South Dakota Healthcare Preparedness Coalition (HPC)

2026 Comprehensive Healthcare HVA and Readiness Assessment Report

Sector-Wide Synthesis: Hospitals, EMS, and LTC

1. Executive Summary

The compiled 2026 Hazardous Vulnerability Assessment HVA) and Readiness Assessment dataset provides a system-wide view of nearly 40 diverse healthcare organizations across South Dakota, including over 25 hospitals, 10 Long-Term Care (LTC) facilities, and 4 EMS agencies.

The Macro Finding: The South Dakota healthcare sector is physically resilient and possesses a strong baseline of written emergency operations plans within its hospitals and LTCs. However, the network is fundamentally interdependent and digitally fragile. The entire continuum of care—from rural 911 EMS response to Critical Access Hospital triage and Long-Term Care management—shares a critical, systemic vulnerability to **Cybersecurity/IT Failures** and **Severe Meteorological Events**. Because rural facilities heavily rely on regional hubs and external Mutual Aid Agreements (MOUs) during crises, a disruption in communications or the supply chain poses a cascading threat that can rapidly compromise the entire state system.

2. State-Wide Threat Landscape Analysis

When synthesizing the risks across the three main sub-sectors, three universal threat categories dictate the South Dakota landscape:

A. Technological & Systemic Hazards (The Primary Systemic Threat)

- **Cybersecurity / IT Failures [VERY HIGH]:** This is quantitatively and qualitatively the number one threat across the state. Hospitals and LTCs universally score Cyber as a “Very High” because they are completely dependent on networks to provide services. An IT outage strips staff of clinical histories and disrupts operational continuity. For EMS, a cyber-attack on a regional dispatch center or CAD (Computer-Aided Dispatch) system would completely cripple rural routing.
- **Supply Chain Fragility:** This is a major vulnerability across the board. Rural hospitals and LTCs cited supply chain disruptions as a primary vulnerability and barrier to capability. Because facilities utilize "just-in-time" supply chains, a multi-

day disruption (e.g., a massive blizzard) rapidly depletes food, oxygen, and critical medical supplies.

B. External & Natural Hazards (High Probability, High Structural Threat)

- **Severe Weather (Thunderstorms, Hail, Extreme Cold, Tornadoes):** Severe weather heavily dictates operational continuity across all sectors. Thunderstorms and hail scored universally high due to high annual flash density and historical event data. Weather remains a constant disruptor to EMS physical transport capabilities and poses significant structural threats to isolated hospitals and LTCs.
- **Highway HAZMAT Incidents:** Rated as a high threat across hospitals and LTCs due to proximity to major interstates. This presents a unique nightmare scenario for LTC facilities, where the rapid evacuation of non-ambulatory residents away from a toxic plume is logistically impossible.

C. Biological Hazards (Sector-Specific Escalation)

- **Epidemics / Pandemics:** While localized outbreaks and baseline infection control are managed well internally ("Mostly Complete"), widespread community epidemics act as a massive tipping point. During a pandemic, rural reliance immediately jumps from internal capabilities to requiring **State or Federal** support across hospitals, EMS, and LTCs due to PPE and staffing exhaustion.

3. Vulnerability Profile by Sub-Sector

The strength of the state network lies in its diversity, but each sector harbors distinct operational vulnerabilities:

- **Hospitals (Acute Hubs & Rural CAHs):** Acute care hubs (100+ beds) possess deep resource pools but are highly lucrative targets for cyber threats. Critical Access Hospitals (1-25 beds) are highly agile for daily emergencies but lack the physical stockpiles to endure multi-day infrastructure failures.
- **Emergency Medical Services (EMS):** The EMS network is severely polarized. While high-volume ALS agencies have highly formalized plans, rural private and BLS squads report a severe lack of formalized planning and functionally operate without written emergency procedures.
- **Long-Term Care (LTC):** LTC facilities possess exceptionally high internal capabilities for managing daily resident support services (food, housekeeping, daily care). However, they are profoundly vulnerable to external supply chain shocks and are heavily dependent on external communication lines with hospitals/EMS since advanced medical providers are rarely on-site 24/7.

4. System-Wide Capability & Readiness Assessment

Across the thousands of data points evaluating the state's operational readiness, the consensus is clear:

- **Written Plans & Policies:** Almost all hospitals and LTCs score strongly, having formalized Hospital Incident Command Systems (HICS) and support service plans in place. Operational plans within the EMS sector are highly inconsistent, ranging from strong formalized policies down to a complete lack of written plans in rural squads.
- **Real-World Activations:** Across all sectors, formal emergency command centers are rarely activated (**0-5 incidents per year**). While this indicates a generally safe daily environment, it results in theoretical, untested readiness.
- **Resource Sharing:** Facilities across the sectors rely heavily on Memorandums of Understanding (MOUs) and Mutual Aid Agreements, indicating a strong willingness to share resources regionally.

5. Primary Barriers to Total Capability

When assessing what prevents the state from achieving complete operational resilience, four systemic barriers emerged:

1. **IT / Cybersecurity Infrastructure:** Hospitals and LTCs lack the capital to invest in the redundant, hardened IT systems required to mitigate Cyber threats. EMS agencies lack the IT budgets of hospitals, leaving dispatch and CAD systems highly vulnerable.
2. **Administrative Capacity & Staffing:** Rural EMS leaders often lack dedicated administrative time, meaning formal emergency plans do not get written. Across all sectors, chronic baseline staffing shortages act as a threat multiplier, meaning there is no "surge capacity" available when disaster strikes.
3. **Training & Regional Exercises:** Because real-world command center activations are exceptionally rare, staff proficiency naturally degrades, requiring more funded, cross-sector simulation exercises.
4. **Supply Chain Isolation:** Rural hospitals and LTCs do not have the physical footprint to warehouse large stockpiles, leaving them highly vulnerable to transportation delays.

6. Strategic Conclusion

South Dakota healthcare facilities are highly capable of managing localized, internal, and daily operational emergencies. However, the 2026 data indicates that the primary threats to South Dakota's healthcare sector are now borderless and systemic (Cyber Warfare, Widespread Extreme Weather, Regional Supply Chain collapse). To build a resilient state network, the Coalition must prioritize **digital infrastructure hardening**,

deploy **standardized emergency policy templates to rural EMS**, and focus heavily on **supply chain resilience planning**. Ensuring seamless cross-sector interoperability—such as an EMS unit communicating with a CAH when digital networks fail, or an LTC sheltering in place during a hazard—will be the defining marker of true systemic survival.