appointment request, and 8% stated one month from appointment request.

As mentioned in the SWOT analysis, many clients tend to have substance abuse and/or mental health issues. The survey for consumers found the following information in the table below for the 40 HIV positive respondents.

Table 9. HIV+ Substance Abuse/Mental Health Results n=40

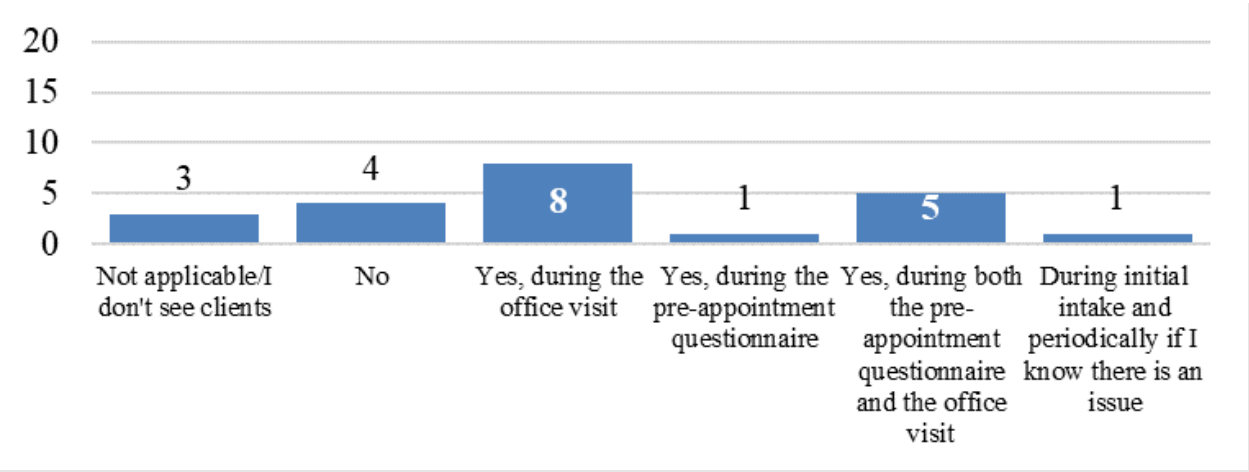
Have you been diagnosed by a mental health provider with a substance use disorder?	
No, I am not in need of substance use services	35
No, but I think I am in need of substance use services	1
Yes, and I am receiving care	2
Not sure	1

In the past year, have you used any of the following substances without a prescription from a medical or mental health provider?			
Alcohol (21)	Tobacco (17)	Marijuana (11)	Cocaine (1)
Amphetamines / methamphetamines (3)	Prescription pain killers / opiates (3)	Other (1)	

To contrast this information, in the provider survey, when asked for a suggestion of change that would make it easier for clients to access services, several providers mentioned more drug and alcohol treatment and an expansion of medications placed on the formulary. This may include those medications necessary to help with co-morbidities. Among the sample size, there seemed to be a larger number of people who claim to use substances with less people being diagnosed with substance use disorders.

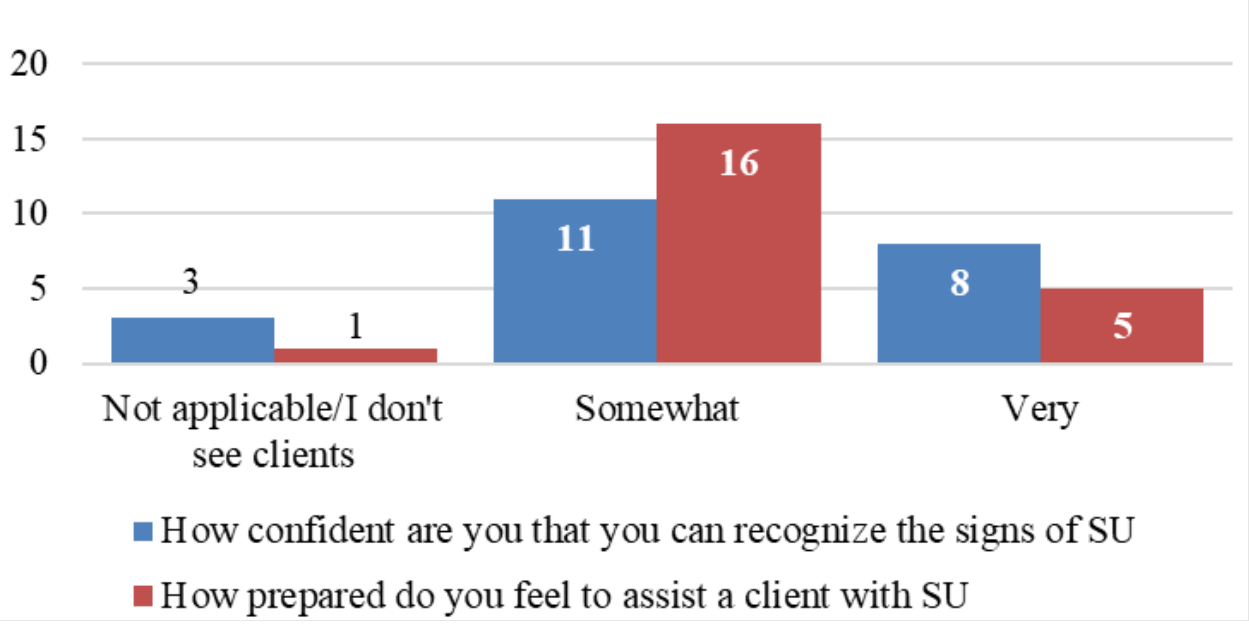
The below charts show how providers of the needs assessment survey (22 each) responded regarding substance use disorders and assisting clients with substance use disorders.

Figure 20. Do you regularly screen your clients for substance use disorders?



Of the 19 applicable providers (3 indicated they do not see clients), 15 stated they screen clients for Substance Use Disorders. Approximately 58% of those providers, to include case managers, indicated they were somewhat confident they could recognize the signs of Substance Use. Concerning assisting clients with Substance Use issues, only 5 indicated they were very confident.

Figure 21. Recognizing and assisting clients with substance use disorders: provider's responses



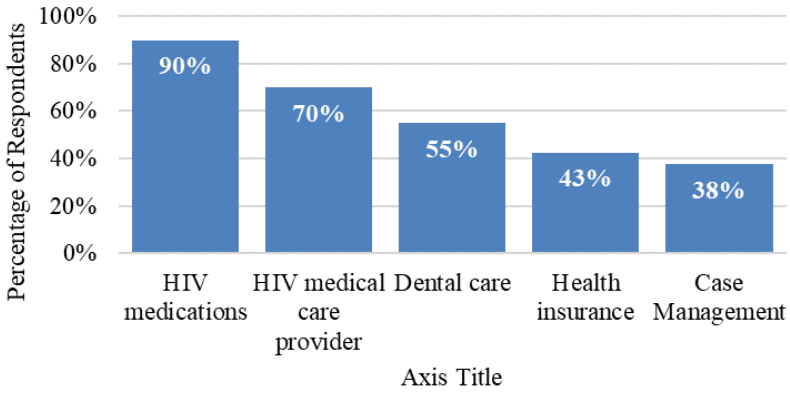
Since many clients do not live within close proximity to their medical providers, it was important to understand the state of telehealth and telemedicine in South Dakota. Although these services are an available option, several barriers still exist. During the SWOT analysis it was discovered that the resources for education on telehealth as offered through AETC were either not being utilized or providers are not aware of this offering. The below table shows the contrasting outcomes between the provider and the community needs assessment survey concerning telehealth uptake. This includes HIV positive and negative individuals.

Table 10. Provider vs Consumer Telehealth Results			
PROVIDER n=22			
Does your organization offer telehealth/telemedicine services?		Yes	31.8%
		No	54.5%
		I don't know	13.6%
If you do not provide telemedicine/telehealth services, why not.			
Clients do not have reliable phone service	33%	Client lack of internet access/technology	25%
Staff not trained to provide this service	25%	Lack of guidelines and protocols	25%
COMMUNITY n=43			
I have personal internet (Wi-Fi) at my home, on my own device (computer, phone, tablet) and am familiar with different forms of apps to video chat/conference		93%	
I use someone else's internet (Wi-Fi) outside of my home, on my own device (computer, phone, tablet)		2%	
I do not have internet (Wi-Fi) access		5%	
I do not have access to video chat/conferencing app		21%	
Are you aware that you can attend virtual medical appointments via telehealth/telemedicine, without having to travel to your medical care provider's location?		Yes	67%
		No	14%
		Not sure	19%
Would you be comfortable seeing your medical care provider or case manager using telehealth/telemedicine?		Yes	56%
		No	35%
		Don't Know	9%
If not, what concerns do you have about using telehealth/telemedicine?			
Rather see in person; I want to be face to face; Would rather talk to doctor face to face; I like one on one contact; I like to see my care providers in person; Privacy, cost, personal interaction; Can't sign on, computer illiterate; Not covered; I am concerned about the person I am talking to on the other end of the telephone. Is he/she a professional and able to provide the right care I need and my health confidentiality?			

Providers who responded to the survey indicated a low uptake with using telehealth/telemedicine (54.5%) and also indicated clients having unreliable phone service or lack of internet access/technology for why they do not use telehealth. However, in the consumer responses, a large majority attested to having personal internet and 67% are aware of the ability to use telehealth/telemedicine as an option for getting medical care. These outcomes make it clear there are opportunities for education for providers and clients alike to help close this gap for utilizing telehealth/telemedicine to deliver medical care.

The community survey asked PLWH what their top services they use to stay in care for their HIV. The following graph shows the top services selected for 40 PLWH.

Figure 22. Top services used to stay in care for HIV



A final mention concerning helping HIV positive clients to stay in care and reach viral suppression is sufficient medical care that is unique to their needs. During the consumer Townhall the mother of a youth client stated that they had to go to a neighboring state to receive comprehensive pediatric HIV care; despite their being an HIV infectious disease doctor accessible to them, they needed specialty HIV care for pediatrics.

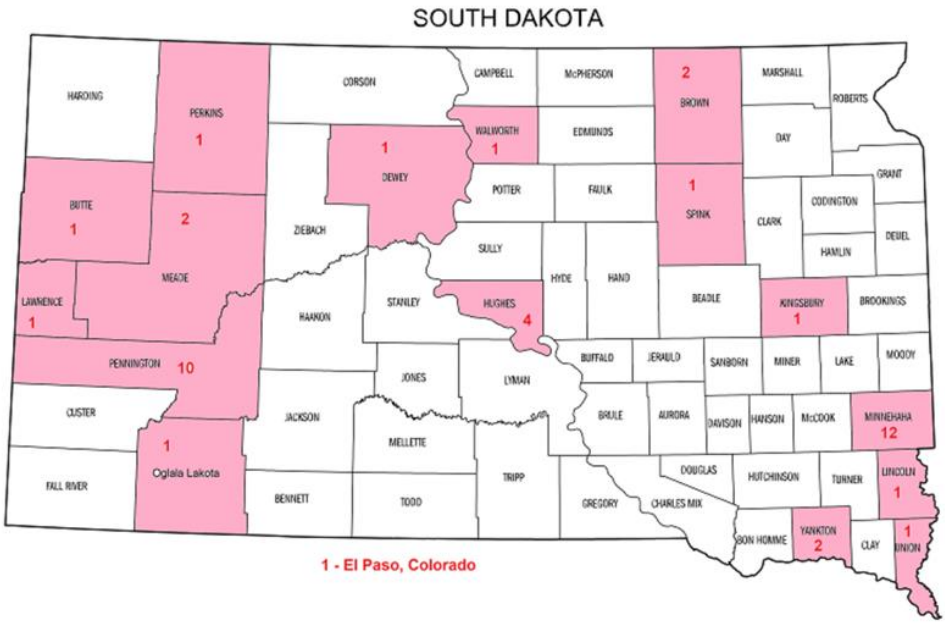
5. Barriers and Accessibility to Existing HIV Testing, Prevention Services, and Care and Treatment Services

The overarching barriers and issues that exist for South Dakota with regard to accessing prevention and care services for the entire state that were identified in the needs assessment were as follows:

Rural

Many residents live in rural locations which can make it difficult to access services, regardless of type. As the map below indicates, the respondent populations from the community needs assessment survey either live in the far westernmost or easternmost part of the state with a few outliers.

Figure 23. Geographic distribution of respondents of the needs assessment survely

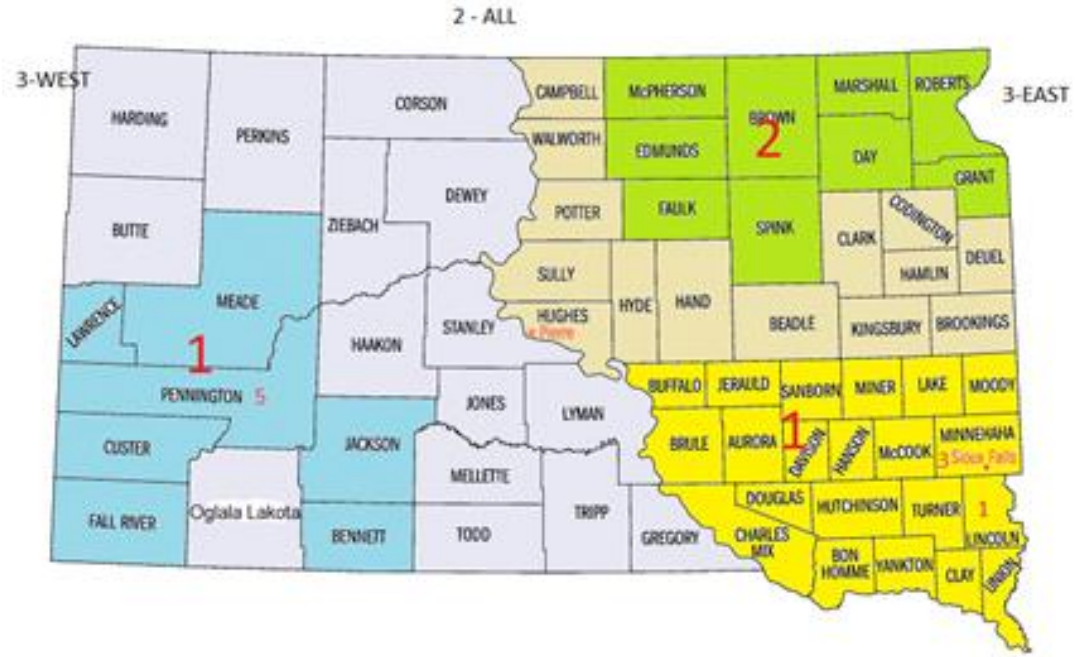


Services that are offered by providers in South Dakota will encompass entire counties, or as indicated in the provider needs assessment, east or west of the Missouri River. The locations of the provider survey are in Figure 24.

Tribal

Geographically, South Dakota shares land with nine federally recognized American Indian Tribes. Tribal members may choose to receive health services through public or private community health care providers or through the federal Great Plains Area Indian Health Service (IHS). The Great Plains Area IHS operates 19 Health Service Units across North Dakota, South Dakota, Nebraska and Iowa, each facility incorporating its own comprehensive healthcare delivery system. Some tribes within the Great Plains Area streamline healthcare delivery by contracting or compacting with the federal IHS to assume management of their own healthcare programs through the IHS Tribal Self-Governance Program (TSGP). Few South Dakota tribes participate in this program. With limited Tribal self-governance in South Dakota, coordinating the utilization of available resources for priority populations is challenging.

Figure 24. Provider needs assessment surveys, locations.



Mobile and At-Home Testing

Many providers indicated during the Townhall, SWOT analysis, and through the SurveyMonkey survey that mobile testing is limited and would be a good avenue to explore further. This would not only help with getting more people tested for HIV and other STI's but also address the privacy issue that many mentioned in the survey as being a reason clients shy away from attending appointments or getting tested. As Table 6 above showed, of the 34 people who responded, 47% stated they would be likely to very likely to get tested more often if mobile testing was made available. Regarding privacy, there were 62% who indicated they would be likely to very likely if they were provided a more discrete location. At-home testing kits are another option as several providers stated this as a suggestion that might make it easier for clients to access services. Of the 19 agencies who responded in provider survey, only one stated they offer at-home testing; however, they are waiting on the state for the tests and program guidance. More than half of the community respondents (62%) in needs assessment survey stated they would be likely to very likely to test more frequently if there were at-home testing available.

PrEP

Per AIDSVu.org, there are 24 locations where PrEP is offered for the 77,116 square mile state. During the Townhall session, it was stated that providers delivering services to clients who are on PrEP have in the past asked why a client was on an HIV medication when they are not diagnosed positive with HIV. Also, it was mentioned that PrEP tends to be offered in a more convenient setting such as when a client is getting tested for STD/STIs and they are already in a setting where PrEP is normalized. The SWOT analysis also revealed that due to religious preference, some providers choose not to prescribe or are not allowed to prescribe PrEP. Therefore, despite having education

available for providers to learn about this preventative measure, uptake will not happen due to these administrative barriers in policies or personal beliefs.

Resource Awareness

With having so many different funding sources and locations where programs and organizations reside, it can be difficult to keep up with the information and still be able to help clients where they are. South Dakota has many different types of providers and resources that the HIV community needs to network with as it was discovered through the needs assessment analysis. Providers during the Townhall and SWOT analysis voiced their opinions that knowledge about each other's provisions was lacking. Websites did not always have links to other resources that were needed to help clients and staff alike to navigate the options for available health services.

HIV Services

The consumer needs assessment survey asked HIV positive clients what services were hard to get or which ones they could not get. The two graphs below show those results.

As mentioned in the chart "Top Services You Use to Stay In Care," some services they use were also indicated as services that were also challenging to get (i.e., dental care). Through identification of what clients identify as what they need to achieve viral suppression and comparing that to what they perceive as difficult to access, the Integrated Plan can facilitate closing access to care and treatment gaps for PLWH.

Figure 25. Services needed that you cannot get

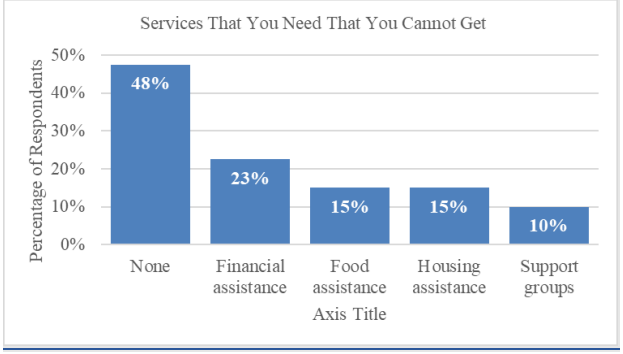
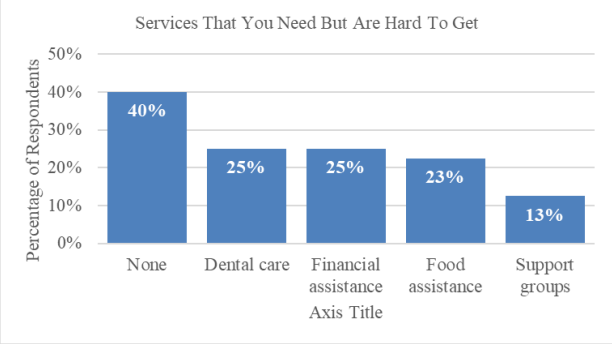


Figure 26. Services that you need but are hard to get



6. Identified Needs Assessment Priorities

Although many needs and barriers were identified, it was important that the proposed activities be achievable and relevant for the responsible partners of the Integrated Plan. During the overall needs assessments, key priorities that were identified that align with the goals and objectives are:

Outreach

Enhance outreach targeted to identified priority populations

- Collaboration with additional community centers and churches
- Promotion of STI/HIV testing and partner notification services
- Advertise Mobile testing

Substance Abuse and Mental Health

- Promote awareness of current Substance Abuse and Mental Health providers
- Educate Substance Abuse and Mental Health providers on unique needs of HIV positive persons

Existing Care Networks

- "Fast-tracking" entry to HIV medical care
- Education to non-Infectious Disease providers to broaden care across the state
- Education and awareness of telehealth/telemedicine for providers (policies and procedures)

Awareness of Available Resources and Education:

- Boost education on resources and materials for PLWH who are out of care and how they can access and pay for care (i.e., Health Insurance availability)
- Promote trainings for providing culturally appropriate HIV care for PLWH who have co-occurring medical conditions
- Conduct additional studies such as zip code study to help optimize campaign strategies and increase awareness of PrEP locations and other medical care resources

Collaboration and Leveraging Resources

- Encourage meetings that occur at least annually to network and share resources
- Collaborate across the state to identify new and current funding opportunities
- Identify new and existing stakeholders and discover additional prevention models to adopt

7. Key Actions Taken to Address Needs and Barriers during Needs Assessment

The process in developing and implementing the Needs Assessment for the 2022 Integrated Plan took place over six months and was initiated at the beginning of the Part B grant year in April 2022. It was imperative that first the PPG become apprised as to the steps necessary to create an updated assessment and conduct a thorough analysis of the current state of HIV care and prevention.

As mentioned, data analysis and the SWOT analysis were quantitative and qualitative ways to be able to develop a baseline of what the current HIV care and prevention programs look like. In response to these assessments, an opportunity to expand collaboration with the regional MWAETC was identified quickly with the assistance of the Health Access consultant. The MWAETC representative confirmed that the content offered through their resources can be opened up and expanded to include South Dakota providers for training sessions that may pertain to prevention and care for the community. The South Dakota prevention and care programs have a strong relationship with the local AETC and look forward to developing new opportunities.

The resource inventory was also a key focal point to being able to identify what prevention and care resources were available at the time of creating the Integrated Plan. The HRSA Inventory Tool was used to design South Dakota's inventory. The HIV Prevention Plan also has a resource inventory which was merged to establish a comprehensive inventory for both care and prevention.

8. Approach to Complete Needs Assessment

As mentioned in the Executive Summary, a needs assessment with providers who were Ryan White and non-Ryan White funded and consumers was conducted to provide more up-to-date information.

A SWOT analysis was performed to generate new strategies and was conducted with consumer involvement, provider input, and hosted on-site during a PPG planned strategic meeting. Two statewide Townhall meetings were conducted as an additional recruitment activity to promote qualitative discussion in the evaluation of current challenges and needs from the provider, consumer, and community views.

The PPG in-person meeting was held first with the SWOT analysis on April 29-30, 2022. It was determined after this to conduct two Townhall meetings; one for providers and another for community. The Townhalls were held virtually to promote attendance across the entire state and were offered at times conducive for providers and community. The provider Townhall was held in the early afternoon and the community Townhall was held in the evening on June 29, 2022.

The consultant for SDDOH and staff from the Ryan White Part B and HIV Prevention program met several times to develop an updated needs assessment survey for both provider and consumers/community. During the months of May and June the surveys were created to include questions previously asked in the 2014 assessments, Spanish-version and a paper-PDF version of the consumer survey, and flyers to promote the surveys with a QR link. During the Townhall sessions, the links were shared, and attendees were encouraged to promote the surveys. The surveys were open from June 29 through August 31, 2022 and evaluated in the month of September.

IV. Situational Analysis

A. Strengths, Challenges, and Needs Identified

The South Dakota Community Engagement and Planning Process to creating the Integrated Plan was conducted through 3 major steps:

1) Current data analysis
2) SWOT analysis
3) Needs Assessments (Town-Halls and Surveys)

Each step identified strengths, challenges, and gaps in the areas of diagnosis, treatment, prevention, and/or responding to HIV. For purposes of identifying which area reflects which part of the NHAS/EHE it focuses on, a letter corresponding to that area is noted in red (D-Diagnose, T-Treat, P-Prevent, R-Respond).

Data analysis

- (D) As compared to the United States prevalence-based HIV care continuum for 2019 (source: National HIV/AIDS Strategy: 2022-2025), the South Dakota prevalence-based HIV Care Continuum documents better linked-to-care, retention-in-care, and viral suppression rates. The State has seen significant progress year over year in all areas. While this is identified as a strength, it was noted during the SWOT analysis that data quality restricts the ability to do detailed analysis, and drilling down on specific data is restrictive due to the numbers being so low and potential for identifying clients could have occurred when identifiers were revealed.
- (P) PrEP locations and community awareness of PrEP: A strength noted, per AIDSVu.org, there are 24 locations where PrEP is known to be available in the entire State. Many providers and clients are unaware of these sites. Since many of the PPG members are familiar with using advertising to raise awareness about HIV, the PPG could explore awareness campaigns for Providers, clients, and program administrators.

SWOT analysis

- (P, R) AETC: It was identified that there was lack of awareness of the role of the AETC regarding the CDC's Compendium of Evidence-based Interventions and Best Practices for HIV Prevention. Furthermore, there was evidence of this as there was no change in prevention provider approach to testing and promotion of PrEP among primary care providers. This, along with the next few statements were challenges that will be addressed in the goals/objectives of the Integrated Plan.
- (T, R) AETC: Under-utilization of AETCs was clear during the inventory evaluation; it was realized that the HIV Care and Prevention programs have had limited access to the RWHAP Part F AETC that services the state and many providers are not aware of the services that include HIV care mentoring and training.
- (D, T, R) MWAETC: The Mountain West AETC is the flagship for the western states and is a resource for South Dakota Providers that can help meet statewide need of more HIV care providers via several evidence-based training venues, for example using ECHO®, tele-

mentorship and in-person training. The MWAETC's medical director also expressed that he and his staff are willing to support South Dakota providers to become more skilled at HIV Prevention and Care. In 2019 the RWHAP Part B program initiated a partnership with Part F and routinely meets with the Part F program to identify collaborative opportunities. Part F was invited to become a PPG member and the Part B program supports Part F through allowable in-kind support.

- (D, T, P, R) Lack of Capacity Building: A result of the Town Hall held in June 2022 was an awareness that HIV care providers and non-HIV care providers do not meet regularly or know about their resources. In many cases, none of the agencies have memorandums of understanding to facilitate referrals as many agencies do not know of other providers (i.e., FQHC's or mental health services). Developing recurring meetings to promote capacity building in the Integrated Plan will be a solution to this challenge.
- (P) PrEP underuse: The SWOT analysis identified that PrEP is being under-prescribed due to lack of awareness by non-infectious disease doctors. To change the underuse of PrEP in the community based on lack of knowledge or discrimination, training could be conducted for non-HIV care providers, especially those in primary care, about the role of PrEP use in primary care and treating clients without stigma[17].
- (P, T) Indian Health Services (IHS) as a Federal Agency: Since the Indian Health Service is a federal agency, a strength would be the access to additional federal funds to meet Integrated Plan goals; however, IHS is underfunded. Case managers and DIS collaborate with IHS facilities to ensure linkage to care and treatment for clients who choose to have their care and treatment at IHS facilities. To continue to enhance collaboration with case managers and IHS, another strength is that there could be a renewed communication between SDDOH, the PPG, and the Indian Health Service. This could benefit all agencies by demonstrating collaboration between state and federal agencies.
- (D, P, T, R) Weak tribal relations: A few areas were identified as continual challenges between the Indian Health Services and Department of Health Services relationship. 1) Prevention subrecipients have no access to reservations for testing or to provide education about PrEP; and 2) Limited client access to specialty HIV services and client awareness that these services can be accessed out of I.H.S. facilities.
- (T) Lack of capacity building specifically for IHS Providers: At the current time, the extent of IHS Providers to provide HIV care or the extent of need for training is unclear but by increased communication between the PPG, SDDOH and MWAETC the program can uncover where capacity building is needed for medical providers and support staff. Through collaborative efforts with the AETC the State could look at developing a training plan that would address needs of Native American healthcare providers.
- (D, P, T) Under use of Indian Health resources: To minimize under-use of Indian Health Service providers and funds, the first step needs to be building a relationship between the DOH, PPG, and the subrecipients. Underuse of federal resources could be minimized through collaborative and referral agreements by all programs and would increase capacity for PLWH statewide.

[17] Hull SJ, Tessema H, Thuku J, Scott RK. Providers PrEP: Identifying Primary Health care Providers' Biases as Barriers to Provision of Equitable PrEP Services. J Acquir Immune Defic Syndr. 2021 Oct 1;88(2):165-172. doi: 10.1097/QAI.0000000000002750. PMID: 34506359; PMCID: PMC8577287.

- (P, R) Harm Reduction: A continual challenge that South Dakota has is that the State laws do not promote Syringe Exchange Programs. In 2018, 13% of South Dakotans who were diagnosed with HIV reported HIV transmission was due to injection drug use[18]. South Dakota law makes it illegal to possess syringes[19] as they are considered drug paraphernalia and needle exchange is not allowed by law.
- (P, R) Safe Needle Disposal: Although the laws make it cumbersome to effectively address transmission of HIV among persons who inject drugs, a strength is that a possible bridge to the lack of needle/syringe programs in South Dakota is the "SafeNeedleDisposal.org" program. The program provides guidance on how to store needles in a safe manner for disposal and limit unintended transmission of infectious disease. In South Dakota, there are only two program needle-drop off locations (Rapid City and Sioux Falls), which are two areas with the greatest prevalence of HIV.
- (P, R) Prevention collaboration: Since the 2022 Town Hall demonstrated that many of the general healthcare providers do know about each other, the first step to capacity building is simply more contact between each other and sharing knowledge about programs that can minimize harm.
- (P, R) Resource under-use: Through avenues with the PPG, SDDOH can increase information shared with clients about the national "SafeNeedleDisposal.org" program and how it can help enhance use of a best practice for risk reduction for transmission of HIV via injection drug use.

B. ACCESS TO SERVICES

Client broadband internet

Weakness

To participate in telehealth visits, as per 2020 U.S. Census data, 83.2 % of all South Dakota households have broadband internet compared to 85.2% on a national basis and for persons making less than $20,000 per year the disparity is more pronounced, at 58% compared to 62% at the national level.

Strength

Laws in South Dakota favor telehealth adoption. For example, to address HIV care provider shortage SD law allows providers from other states who provide care to engage clients, and Advanced Practice Nurses can practice independently. This does two things: increases the eligible number of HIV care providers and helps combat geographic boundaries that lead to the bulk of HIV care and prevention services concentrated at the southeastern and southwestern part of the State. Another strength that can support telehealth adoption is the increased federal funds to support telehealth adoption (bandwidth, equipment, and client access to funds to cover internet access).

Capacity building

A substantial amount of capacity building is needed in order to implement telehealth to combat geographic barriers for care as access must be equitable too. For example, while the general population may have more access to smartphones the same may not be true for PLWH. For the

[18] South Dakota Department of Health, 2021 HIV/AIDs Surveillance Report, https://doh.sd.gov/documents/diseases/infectious/HIVSurveillanceReport.pdf
[19] https://sdlegislature.gov/Statutes/Codified_Laws/2047757

capacity building plan, SDDOH and PPG may be able to take advantage of the MWAETC's telehealth program, the HRSA-funded Telehealth Resource Center.

Underutilization of resources

Since SD law for Medicaid and other payers permit audio-only visits for clients who do not have internet access, this is a way to maximize existing policy to include implementing audio only telehealth visits (for follow-up appointments or low acuity clients). This could allow time for providers to receive training and for the State to seek additional funding opportunities that are part of the Infrastructure Investment and Jobs Act[20].

Stigma

Gap

Important challenges facing PLWH are stigma and discrimination. There are significant associations between low ARV adherence and retention in care by PLWH who believe they face stigma in the general community and when they seek medical care[21]. There is a growing body of research that suggests stigmatizing attitudes and behaviors toward PLWH act as barriers to testing, medication adherence, and retention in care among male and female PLWH thus resulting in a negative quality of life with HIV and poor psychological wellbeing[22].

Strength

In the 2022 survey of clients, SDDOH included questions to help assess the level of stigma that exists in the general population and especially by their healthcare providers.

Of the 43 total community members who took the needs assessment survey, five respondents indicated stigma or concerns about being judged by a medical care provider as a reason they did not get tested or delayed getting tested for HIV or STIs.

Emerging evidence indicates that how a medical facility treats PLWH remains a formidable barrier to an individual deciding to engage in HIV prevention and treatment among both HIV-negative and HIV-positive MSM.

Building capacity

In order to combat stigma in healthcare, persons who work with PLWH will benefit from training opportunities. The AETC, TargetHIV.org, and the State of Minnesota offer non-cost training and tool kits. As part of the plan to combat stigma in healthcare, the plan will need to include clients and the development of policy that applies to organizations that provide HIV services.

Underutilization

According to literature, effective strategies to minimize stigma in healthcare include involving PLWH in policy development and periodic monitoring of stigma among healthcare workers. One of the most effective policies that is often underutilized provides consequences for staff who discriminate against PLWH and conveys understanding with PLWH that staff who discriminate will

[20] https://www.congress.gov/bill/117th-congress/house-bill/3684
[21] Rueda S, Mitra S, Chen S, et al. Examining the associations between HIV related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. BMJ Open 2016;6:e011453. doi:10.1136/bmjopen-2016- 011453
[22] AIDS Behav. 2016 January ; 20(1): 115–125. doi:10.1007/s10461-015-1256-y; https://onlinelibrary.wiley.com/journal/17582652

face consequences. The integration of different measures of stigma-recognition approaches, along with psychological and social supports, is recommended to be incorporated into the national HIV response[23] (AIDS Behavior and Journal of Internationals AIDS).

Culturally competent case managers

Gap

A 2013 study of HIV care providers found increased attention to the role of cultural competence in providing HIV care[24]. The exact gap between the need for cultural competency training and actual practice is yet to be determined. The integrated plan needs assessment survey for the community included questions that try to assess cultural competency. The healthcare sector in many countries faces challenges related to increased diversity outpacing opportunities to strengthen cultural competency, which may result in challenging intercultural interactions between patients and clinicians. It is worthwhile to consider this is a gap across the entire healthcare system.

Strength

A strength is that SDDOH and its subrecipients have access to cultural competency training and resources from a number of sources, including TargetHIV[25], MWAETC[26], Health and Human Services[27] and SAMHSA[28].

Capacity building

There may be a significant need for capacity building with providers in South Dakota who are involved in HIV care and/or support services. A first step may be to support educational opportunities for the provider community about cultural competency resources. This step could be followed by initiating a plan to engage persons involved in HIV care and prevention to complete training modules on cultural competency in healthcare.

Underutilization of resources

Since the 2016 resource inventory did not include resources for cultural competency as a necessary skill set to provider HIV care and prevention, cultural competency resources will be added to the new resource inventory.

Awareness/Education

Sexual health education for youth in schools: As South Dakota is a local control state with regard to school curriculum, any outside presentations would be requested by the local school district.

C. Priority Populations

South Dakota's newly updated 5-year Integrated HIV Prevention and Care plan aligns with the NHAS and EHE Pillar initiatives to diagnose, treat, prevent, and respond. With these national goals

[23] https://targethiv.org/escalate/training; https://www.health.state.mn.us/diseases/hiv/partners/strategy/smtoolkit.html; https://aidsetc.org/topic/stigma
[24] Tyrel J. Starks, Simone J. Skeen, S. Scott Jones, Brett M. Millar, Sitaji Gurung, Christopher Ferraris, Ana Ventuneac, Jeffrey T. Parsons, Martha A. Sparks. (2022) The importance of domain-specific self-efficacy assessment for substance use and HIV care continuum outcomes among adults in an urban HIV clinic network. *AIDS Care* 34:5, pages 670-678.
[25] https://targethiv.org/library/topics/cultural-competency
[26] https://aidsetc.org/topic/cultural-competence
[27] https://thinkculturalhealth.hhs.gov/
[28] https://www.samhsa.gov/section-223/cultural-competency/resources

as the backbone, community engagement and planning activities, including an in-depth analysis of the most recent trended data sets and assessments, were conducted through collaborative efforts with both care and prevention providers and other stakeholders that affect the lives of the South Dakota community. The following specific activities were conducted to identify relevant information needed to develop goals and strategies for the Integrated HIV Prevention and Care Plan and include a focus on the needs of priority population

Data Stratification and Literature Research

The acquisition of stratified data on specific demographics such as Native American men who have sex with men (MSM), Black/African American MSM, Youth ages 13-24 yr MSM, and women guided the alignment of the State's goals and objective activities in development of the IP with respect to current priority populations. Geographic data heat maps with overlay maps locating current medical care locations as well as American Indian reservation boundaries also were used when identifying where HIV care "deserts" may exist. Additional analysis of the data indicated disproportionate socio-economic and demographic factors and assisted in identifying locations and specific populations on which the goals and strategies should be focused.

A literature search on co-occurring conditions and other types of socio-economic concerns that lie in the geographic area and in the populations of focus identified the susceptibility that these populations have towards those socio-economic issues. The strategies proposed have a narrowed focus on these particular disparities and include proposing more collaborations from providers who serve the populations with the intent to treat individuals wholistically rather than create silos of care.

Needs Assessments: Surveys and Townhalls

The last state-wide needs assessment for HIV care and prevention was conducted in 2014. No other comprehensive needs assessment has been conducted. Therefore, the SDDOH HIV Prevention and Ryan White Programs disseminated a comprehensive HIV prevention and care needs assessment in May 2022. One of the surveys had an intended audience of providers, clinicians, and case managers of HIV care and prevention. The provider survey intent was to identify gaps and weaknesses specifically in the care and delivery of care and prevention from the provider perspective. The outcomes were used to develop strategies that are geared towards system change to help improve areas where there are gaps in care and prevention delivery to include linkage to care, lack of cultural competency, or education needed for providers to be able to deliver services to the most vulnerable populations.

The second survey was intended for PLWH and/or at-risk community members. Similar to the provider survey, the intent was to identify gaps and weaknesses in care and delivery of services as perceived or experienced by the community. Outcomes were used to help develop strategies specific to the populations of focus to address areas of weakness and gaps in linkage to care and prevention.

Qualitative data is a vital part to collecting information to help understand processes and perceived barriers or system failures in delivering services. The SDDOH held two Town Hall sessions in order to collect this information in April 2022: one for providers, clinicians, and case managers of HIV care and prevention and the other for PLWH and/or at-risk community members. HIV prevalence and incidence data from the past 3 years was presented to both groups with guided discussions. The open dialogue helped solidify the data and identify models of change that could be implemented in

South Dakota that could be a part of the HIV Prevention and Care Plan. The data presented specific to the populations of focus helped guide the conversation to brainstorm strategies that would be tailored to them and how some models may not work for the geographic region or demographic.

SWOT Analysis during PPG meeting

Since the PPG will be responsible for monitoring the outcomes of the HIV Prevention and Care Plan, the SDDOH felt it important to get a better idea of what the PPG group felt about how HIV care and prevention delivery was being done. Therefore, the SDDOH provided a group session to conduct a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis in April 2022. One was done with the focus on HIV Care and another on HIV Prevention.

The outcomes can be found in **Appendix B** and helped to affirm data outcomes and identify the leading priorities where strategies should be tailored. While data suggests the populations of focus are Native American MSM, youth ages 13-24 yr MSM, and women, the SWOT showed evidence where there are gaps in getting the care and resources to these individuals and why those gaps exist. The strategies of the HIV Prevention and Care plan will include suggested solutions offered during the SWOT analysis.

Integration with the HIV Prevention Plan

The SDDOH HIV Prevention division was developing their updated HIV Prevention Plan at the same time as the Integrated HIV Prevention and Care Plan was being developed. As a result, the SDDOH Ryan White Program was able to partner with their planning group to collaborate on mutual goals and strategies that were non-duplicative and complimentary to each other. The HIV Prevention Plan identified the following demographic populations as having the highest prevalence rate of HIV in 2019: Sex – males; Race and Ethnicity – Black/African American with American Indians being second highest rate; Age – 45-64 years; Nationality – African; and Exposure risk – IDU and MSM.

Recommended strategies for the HIV Prevention Program:

1) HIV Testing
2) Comprehensive Risk Counseling and Services
3) Partner Services
4) ARTAS (Anti-Retroviral Treatment and Access to Services)

Proposed interventions

1) Biomedical: Medication Adherence and HIV Navigation Services
2) Public Health: ARTAS; Ask, Screen, Intervene; Data to Care; Partner Services; Comprehensive Risk Counseling and Services (CRCS); Couples HIV Testing and Counseling (CHTC); Social Network Strategy (SNS) for counseling, testing, and referral; and HIV testing
3) Behavioral: Choosing-Life: Empowerment! Action! Results! (CLEAR); Personalized Cognitive Counseling (PCC); Safe in the City (SITC); and Sister to Sister
4) Structural: Condom Distribution
5) Social Marketing: The Health Communicator's Social Media Toolkit

The goals and strategies of the Integrated HIV Prevention and Care Plan will complement the HIV Prevention Plan strategies and interventions, allowing for non-duplication and enhancement to promote a status neutral and wholistic approach to preventing and treating all South Dakotans who

are at risk and/or who have HIV. Both plans emphasize the importance of the same populations of focus and allow for strategies to focus on those who are most vulnerable to either contracting HIV or not reaching viral suppression.

V. 2022-2026 South Dakota Goals and Objectives

The following is a list of South Dakota's HIV Prevention and Care Plan Goals and key Strategies with reasons. The comprehensive Goals and Strategies with responsible partners, potential funding sources, outcomes, monitoring data, and expected impact on the HIV Care Continuum can be found in **Appendix C.** The Goals and Strategies will be treated as a living document and not be static. They will be reviewed at least annually and updated or revised to reflect current community needs or environment and include outcomes and continuation of strategies as necessary.

NHAS GOAL 1: PREVENT NEW HIV INFECTIONS

(Corresponds to EHE PILLAR 3)

LOCAL GOAL 1: BY DECEMBER 31, 2026, THE NUMBER OF NEW HIV DIAGNOSES WILL BE REDUCED BY 2% ANNUALLY FROM A 2021 BASELINE.

OBJECTIVE 1: Provide at least 2 targeted outreach events annually for priority populations including refugees, Native Americans/American Indians, women, and at-risk population who use intravenous drugs.

Reason: *Outreach events are a backbone to being able to offer education and resources to attendees in large masses. However, location of outreach events has typically been at locations that are not rural, nor tailored toward those that are most impacted or at highest risk of HIV; namely AI/AN, Women, and Black/African Americans-Refugees, and intravenous drug users.*

Strategies	Activities/Interventions	Target Populations	Responsible Parties
Provide at least 2 targeted outreach events annually for priority populations including refugees, American Indians/Alaska Natives, women, and individuals at risk for HIV infection	1. Collaborate with local religious, tribal, and spiritual community partners to organize outreach opportunities such as local health fairs, food drives, market days, etc. 2. Have fliers and pamphlets available at local health fairs, community centers during large events such as Powwows, World AIDS Day, Pride, Sturgis, etc.	Refugees, Native Americans/American Indians, women, IDU	Agencies providing outreach activities in South Dakota, SDDOH, Prevention and RW subrecipients

OBJECTIVE 2: By December 31, 2026, develop at least 5 collaborations with local religious, tribal, and spiritual community partners and community centers in South Dakota.

Reason: *Through literature research and provider feedback, the target populations including refugees migrating to South Dakota have been an increasing concern as this is an identified area where HIV/AIDS is highly prevalent.*

NHAS GOAL 1: PREVENT NEW HIV INFECTIONS *(Corresponds to EHE PILLAR 3)*			
Strategies	**Activities/Interventions**	**Target Populations**	**Responsible Parties**
Provide HIV resource inventory and testing information in local and rural areas to at least 5 partners	1. Have resource inventory shared with local and rural churches 2. Increase awareness through the shared resource inventory to at least 5 local and rural community centers or partners	Refugees, Native Americans/American Indians, women, IDU	Churches that assist refugee populations, PPG team members, public health departments, local and rural community centers
OBJECTIVE 3a: By December 31, 2023, SDDOH will promote no- cost STI/HIV testing resources through their website so that clients and providers alike may be able to have awareness that this is offered for free and how and where they can access it. ***Reason**: The SDDOH HIV Prevention Plan promotes the Disease Intervention Specialists (DIS) who may provide HIV and STD testing free of charge. In the 2022 preliminary consumer needs assessment (22 respondents), almost 70% indicated they would be likely to very likely to test more often if there were more free testing locations.*			
Strategies	**Activities/Interventions**	**Target Populations**	**Responsible Parties**
Provide increased awareness of "free" STI/HIV testing to providers and community	1. Create campaign on SDDOH website using U=U marketing tools 2. Work with internal SDDOH partner divisions to promote links to the RW and Prevention websites	All PLWH and High-Risk individuals throughout SD	SDDOH PPG SDDOH partnering divisions IT
OBJECTIVE 3b: By December 31, 2026, SDDOH will create a link on their website where clients and providers can enter a request for STI/HIV testing to be conducted at a client's location. ***Reason:** In the 2022 provider needs assessment survey, a provider indicated they can provide STI testing at-home with their mobile unit upon the client's request. Additionally, in preliminary review of the consumer survey with 22 respondents, almost 70% individuals indicated they would be likely or very likely to test more often if there were more free testing locations offered. This may help in allowing clients and providers alike to be aware that this is a service offered and providers or others may also make the inquiry on the client's behalf.*			

NHAS GOAL 1: PREVENT NEW HIV INFECTIONS *(Corresponds to EHE PILLAR 3)*			
Strategies	**Activities/Interventions**	**Target Populations**	**Responsible Parties**
1a. Promote at-home testing through mobile testing sites or self-testing kits	1. Develop link within SDDOH website 2. Share link with community at large	All PLWH and High-Risk individuals throughout SD	SDDOH Case Managers DIS workers PPG SDDOH partnering divisions IT
1b. Evaluate effectiveness of website marketing for mobile-/self-testing	1. Review testing data quarterly 2. Based on data-increase or change activities in 1a for better promotion	All PLWH and High-Risk individuals throughout SD	SDDOH PPG IT

NHAS GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES OF PEOPLE WITH HIV *EHE PILLAR 2*
LOCAL GOAL 1: BY DECEMBER 31, 2026, PLWH IDENTIFIED WITH SUBSTANCE USE AND MENTAL HEALTH NEEDS ARE MADE AWARE OF RESOURCES.
OBJECTIVE 1: By December 31, 2026, increase access to Substance Abuse and/or Mental Health services by 50%. ***Reason**: Providers who responded to the 2022 needs assessment survey indicated that one of the lead reasons why clients are not in treatment is due to availability of options; however, upon the resource inventory discovery phase, it was discovered that there are almost 20 different programs and facilities who have funding to treat substance use disorders or mental health issues in an inpatient and/or outpatient setting. A gap found was knowledge of these resources is not widespread among clients and providers alike for clients to self-refer or providers to refer to.* *It was conveyed that some Substance Abuse and Mental Health providers in South Dakota may not have experience with the unique needs of PLWH and there is a continued sense of stigma experienced by PLWH by these providers resulting in clients being less likely to continue to use that provider; training is vital to providers so that they can deliver substance abuse care and treatment in a meaningful and appropriate manner that is specific to PLWH.*

NHAS GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES OF PEOPLE WITH HIV *EHE PILLAR 2*			
Strategies	**Activities/Interventions**	**Target Populations**	**Responsible Parties**
1. Persons diagnosed with SA and/or MH receive referrals within 10 business days 2. Increase community partners education of harm reduction 3. Increase awareness of SA and/or MH programs available	1. Work with DIS and case management on SA and MH referrals 2. Share Harm Reduction training resources and opportunities for HIV care and prevention partners in community 3. Promote SA and/or MH programs on SDDOH website	All PLWH, PWID, and High-Risk individuals throughout SD	SDDOH Case Managers DIS workers PPG SDDOH partnering divisions SA and MH providers in community
LOCAL GOAL 2: BY DECEMBER 31, 2026, VIRAL SUPPRESSION RATES FOR PLWH HAVE IMPROVED BY 5%			
OBJECTIVE 1: By December 31, 2026, Reduce Late to Care PLWH in Newly Diagnosed population through enhancement of existing care networks to increase referral system across SD ***Reason:*** *Research has found that "…immediate ART initiation following HIV diagnosis resulted in very high rates of viral suppression over time[29]."*			
Strategies	**Activities/Interventions**	**Target Populations**	**Responsible Parties**
1. Focus on "fast-tracking" entry to HIV medical care 2. Promote availability of telemedicine for access to care 3. Conduct newly diagnosed needs assessment to determine barriers to access	1. Promote "fast-track" appointments focusing on newly diagnosed PLWH 2. Increase awareness and education of telemedicine/telehealth options, including assistance in accessing telehealth/telemedicine 3. Create and conduct survey for newly diagnosed clients who enter into care	All newly diagnosed PLWH and High-Risk individuals throughout SD	HIV care providers; Case Managers; HIV prevention providers; DIS; Substance Abuse and Mental Health providers

[29] Coffey S, Bacchetti P, Sachdev D, et al. RAPID antiretroviral therapy: high virologic suppression rates with immediate antiretroviral therapy initiation in a vulnerable urban clinic population [published correction appears in AIDS. 2019 Nov 1;33(13):2113]. AIDS. 2019;33(5):825-832. doi:10.1097/QAD.0000000000002124

NHAS GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES *(Corresponds to EHE PILLARS 2, 4)*			
LOCAL GOAL 1: BY DECEMBER 31, 2026 , REDUCE DISPARITIES IN NEW HIV INFECTIONS AND KNOWLEDGE OF STATUS FOR EACH POPULATION BY 3% ANNUALLY.			
OBJECTIVE 1: Increase awareness of HIV-related disparities by decreasing stigma related to medical care. ***Reason**: According to the Joint United Program on HIV/AIDS, HIV-related stigma and discrimination serve as barriers limiting access to and acceptance of prevention services, engagement in care, and adherence to ART.*[30]			
Strategies	**Activities/Interventions**	**Target Populations**	**Responsible Parties**
Implement mechanisms to identify and re-engage individuals who are out of care	1. Provide education and materials to PLWH who are out of care to reduce fears of ART issues, stigma 2. Enhance messaging statewide to promote Health Insurance availability for PLWH 3. Enhance efforts of promotion of telemedicine through social media venues, community centers, bars, churches, substance use centers, legal aide, etc. to decrease barriers real or perceived for PLWH who are out of care 4. Fast-Track activities to medical care for PLWH	**PLWH**	**SDDOH, Positive Connections Program, Prevention and RW subrecipients, case managers**
LOCAL GOAL 2: **BY DECEMBER 31, 2026, ADDRESS SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH AND CO-OCCURRING CONDITIONS THAT IMPEDE ACCESS TO HIV SERVICES AND EXACERBATE HIV-RELATED DISPARITIES BY INCREASING PROFESSIONAL DEVELOPMENT TIME FOR PROVIDERS BY 25% EACH YEAR.**			
OBJECTIVE 1: Improve education to specialty providers for PLWH with co-occurring medical conditions and improve screening and linkage to services for people living with or at risk for HIV who are diagnosed with and/or are receiving services for co-occurring conditions.			

[30] https://www.cdc.gov/globalhivtb/who-we-are/features/amplifying-undetectableuntransmittable.html

NHAS GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES *(Corresponds to EHE PILLARS 2, 4)*			
Reason: Persons with HIV infection have a higher number of comorbidities, compared to HIV-negative persons. PLWH have been shown to be at higher risk for cardiovascular disease, liver & kidney disease, osteoporosis and fractures, metabolic disorders, and several non– AIDS-defining.[31]			
Strategies	**Activities/Interventions**	**Target Populations**	**Responsible Parties**
1. Promote educational training opportunities for health care providers who serve PLWH 2. Improve network opportunities with currented funded providers	1. Promote AETC trainings to include ECHOs 2. Host one case-conference Town Hall for providers twice a year at minimum	PLWH with co-occurring conditions	SDDOH PPG RW funded providers
LOCAL GOAL 3: BY DECEMBER 31, 2026, IMPROVE RETENTION IN CARE BY 10% FOR ALL PLWH IN RURAL AREAS.			
OBJECTIVE 1: Ensure availability of quality medical care and support services by promoting telemedicine/telehealth. By the end of calendar year 2024, a zip code study will be conducted on all South Dakota zip codes and stratified by SES factors and demographics. ***Reason**: Retention in care is a critical component to a person's overall health to include their ability to reach and stay virally suppressed. Continuous retention in care and achieving viral suppression allows those who are positive to actively partake in "prevention as treatment" and end the HIV epidemic.*			
Strategies	**Activities/Interventions**	**Target Populations**	**Responsible Parties**
1. Identify areas where PLWH have lower SES 2. Collaborate with partners who are in higher SES areas to inform about current services 3. Promote quality of life through retention in care	1. Conduct zip code study 2. Through PPG meetings, provide data from zip code study 3. Utilize different campaigns (i.e., U=U; OPT-In for Life) 4. Increase awareness of PrEP locations by linking the AIDSVu website to the SDDOH website	All PLWH throughout SD	All funded Ryan White Programs PPG Community stakeholders

[31] Gallant J, Hsue PY, Shreay S, Meyer N. Comorbidities Among US Patients With Prevalent HIV Infection-A Trend Analysis. J Infect Dis. 2017 Dec 19;216(12):1525-1533. doi: 10.1093/infdis/jix518. PMID: 29253205

NHAS GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES *(Corresponds to EHE PILLARS 2, 4)*			
4. Promote prevention of HIV			

NHAS GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND STAKEHOLDERS

(Corresponds to EHE PILLAR 4

LOCAL GOAL 1: EACH FISCAL YEAR A MINIMUM OF ONE STATEWIDE INTEGRATED MEETINGS (E.G. PREVENTION PLANNING GROUP) WILL BE HELD

OBJECTIVE 1: To share best practices among HIV programs for prevention, care, and treatment.

At the end of each fiscal year the SDDOH will convene a virtual Town Hall meeting to include staff with IHS to discuss the priorities, data, and status of the Integrated Plan. Discussion will also include updates, next steps, and implementation changes.

Reason*: "The challenge for primary care and public health systems is…how to best combine evidence-based interventions and deliver them to at-risk individuals. While the CDC offers the compendium and Target HIV the Best Practices compilation…Creating a space for interaction and discussion allows participants to discuss concepts in real-world situations"*[32]

Strategies	Activities/Interventions	Target Populations	Responsible Parties
Engage with stakeholders who have not previously collaborated with the HIV Prevention or Ryan White Programs to include staff with IHS to discuss the priorities, data, and timeline of the Integrated Plan	1. An annual strategic meeting will be held between the SDDOH and prevention and care providers of HIV 2. Each meeting will contain an agenda item for sharing of best practices, data, and review status of the Integrated Plan	All PLWH throughout SD	SDDOH Ryan White Programs; SDDOH Partner programs; PPG; HIV Prevention; All Integrated Plan stakeholders and partners Epidemiologist

OBJECTIVE 2: All stakeholders and/or partnering agencies and programs who have an active role in the prevention and care of persons living with HIV will discuss possible funding opportunities and if found, add to the resource inventory.

Reason: **"***The lived experience of stakeholders and clients is incredibly valuable developing strategies and can lead to greater uptake by clients & stakeholders in the healthcare community."*[33]

[32] National LGBT Health and Education Center. (2014). *BEST PRACTICES IN HIV PREVENTION: TRANSLATING INNOVATION INTO ACTION. Retrieved from* HIV-Best-Practices-Final.pdf (lgbtqiahealtheducation.org)

[33] Patient Centered Outcomes Research Institute. 2018. The value of engagement. Retrieved from https://www.pcori.org/engagement/value-engagement

NHAS GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND STAKEHOLDERS *(Corresponds to EHE PILLAR 4*			
Strategies	**Activities/Interventions**	**Target Populations**	**Responsible Parties**
Prevention and care funding opportunities that are offered locally, by state, and/or federally will be explored, to include pharmaceutical grants to assist in awareness campaigns	1. Review grants.gov 2. Work with partnering agencies for local funding availability 3. Work with pharmaceutical companies for funding availability	All PLWH and High-Risk individuals throughout SD	SDDOH Ryan White programs; SDDOH Partner programs; PPG; HIV Prevention; All Integrated Plan stakeholders and partners
LOCAL GOAL 2: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND STAKEHOLDERS, TO INCLUDE INCREASED PARTICIPATION OF NON-RYAN WHITE FUNDED PARTNERS BY 10%			
OBJECTIVE 1: Introduce at least 2 new stakeholders and/or partnering agencies into the Integrated Plan stakeholder group (e.g., opioid program, tobacco, maternal and child health, nursing and medical schools, public health program, CBO's [e.g., LGBTQIA+ coalitions], SAMHSA, student/cultural societies, Call to freedom/freedom's journey). ***Reason**: "Effective engagement of patients and stakeholders requires a well-thought-out engagement plan. For a plan to be effective, an outline of how stakeholder partners will be involved & result in a vested interest in the plan."*[34]			
Strategies	**Activities/Interventions**	**Target Populations**	**Responsible Parties**
1. Request various recipients to present on expert specialties to raise awareness 2. Incorporate additional prevention models	1. Hold presentations on topics such as: A. Safe needle practices B. PrEP C. Tobacco Cessation D. Maternal and Child Health E. Call to Freedom/Freedom's Journey 2. Promote safe needle program by adding the SafeNeedleDisposal.org	All PLWH and High-Risk individuals throughout SD	PPG; Thunder Valley Community Development Corporation; SafeNeedleDisposal Program; All Integrated Plan stakeholders and partners

[34] Patient Centered Outcomes Research Institute. 2018. The value of engagement. Retrieved from https://www.pcori.org/engagement/value-engagement

NHAS GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND STAKEHOLDERS *(Corresponds to EHE PILLAR 4*			
	link to the SDDOH website		

VI. Monitoring and Follow Up to Goals and Objectives

A. Implementation

Coordination of Partners

During the process of developing the Integrated Plan, it was discovered the need to establish relationships between providers, agencies, and programs across the entire state of South Dakota. For example, responses from partners on the needs assessment survey was low. To build interest and attendance, program staff developed colorful flyers and directly reached out to participants about the Town Halls and the opportunity to provide input on the objectives/strategies in the next five years.

The SDDOH helped organize and promote the event which brought great attendance to the meeting. After the Town Halls were conducted, feedback from the participants suggested it was a novel idea and could be something they should do in the future. They communicated that this would be a valuable way to meet with their peers and discuss issues and common challenges they face. The Town Hall also brought together agencies that had not worked together before. Many agencies did not know about the complementary services offered by other participants who provide care to the HIV Prevention and Care Community.

As mentioned in previous sections, the State of South Dakota is a state with great distances between organizations, resulting in many partners not knowing about each other and their services. Offering regular virtual Town Halls could help create linkages and educate participants about client services to which they can refer clients. Regular Town Halls (virtual and potentially in-person) could be an effective model to promote the coordination of partners, create linkages, and share resources. One of the objectives in the goals will be to continue this practice of holding Town Halls in order to complete these activities to evaluate the goals and objectives/strategies of the Integrated Plan as well as build on coordination of partners.

Leveraging of Funding Streams

The SDDOH and partners will leverage funding streams to the fullest extent by continually evaluating resources and determining additional outreach opportunities that will maximize capacity in the State. Knowledge of external resources will assist in conserving resources and adhering to payer of last resort requirements per HRSA/HAB Policy Clarification Notice (PCN) 21-02.

To this end, the SDDOH Ryan White Programs will continually monitor funding opportunities via searches of the grants.gov and other websites on which funding opportunities are made available. In addition, the SDDOH Ryan White Programs will seek out funding availability from pharmaceutical companies to assist in HIV education and awareness campaigns. The sharing of funding opportunities will be a standard item of discussion at all regular Town Hall meetings between plan stakeholders and partners, allowing for the discovery of local opportunities and those that are not communicated on the larger funding opportunity websites.

Funding opportunities, as appropriate, will be added to the HIV Resources Inventory Compiler to allow for the sharing between SDDOH and its partners in one comprehensive file of all available HIV resources.

B. Monitoring

The South Dakota Integrated HIV Prevention and Care Plan spans a wide geographic area with regard to its desire to be successful in the implementation of the proposed goals and objectives. Given the difficulty this may pose, those involved in developing the plan foresaw this as being a challenge that would need to be addressed. Therefore, a solution to collaborating state-wide with stakeholders and partners was built into one of the objectives. The objectives propose a virtual Town Hall be held annually to not only discuss the progress of the plan but also to collect necessary information to help understand how each objective is going. This would include quantitative and qualitative data collection.

Members of the PPG will convene to discuss received information from the Town Halls and other sources to identify next steps with each objective/strategy. The Integrated Plan will be an agenda item on every quarterly meeting as well.

C. Evaluation

Evaluation of the Integrated Plan will be both qualitative and quantitative. The qualitative evaluation will be held during proposed Town Halls held annually. Each objective/strategy will be reviewed as applicable to determine the level of achievability, appropriateness, and if it requires a revision, continuation, or elimination. Data will also be an integral part of evaluating the objectives/strategies therefore, each goal will have a quantitative evaluation linked to it. For example, trending of the number of PLWH linked to care within 90 days will be trended annually to help evaluate the success of the goal "The number of new HIV diagnoses will be reduced by 2% from the 2021 baseline." Reporting of this data will occur annually during the Town Halls and at the PPG meetings which are held quarterly.

D. Improvement

As mentioned in the evaluation, a specific performance measure is linked to each objective/strategy. The performance measure may be one that is already collected, such as viral suppression rates while others may be more tailored to the specific activity. An example of this is for the goal "PLWH identified with substance use and mental health needs are made aware of resources." The quantitative measure linked to this is two-fold: 1) Number of PLWH with identified SA issues who enter/linked to treatment and 2) number of PLWH with SA issues who complete treatment after entry. Data will be run either quarterly or annually, depending on the measure and appropriateness. Members of the PPG and Town Halls will provide their feedback on how to proceed with the proposed activities to determine their effectiveness on the outcomes and decide if it requires a revision, continuation, or elimination.

E. Reporting and Dissemination

An annual Town Hall of the stakeholders and planning members of the Integrated Plan will hold agenda items to provide outcomes of the objectives/strategies and discuss next steps. The PPG will also hold an agenda item during their quarterly meetings to discuss the Integrated Plan. The reports will be provided through a presentation with handouts or other form of report out and disseminated after each meeting via email to those who request it. Voting via surveys or live polling will assist in collecting the consensus for each activity to help determine how to proceed.

A template excel tool holds the goals and objectives/strategies which allows a snapshot of what the activities are, key partners, funding resources, and expected impact on the HIV Care Continuum. An area at the bottom of each Goal allows for annual updates with trended data, and a brief explanation of what was done for each objective/strategy. Any changes to activities can be reported here as well. Each year, after the information has been entered, the tool can be printed as a report to be distributed to members who desire a copy and for reporting purposes.

APPENDIX A

Section	Brief Detail	New Material (Y or N)	Page location
I. Executive Summary	Description of the Integrated Plan	Y	7
a. The Approach	Approach to preparing the IP submission	Y	8
b. Documents Submitted	List and describe all documents used to meet submission requirements	Y	9
II. Community Engagement and Planning Process	Describe how your jurisdiction approached the planning process	Y	10
a. Entities Involved	List and describe the types of entities involved in the planning process	Y	10
b. Role of the RWHAP Part A Planning Council/Planning Body	Describe the role of the RWHAP Part A Planning Council(s)/Planning Body(s) in developing the Integrated Plan	N	10
c. Role of Planning Bodies and Other Entities	Describe the role of CDC Prevention Program and RWHAP Part B planning bodies, HIV prevention and care integrated planning body, and any other community members or entities who contributed to developing the Integrated Plan	N	11
d. Collaboration with RWHAP Parts	Describe how the jurisdiction incorporated RWHAP Parts A-D providers and Part F recipients across the jurisdiction into the planning	Y	11
e. Engagement of People with HIV	Describe how the jurisdiction engaged people with HIV in all stages of the process, including needs assessment, priority setting, and development of goals/objectives	Y **Appendix B**	12
f. Priorities	List key priorities that arose out of the planning and community engagement process	Y	15
g. Updates to Other Strategic Plans Used	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement:	Y	26
1. How South Dakota will use annual needs assessment data to adjust priorities		Y	26
2. How South Dakota incorporates ongoing feedback from PLWH and		Y	26
3. Changes to the plan as a result of updates, assessments, and community input		Y	27
4. Changes made to the planning process as a result of evaluating the planning process		Y	27

Section	Brief Detail	New Material (Y or N)	Page location
III. Contributing Data Sets and Assessments		Y	28
A. Data Sharing and Use	Provide an overview of data available to the jurisdiction and how data were used to support planning	Y	28
B. Epidemiologic Snapshot	Provide a snapshot summary of the most current epidemiologic profile for the jurisdiction which uses the most current available data (trends for most recent 5 years)	Y	28
C. HIV Prevention, Care, and Treatment Resource Inventory	Create an HIV Prevention, Care and Treatment Resource Inventory	Y **APPENDIX D**	35
1. Inventory Narrative		Y	35
2. Strategy for Coordinating the Provision of Substance Use Prevention and Treatment Services		Y	36
3. How Services Will Maximize the Quality of Health and Support Services Available to Persons at Risk for or with HIV		Y	38
4. Strengths and Gaps of the Resource Inventory	Describe strengths and gaps in the HIV prevention, care, and treatment inventory for the jurisdictions	Y	39
5. Approaches and Partnerships	Describe the approaches the jurisdiction used to complete the HIV prevention, care and treatment inventory	Y	40
D. Needs Assessment	Identify and describe all needs assessment activities or other activities/data/information used to inform goals and objectives in this submission	Y	41
1. Status Neutral Services for At-Risk and Newly Diagnosed	Services people need to access HIV testing, as well as the following status neutral services needed after testing	Y	41
2. Services PLWH Need to Stay in Care and Achieve Viral Suppression	Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression –Needs	Y	41
3. Barriers and Accessibility Existing HIV Testing, Prevention Services, and Care and Treatment Services	Barriers to accessing existing HIV testing, including State laws and regulations, HIV prevention services, and HIV care and treatment service – Accessibility	Y	46
4. Identified Needs Assessment Priorities	List the key priorities arising from the needs assessment process	Y	49

Section	Brief Detail	New Material (Y or N)	Page location
5. Key Actions Taken to Address Needs and Barriers during Needs Assessment	List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process	Y	50
6. Approach to Complete Needs Assessment	Describe the approach the jurisdiction used to complete the needs assessment	Y	50
IV. Situational Analysis		Y	51
A. Strengths, Challenges, and Needs Identified	Provide a short overview of strengths, challenges, and identified needs with respect to HIV prevention and care	Y	52
B. Priority Populations	Describe how the goals and objectives address the needs of priority populations for the jurisdiction	Y	56
V. 2022-2026 South Dakota Goals and Objectives	List and describe goals and objectives for how the jurisdiction will diagnose, treat, prevent and respond to HIV. Be sure the goals address any barriers or needs identified during the planning process	Y **APPENDIX C**	58
VI. Monitoring and Follow Up to Goals and Objectives	Describe the infrastructure, procedures, systems or tools that will be used to support the 5 key phases of integrated planning to ensure goals and objectives are met	Y	66
a. Implementation	Describe the process for coordinating partners, including new partners, people with HIV, people at high risk for exposure to HIV, and providers and administrators from different funding streams, to meet the jurisdictions Integrated Plan goals and objectives	Y	67
1. Coordination of Partners		Y	67
2. Leveraging of Funding Streams		Y	67
b. Monitoring	Describe the process to be used for monitoring progress on the Integrated Plan goals and objectives	Y	67
c. Evaluation	Describe the performance measures and methodology the jurisdiction will use to evaluate progress on goals and objectives	Y	68

Section	Brief Detail	New Material (Y or N)	Page location
d. Improvement	Describe how the jurisdiction will continue to use data and community input to make revisions and improvements to the plan	Y	68
e. Reporting and Dissemination	Describe the process for informing stakeholders, including people with HIV, about progress on implementation, monitoring, evaluation and improvements made to the plan	Y	68
f. Updates to Other Strategic Plans Used to Meet Requirements			
VII. Letters of Concurrence	Provide letters of concurrence or concurrence with reservation	Y	2

Care

South Dakota
2022-2026 Integrated Plan Development

APPENDIX B

	STRENGTHS	WEAKNESSES
Internal	Positive connections program at SDOH	Need more HIV care providers
	RW program allows access to persons at or below 300% of FPL	Long distance for patients to drive for HIV services
	VOA Health Services Face Book Page (provides information/resources)https://voahiv.org/	Lack PrEP providers
	Dedicated HIV Care Providers	Weak tribal relations
	Good HIV Data (Viral suppression, retention & ARV Rx)	Demographics of the state of South Dakota
	Ryan White Program Case Managers who are passionate about their work	Access to HIV services and care
	Additional HIV Care Providers	Stigma of HIV in the state
	Linkage to care	Not enough education for providers
	RW porgrams on East and West side of state (Rapid City and Sioux Falls)	Provider education to refer to mental health
		Provider education to refer to SUD treatment services (drug rehab)
		Lack of staff time to do all the things that are needed
		Lack of culturally competent case managers
		Not funded for SA (Opioid issues)
		AI/NA clients state they do not want to get services at Indian Health Services
External	Providers who see clients with health insurance	Distance to drive to access HIV care
	Foundations that provide grants	Lack of thorough follow-up (by providers or in general)
	Grant funds	Political climate in the State of SD
	Telemedicine services	Lack of concern by HIV care providers
	Telehealth for case management	Lack of funding
	More case managers	Lack of mental health services in SD
	Strategic planning between RW, HIV Prevention and STI (STD)	Lack of SUD treament services in SD
	Listings for easy access for referals for SUD treatment (rehab)	Funding reduction to SMAIF in FY2018; eliminated funding for IHS and loss for prevention, outreach, education, treatment with OMH, Office of Womens' Health, & HIV.gov
	Could potentially participate in Stage II of the Environmental Scan of Tribal Opioid Overdose Prevention Responses: Community-Based Strategies and Public Health Data Infrastructure	No EHE funding; Only receive dollars for Part B & C and Prevention
	Potential for partnering with AETC for TA	
	There are funding opportunities for CHWs	
	OPPORTUNITIES	**THREATS**

Prevention

South Dakota
2022-2026 Integrated Plan Development

Internal

STRENGTHS	WEAKNESSES
Advertisements on stigma presentations	Lack Free needle exchange
testing education	Lack of HIV Prevention providers on reservations
HIV testing options are provided at no cost	Working with minorities
HIV testing	Lack of condom distribution sites
Partner services for clients who have postive test results	PrEP availability
Community testing events	Sexual health education to youth
PrEP	Inability to educate as many sites
3 HIV Prevention Services Contractors (providing services)	Inability to educate at schools
PrEP Available in SD	Sexual health education to parents
HIV Testing Active	Limited testing sites
Prevention Teaching	Limited PrEP providers
Data	Advertising for services for PrEP sites
	Reducing stigma
	Outreach at public events (PRIDE)
	Lack of education information
	Lack of follow up on PrEP by prescribers
	Personal responsibility
	Lack of links of PPG member agencies to each other's websites
	Healthcare providers do not reflect the population they serve (at risk)

Prevention

South Dakota
2022-2026 Integrated Plan Development

External

OPPORTUNITIES	THREATS
Emergency room screenings (women and women who are pregnant)	Conservative state politics
Education partners (Maternal Health)	Political climate
Education partner (Child Heath)	Legislators with knowledge
Education partner (WIC)	Anti-gay-transsexual legislation
Educating partners	State of SD politicians
Mailing testing kits	Stigma
Provider education	Language of grants (allowable vs. not allowable)
Education for high risk individuals	Legislators gatekeeping knowledge
Condom distribution	Evidence-based prevention strategies
Education (general)	Continued stigma in healthcare agencies
Statewide internet access	Long distance to access prevention services
Mobile HIV/STI testing unit	Lack of privacy in accessing health services in rural settings (care and education)
HIV testing kits that have results in 60 seconds	Local faith-based healthcare provider does not allow providers to presribe PrEP
Partner with AETC for education	Systemic racism
Train and mentor providers via AETC	HIV prevention services (and care) hard to find
Available grants	Stigma
Patient access to medical records (prescriptions) to apply for prescription assistance programs	Impact of religious values on health services
Limited pharmacy access ARV's via RW Program (ADAP)	Culture in state
There are funding opportunities for CHWs	Male versus female valuation
Potential for partnering with AETC for TA	IHS requires a drug test prior to services and if found positive they
	A lutheran church in the SE brings immigrants and their families from South Africa; some may have HIV
	HIV Stigma
	Funding reduction to SMAIF in FY2018; eliminated funding for IHS and loss for prevention, outreach, education, treatment with OMH, Office of Womens' Health, & HIV.gov
	Per Harmreduction.org SEP's are not allowed in SD
	No EHE funding; Only receive dollars for Part B & C and Prevention

South Dakota

2022-2026 Integrated HIV Prevention and Care Plan Goals and Objectives

NHAS GOAL 1: PREVENT NEW HIV INFECTIONS (*EHE PILLAR 3*)			
Local Goal #1: By December 31, 2026, the number of new HIV diagnoses will be reduced by 2% annually from a 2021 baseline.			
Objective 1	Provide at least 2 targeted outreach events annually for priority populations including refugees, Native Americans/American Indians, women, and at-risk population who use intravenous drugs.		
Objective 1 Strategies	Provide at least 2 targeted outreach events annually for priority populations including refugees, American Indians/Alaska Natives, women, and individuals at risk for HIV infection.	Objective 1 Activities	1. Collaborate with local religious, tribal, and spiritual community partners to organize outreach opportunities such as local health fairs, food drives, market days, etc.
			2. Have fliers and pamphlets available at local health fairs, community centers during large events such as Pow-wows, World AIDS Day, Pride, Sturgis, etc.
Objective 2	By December 31, 2026, develop at least 5 collaborations with local religious, tribal, and spiritual community partners and community centers in South Dakota.		
Objective 2 Strategies	Provide HIV resource inventory and testing information in local and rural areas to at least 5 partners.	Objective 2 Activities	1. Have resource inventory shared with local and rural churches.
			2. Increase awareness through the shared resource inventory to at least 5 local and rural community centers or partners.
Objective 3a	By December 31, 2023, SDDOH will promote no- cost STI/HIV testing resources through their website so that clients and providers alike may be able to have awareness that this is offered for free and how and where they can access it.		
Objective 3a Strategies	Provide increased awareness of "free" STI/HIV testing to providers and community.	Objective 3a Activities	1. Create campaign on SDDOH website using U=U marketing tools.
			2. Work with internal SDDOH partner divisions to promote links to the RW and Prevention websites.

<table>
<tr><th colspan="5">NHAS GOAL 1: PREVENT NEW HIV INFECTIONS (EHE PILLAR 3)</th></tr>
<tr><td colspan="2">Objective 3b</td><td colspan="3">By December 31, 2026, SDDOH will create a link on their website where clients and providers can enter a request for STI/HIV testing to be conducted at a client's location.</td></tr>
<tr><td rowspan="4">Objective 3b Strategies</td><td rowspan="2">1. Promote at-home testing through mobile testing sites or self-testing kits.</td><td rowspan="2">Objective 3b - 1 Activities</td><td>1. Develop link within SDDOH website.</td></tr>
<tr><td>2. Share link with community at large.</td></tr>
<tr><td rowspan="2">2. Evaluate effectiveness of website marketing for mobile-/self-testing.</td><td rowspan="2">Objective 3b - 2 Activities</td><td>1. Review testing data quarterly.</td></tr>
<tr><td>2. Based on data-increase or change activities in objective 3b strategy 1 for better promotion.</td></tr>
<tr><td colspan="2">Key Partners</td><td colspan="3">Churches that assist refugee populations, PPG team members, public health departments, local and rural community centers; and 3a-b) SDDOH, PPG, SDDOH partnering divisions, IT, case managers, DIS workers</td></tr>
<tr><td colspan="2">Potential Funding Resources</td><td colspan="3"></td></tr>
<tr><td colspan="2">Potential Funding Allocation</td><td colspan="3">$XX</td></tr>
<tr><td colspan="2">Monitoring Data Source</td><td colspan="3">EMR data, surveillance data</td></tr>
<tr><td colspan="2">Expected Impact on the HIV Care Continuum</td><td colspan="3">1) Increase the number of people who know their HIV diagnosis; 2) Increase PLWH linked to medical care within 90 days; and 3) Increase number of HIV tests conducted through mobile outreach</td></tr>
</table>

NHAS GOAL 1: PREVENT NEW HIV INFECTIONS (*EHE PILLAR 3*)					
	2022	2023	2024	2025	2026
Annual Outcomes: # of newly identified persons with HIV					
Annual Outcomes: # of PLWH linked to care within 90 days					
Annual Outcomes: # of HIV tests provided through the mobile outreach team upon request made through website					
Annual Activities Completed (indicate which objective specifically)					
Activity continued to next year or not; comments (indicate which objective it pertains to specifically)					

NHAS GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES OF PEOPLE WITH HIV (*EHE PILLAR 2*)			
Local Goal #1: By December 31, 2026, PLWH identified with substance use and mental health needs are made aware of resources			
Objective 1	By December 31, 2026, increase access to Substance Abuse and/or Mental Health services by 50%.		
Objective 1 Strategies	1. Persons diagnosed with SA and/or MH receive referrals within 10 business days. 2. Increase community partners education of harm reduction. 3. Increase awareness of SA and/or MH programs available .	Objective 1 Activities	1. Work with DIS and case management on SA and MH referrals. 2. Share Harm Reduction training resources and opportunities for HIV Care and Prevention partners in community. 3. Promote SA and/or MH programs on SDDOH website.
Local Goal #2: By end of FY26, viral suppression rates for PLWH have improved by 5%.			
Objective 1	By end of FY26, Reduce Late to Care PLWH in Newly Diagnosed population through enhancement of existing care networks to increase referral system across SD		
Objective 1 Strategies	1. Focus on “fast-tracking” entry to HIV medical care. 2. Promote availability of telemedicine for access to care. 3. Conduct newly diagnosed needs assessment to determine barriers to access.	Objective 1 Activities	1. Promote “fast-track” appointments focusing on newly diagnosed PLWH. 2. Increase awareness and education of telemedicine/telehealth options, including assistance in accessing telehealth/telemedicine. 3. Create and conduct survey for newly diagnosed clients who enter into care.

NHAS GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES OF PEOPLE WITH HIV (*EHE PILLAR 2*)					
Key Partners	SDDOH, Case Managers, DIS workers, HIV prevention providers, PPG, SDDOH partnering divisions, SA and MH providers in the community, HIV care providers				
Potential Funding Resources					
Potential Funding Allocation	$XX				
Monitoring Data Source	EMR data, surveillance data				
Expected Impact on the HIV Care Continuum	Increase the number of PLWH with identified Substance Use issues to enter and complete treatment by 10% annually.				
	2022	2023	2024	2025	2026
Annual Outcomes: # of PLWH with SA issues who enter/linked to treatment					
Annual Outcomes: # of PLWH with SA issues who enter complete treatment					
Annual Activities Completed (indicate which objective specifically)					

NHAS GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES (*EHE PILLARS 2, 4*)			
Local Goal #1: By December 31, 2026, reduce disparities in new HIV infections and knowledge of status for each population by 3% annually.			
Objective 1	Increase awareness of HIV-related disparities by decreasing stigma related to medical care.		
Objective 1 Strategies	Implement mechanisms to identify and re-engage individuals who are out of care	Objective 1 Activities	1. Provide education and materials to PLWH who are out of care to reduce fears of ART issues, stigma. 2. Enhance messaging statewide to promote Health Insurance availability for PLWH 3. Enhance efforts of promotion of telemedicine through social media venues, community centers, bars, churches, substance use centers, legal aide, etc. to decrease barriers real or perceived for PLWH who are out of care 4. Fast-Track activities to medical care for PLWH.
Local Goal #2: By the December 31, 2026, address social and structural determinants of health and co-occurring conditions that impede access to HIV services and exacerbate HIV-related disparities by increasing professional development time for providers by 25% each year.			
Objective 1	Improve education to specialty providers for PLWH with co-occurring medical conditions		
Objective 1 Strategies	1. Promote educational training opportunities for health care providers who serve PLWH 2. Improve network opportunities with current funded providers	Objective 1 Activities	1. Promote AETC trainings to include ECHOs. 2. Host one case-conference Town Hall for providers twice a year at minimum .

NHAS GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES (*EHE PILLARS 2, 4*)			
Local Goal #3: By the end of FY26, improve retention in care by 10% for all PLWH in rural areas.			
Objective 1	Ensure availability of quality medical care and support services by promoting telemedicine/telehealth.		
Objective 1 Strategies	1. Identify areas where PLWH have lower SES. 2. Collaborate with partners who are in higher SES areas to inform about current services. 3. Promote quality of life through retention in care. 4. Promote prevention of HIV .	Objective 1 Activities	1. Conduct zip code study. 2. Through PPG meetings, provide data from zip code study. 3. Utilize different campaigns (i.e., U=U; OPT-In for Life) 4. Increase awareness of PrEP locations by linking the AIDSVu website to the SDDOH website.
Key Partners	SDDOH, Positive Connections Program, Prevention and RW subrecipients, Case Managers, All funded Ryan White Programs, PPG, Community stakeholders		
Potential Funding Resources	AETC (Part F)		
Potential Funding Allocation	$XX		
Monitoring Data Source	EMR data, surveillance data		
Expected Impact on the HIV Care Continuum	1) Increase the number of PLWH who are retained in care through increased usage of telehealth; 2) Increase the number of persons on PrEP; 3) Increase the number of PLWH with co-morbidities who are linked to care for care other than HIV; and 4) Increase the number of PLWH American Indians/Native Americans who are retained in HIV care		

NHAS GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES (*EHE PILLARS 2, 4*)					
	2022	2023	2024	2025	2026
Annual Outcomes: # of PLWH retained in care					
Annual Outcomes: # of South Dakotans who took PrEP at least for one month in the year					
Annual Outcomes: # of South Dakotans who were linked to care for care other than HIV					
Annual Outcomes: # of PLWH American Indians/Native Americans who are retained in HIV care					
Annual Activities Completed (indicate which objective specifically)					
Activity continued to next year or not; comments (indicate which objective it pertains to specifically)					

NHAS GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND STAKEHOLDERS *(EHE PILLAR 4)*			
Local Goal #1: Each fiscal year a minimum of one statewide integrated meetings (i.e. prevention planning group) will be held.			
Objective 1	To share best practices among HIV programs for prevention, care, and treatment. At the end of each fiscal year the SDDOH will convene a virtual Town Hall meeting to include staff with IHS to discuss the priorities, data, and status of the Integrated Plan. Discussion will also include updates, next steps, and implementation changes.		
Objective 1 Strategies	Engage with stakeholders who have not previously collaborated with the HIV Prevention or Ryan White Programs to include staff with IHS to discuss the priorities, data, and timeline of the Integrated Plan	Objective 1 Activities	1. An annual strategic meeting will be held between the SDDOH and prevention and care providers of HIV. 2. Each meeting will contain an agenda item for sharing of best practices, data, and review status of the Integrated Plan.
Objective 2	All stakeholders and/or partnering agencies and programs who have an active role in the prevention and care of persons living with HIV will discuss possible funding opportunities and if found, add to the resource inventory.		
Objective 2 Strategies	Prevention and care funding opportunities that are offered locally, by state, and/or federally will be explored, to include pharmaceutical grants to assist in awareness campaigns	Objective 2 Activities	1. Review grants.gov. 2. Work with partnering agencies for local funding availability. 3. Work with pharmaceutical companies for funding availability.

NHAS GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND STAKEHOLDERS *(EHE PILLAR 4)*			
Local Goal #2: Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders, to include increased participation of non-Ryan White funded partners by 10%.			
Objective 1	Introduce at least 2 new stakeholders and/or partnering agencies into the Integrated Plan stakeholder group (e.g. opioid program, tobacco, maternal and child health, nursing and medical schools, public health program, CBO's [e.g. LGBTQIA+ coalitions], SAMHSA, student/cultural societies, Call to freedom/freedom's journey).		
Objective 1 Strategies	1. Request various recipients to present on expert specialties to raise awareness. 2. Incorporate additional prevention models.	Objective 1 Activities	1. Hold a presentations on topics such as: A. Needle exchange or safe needle practices B. PrEP C. Tobacco Cessation D. Maternal and Child Health E. Call to Freedom/Freedom's Journey 2. Promote safe needle program by adding the SafeNeedleprogram.org link to the SDDOH website.
Key Partners	SDDOH Ryan White Programs, SDDOH Partner programs, PPG, HIV Prevention, All Integrated Plan stakeholders and partners, Epidemiologist, Thunder Valley Community Development Corporation, SafeNeedleDisposal Program		
Potential Funding Resources	Ryan White Part B program; HIV Prevention		
Potential Funding Allocation	$XX		
Monitoring Data Source	EMR data, surveillance data		
Expected Impact on the HIV Care Continuum	All areas of the HIV Care Continuum should be impacted		

NHAS GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND STAKEHOLDERS *(EHE PILLAR 4)*					
	2022	2023	2024	2025	2026
Annual Outcomes: Trended HIV Care Continuum - Should see all bars increase					
Annual Activities Completed (indicate which objective specifically)					
Activity continued to next year or not; comments (indicate which objective it pertains to specifically)					

South Dakota 2022-2026 Integrated Plan Resource Inventory - Abbreviated

Funder	Recipient	Subrecipient	Location	(North East, (NE), North West (NW), South East (SE), South West (SW) & Central (CE) South Dakota	# of Services offered to impact the Integrated Plan	# of Ryan White Care Services Offered	HIV Care Continuum				EHE				
							HIV Care Continuum Steps Impacted: HIV Diagnosis	HIV Care Continuum Steps Impacted: Linkage to Care	HIV Care Continuum Steps Impacted: ART Prescription	HIV Care Continuum Steps Impacted: Viral Suppression	EHE Strategy: Viral Suppression	EHE Strategy: Diagnose HIV	EHE Strategy: Treat HIV	EHE Strategy: Prevent HIV infection/transmission	EHE Strategy: Respond to Outbreaks
(HRSA) HIV/AIDS Bureau (HAB), Ryan White (RW) Part B	South Dakota Department of Health (SDDOH)	N/A				1		X		X	X			X	
HRSA HAB, RW Part B	SDDOH	N/A				1				X	X			X	
HRSA HAB, RW Part B	SDDOH	N/A				4		X	X	X	X		X	X	
HRSA HAB, RW Part B	SDDOH	N/A				1			X	X	X		X	X	
HRSA HAB, RW Part B, AIDS Drug Assistance Program (ADAP)	SDDOH	N/A				1			X	X	X	X	X	X	
HRSA HAB, Ryan White Emergency Relief Funds	SDDOH	Who received these funds and what services were delivered			1										
HRSA HAB, ADAP Drug Rebates	SDDOH	Who received these funds and what services were delivered				1	X	X				X		X	X
Centers for Disease Prevention and Control (CDC), HRSA, RW Part C	SDDOH	Falls Community Health Center https://www.siouxfalls.org/health/falls-community-health	Sioux City, SD	SE	4	4								X	X
Centers for Disease Prevention and Control (CDC), RW Part B	SDDOH	Heartland Health Resources https://heartlandhealthsd.org/	Sioux Falls, SD	NE	5	6	X	X	X	X	X	X	X	X	X
Centers for Disease Prevention and Control (CDC), RW Part B	SDDOH	Volunteers of American of the Northern Rockies https://www.voanr.org/	Rapid City, SD	SW	4	3	X	X				X		X	X
HRSA	52 Federally Qualified Health Centers in SD	Multiple locations in SD to find a health center and for more information go to: https://communityhealthcare.net/chcs/ or https://www.findahealthcenter.hrsa.gov/	Various	All	4	4	X	X	X	X	X	X	X	X	

South Dakota 2022-2026 Integrated Plan Resource Inventory - Abbreviated

Funder	Recipient	Subrecipient	Location	(North East, (NE), North West (NW), South East (SE), South West (SW) & Central (CE) South Dakota	# of Services offered to impact the Integrated Plan	# of Ryan White Care Services Offered	HIV Care Continuum				EHE				
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HRSA, RW Part F	South Central Central AIDS Education Center (SCAETC): https://hsc.unm.edu/scaetc/	Indian County Extension for Community Health Outcomes (ECHO), HIV ECHO Program, https://www.indiancountryecho.org/program/HIV, Email: IHSecho@salud.unm.edu	Albuquerque	NA	1		X	X	X	X	X	X	X	X	
HRSA HAB, RW Part F	Community Health Association of the Dakotas	Community Health Association of the Dakotas, https://communityhealthcare.net/chcs/	Sioux City, SD	SE	4	4	X	X	X	X	X	X	X	X	
HRSA HAB, RW Part F	Mountain West AETC (MWAETC)	MWAETC https://mwaetc.org/	Seattle, Washington	NA	1		X	X	X	X	X	X	X	X	
Indian Health Service	Great Plain Indian Health Service	Various locations, go to this website to find a provider https://www.ihs.gov/greatplains/healthcarefacilities/	Various	NA	5	5		X		X	X				
Department of Housing and Urban Development	Sioux Falls Housing & Development Commission	Sioux Falls Housing and Development Commission https://www.siouxfallshousing.org/	Sioux Falls, SD	SE	1	1		X	X	X	X		X	X	
Centers for Disease Prevention and Control (CDC)-Sexually Transimitted Infection Testing	SDDOH. Sexually Transmitted Disease Control: https://doh.sd.gov/diseases/infectious/std/	SDOH Sexually Transmitted Disease Control, go to this link to find a testing center near your location: https://doh.sd.gov/diseases/infectious/std/get-tested.aspx	Various	All	4	2	X	X				X		X	X
Substance Abuse and Mental Health Services Administration	Great Plains Tribal Chairman's Health Board (GPTCHB)	GPTCHB Behavioral Health: https://bhr.gptchb.org/ GPTCHB to find services please refer to this: https://bhr.gptchb.org/wp-content/uploads/2020/05/Resource-Guide-Final.pdf	Various	All		3		X		X	X		X	X	

South Dakota 2022-2026 Integrated Plan Resource Inventory - Abbreviated

Funder	Recipient	Subrecipient	Location	(North East, (NE), North West (NW), South East (SE), South West (SW) & Central (CE) South Dakota	# of Services offered to impact the Integrated Plan	# of Ryan White Care Services Offered	HIV Care Continuum				EHE				
							HIV Care Continuum Steps Impacted: HIV Diagnosis	HIV Care Continuum Steps Impacted: Linkage to Care	HIV Care Continuum Steps Impacted: ART Prescription	HIV Care Continuum Steps Impacted: Viral Suppression	EHE Strategy: Viral Suppression	EHE Strategy: Diagnose HIV	EHE Strategy: Treat HIV	EHE Strategy: Prevent HIV infection/transmission	EHE Strategy: Respond to Outbreaks
US Department of Commerce	Sisseton Wahpeton Oyate	https://www.swo-nsn.gov/ For information about broadband support for 2023 https://www.swo-nsn.gov/wp-content/uploads/SWO-Broadband-Internet-Asst.-Application-2023.pdf	Various	All	1		X	X	X	X	X	X	X	X	
Planned Parenthood, Private Funds	NA	Planned Parenthood of MN, ND, and SD 6511 W. 41st Street, 605.361.5100, https://tinyurl.com/5n8c3mtd	Sioux Falls, SD	SE	6		X	X				X		X	
HRSA	TBD	Great West Telehatlh Resource Center, https://www.gptrac.org/policy/south-dakota	University of Minnesota	NA	1		X	X	X	X	X	X	X	X	
Federal Communications Commission	**TBD**	Afffordability Connectivity Program, https://www.whitehouse.gov/getinternet/?utm_source=getinternet.gov	NA	NA	1		X	X	X	X	X	X	X	X	
Substance Abuse and Mental Health Services Administration (SAMHSA)	South Dakota Department of Social Services	South Dakota Department of Social Services, Behavioral Health Services To find services and a provider go to: https://dss.sd.gov/behavioralhealth/services.aspx	Various	All	1	2		X		X	X		X	X	
SAMHSA	South Dakota Department of Social Services	South Dakota Department of Social Services Behavioral Health Services Intensive Methamphetamine Treatment for more information: https://dss.sd.gov/formsandpubs/docs/BH/IMT_brochure.pdf	Various	All	1	6		X		X	X		X	X	
SAMHSA	South Dakota Department of Social Services	South Dakota Department of Social Services, Behavioral Health Services , Substance Use Disorder Treatment and Prevention https://dss.sd.gov/docs/behavioralhealth/services/List_of_Treatment_agencies_and_services.pdf	Various	All	1	6		X		X	X		X	X	