Section 1: Rural Health Needs and Target Population

Rhode Island's rural communities are vibrant, resilient, and deeply connected to the State's natural and cultural heritage. From the fishing villages of the South County coastline to the wooded towns along the western border, these areas are defined by strong community identity, local pride and dignity, and a shared commitment to place. At just over 1,000 square miles of land area, Rhode Island is the smallest state in the nation geographically. However, this relatively small size can mask a range of unique challenges faced by its rural residents in terms of accessing, delivering, and maintaining health care services.

Rural Definition and Target Population. The Rhode Island State Office of Rural Health (RISORH) has long defined rural to include **towns with fewer than 25,000 people and lower population density** – a definition which has been accepted by the Health Resources and Services Administration (HRSA) for state health planning purposes. This definition forms the foundation of our RHTP framework. It encompasses **18 towns**, including: Burrillville, North Smithfield, Foster, Glocester, Scituate, and Smithfield in Providence County; East Greenwich and West Greenwich in Kent County; Charlestown, Exeter, Hopkinton, New Shoreham (the town encompassing Block Island), Richmond, and Westerly in Washington County; and Jamestown, Little Compton, Portsmouth, and Tiverton in Newport County.[1]

The total population of these towns is 195,809, representing 17.9% of the State's population, with an average population density of 314 persons per square mile – well below the nearly 2,200 per square mile observed in non-rural areas. By comparison, the HRSA definition used for the Workload section of the Notice of Funding Opportunity (NOFO), covers just 2 of these 18 towns and only 24,147 residents, yet has twice the population density of the broader State-defined rural area. It is important, therefore, to approach the resources and initiatives supported by the RHTP

from the perspective historically used by the State in addressing rural issues. These communities share common rural health challenges – including limited provider availability, workforce shortages, fragile Emergency Medical Services (EMS) systems, weak digital infrastructure, and long travel times to essential services – that shape the daily experiences of their residents and underscore the need for a comprehensive rural health transformation strategy.

The target population for Rhode Island's RHTP includes **all residents of the 18 State-designated rural towns**. Priority focus will be on addressing **chronic disease**, **mental and behavioral health needs**, **oral health**, and supports for the **elderly. Block Island** residents who face extreme access challenges due to geographic isolation, and members of the federally-recognized **Narragansett Indian Tribe**, a distinct rural community that faces unique health care challenges, are also a critical group requiring targeted interventions. Health care facilities that will benefit from the proposed initiatives include: all **hospitals and hospital systems serving rural populations**; all **Federally Qualified Health Centers (FQHCs)**; **primary and specialty care practices** serving rural communities; and **schools** and **community learning centers (CLCs)** in rural towns.

Rural Demographics and Health Care Infrastructure. Rhode Island's rural health care system is best described as fragile but functioning – the result of purposeful efforts, with limited capacity to absorb additional strain. Detailed statewide rural health statistics, included in *Attachment D: Other Supporting Materials*, reveal critical gaps in access, health care workforce, and infrastructure that place rural communities at risk.

Demographics. Like many rural regions, Rhode Island's rural population is older and more vulnerable. Adults aged 65 and older make up 23% of the rural population compared to 17% in non-rural areas, a difference mirrored in higher Medicare enrollment. Nearly 13% of rural

residents have incomes below 200% of the federal poverty level, and 5.4% have less than a high school diploma. Employment patterns differ, with rural residents less likely to work in scientific, professional, management, manufacturing, or education sectors, and more likely to work in construction and agriculture/fishing – industries that often do not offer insurance coverage.

Outcomes. Certain outcomes are more prevalent in rural areas. Adults in rural Rhode Island experience a 15% higher rate of hypertension (36% vs 31%), a 28% higher rate of cardiovascular disease (16% vs 13%), and 15% higher rate of tobacco use than their non-rural counterparts.

Access. Provider availability represents the most significant barrier to health care access in Rhode Island's rural areas. Parts of Providence and Washington Counties are designated Primary Care Health Professional Shortage Areas. The overall availability of primary care physicians is 37% lower than in non-rural areas (0.59 per 1,000 population compared to 0.94 FTE per 1,000 for non-rural areas). Rural areas have only 0.34 FTE per 1,000 Medicaid enrollees compared to 0.48 per 1,000 in non-rural areas. Dental access is also a concern with parts of Newport and Providence Counties designated as Oral Health Professional Shortage Areas.

Access to psychiatric care is especially limited. All of Newport and Washington counties, and part of Providence County, are designated mental health professional shortage areas. Rural areas have only 0.02 FTE psychiatrists per 1,000 residents, compared to 0.34 in non-rural areas – a 95% difference. The crisis is particularly acute for Medicaid beneficiaries: based on recent claims data, there are no psychiatrists accepting Medicaid in the 18 rural towns. The mental health provider shortage coincides with concerning health outcomes – the suicide rate in rural Rhode Island is 32% higher than in non-rural areas (13.0 deaths per 100,000 population compared to 9.8 per 100,000 in non-rural areas). Access to facility-based care is more limited for rural residents. In *Attachment D: Other Supporting Materials*, we provide a map depicting the

rural and non-rural areas of Rhode Island, along with geographic locations of Certified Community Behavioral Health Clinics (CCBHCs), FQHCs, and Rural Health Clinics (RHCs). The map shows that these health care facilities are primary concentrated in urban areas, highlighting gaps in access to behavioral and primary health services for individuals living in rural communities. Also, there are no rural birthing facilities.

Facility Financial Health. Rhode Island has only one acute care hospital in a rural area – Westerly Hospital – which operates with a negative operating margin, the lowest in the state. In Block Island, the State's only RHC is also the island's only resource for medical care.

Rhode Island's Rural Health Landscape. Beyond the data lies a more complex picture of rural Rhode Island. The State's coastal and island topography, with its peninsulas, bridges, and ferry-dependent communities, often separates residents from essential services despite their geographic proximity. Communities along the western border with Connecticut also experience limited access to health care and other critical resources.

Unlike large contiguous regions found in other states, Rhode Island's rural communities are dispersed and often separated by urban or suburban areas. This geographic fragmentation makes coordinated planning and resource sharing more complex. Health systems, local governments, and emergency responders must work across multiple jurisdictions, each with distinct governance structures, funding streams, and community priorities. As a result, developing a unified response to statewide rural health needs significant collaboration and investment in a self-sustaining infrastructure of regional networks.

Many of Rhode Island's rural areas are popular tourist destinations, which creates seasonal strains on infrastructure, despite the economic benefit. During peak tourism months, local infrastructure and services, including health care, must rapidly expand to meet the needs of a

population that can temporarily double or more than triple. Local clinics need months in advance planning to expand staffing, secure additional medical supplies, and coordinate with local first responders. Yet once the tourist season ends, maintaining that surge capacity becomes financially difficult, leaving year-round residents with fewer resources and limited access to care.

Economic pressures further complicate the picture. The high cost of living – driven in part by seasonal housing and vacation properties that limit options for year-round residents – has made it challenging to attract and retain health care professionals to rural areas. Seasonal housing accounts for nearly 10% of rural units statewide – over three times the proportion in non-rural areas – and nearly a quarter of homes on Block Island and in Westerly. As housing prices rise, local health care workers are forced to commute long distances or relocate altogether, contributing to persistent provider shortages.

Community-Identified Barriers to Care. It is critical that the design of the RHTP – including how resources and initiatives are identified and planned – reflect the perspectives of those who live and work in Rhode Island's rural communities. To prepare a strong, community-informed response to this opportunity, Rhode Island conducted a series of community listening sessions across the state's rural areas. During these sessions, residents, health care providers, and community partners identified a common set of barriers affecting health care.

Workforce was a central concern. Primary and behavioral health clinicians are concentrated in urban centers, forcing rural residents to travel long distances to obtain care. Shortages of primary care providers and behavioral health clinicians result in long wait times for appointments. Access to home- and community-based services is further restricted by lengthy waiting lists, reimbursement limitations, and geographic isolation. Transportation challenges compound these barriers, with residents living on islands or across bridges indicating that routine

or follow-up appointments can turn minor health needs into significant logistical burdens.

Providers practicing in rural areas expressed their struggle to adopt or maintain interoperable electronic health record (EHR) systems due to high upfront costs, limited information technology support, and inconsistent broadband connectivity. These technological challenges contribute to mounting pressure for independent practices to merge with larger health systems that are less connected and responsive to the needs of smaller communities.

Advancing Rural Innovation and Collaboration. Our rural communities are uniquely positioned to serve as incubators for creative, community-driven solutions to health care challenges. They have generated a wealth of promising ideas – from integrated care delivery models to technology-enabled outreach – that have too often been constrained by limited start-up investment. The RHTP grant offers a critical opportunity to bring these ideas to life. Our rural communities embody deep social cohesion, mutual support, and creativity. By building on these strengths – and building strong systems that sustain them – we will transform care for rural residents and ensure that rural Rhode Islanders continue to thrive in the places they call home.

Section 2: Rhode Island's Rural Health Transformation Plan Goals and Strategies

Rhode Island's rural towns are defined by their deep sense of connection – to their communities, their land, and the traditions that have sustained them for generations. Throughout our stakeholder engagement process, rural residents expressed a clear desire for a health care system that reflects this strength and dignity, providing quality, affordable care close to home. Our rural health transformation vision is **a connected, community-driven system that ensures every rural resident has timely, coordinated, high quality care where they live**.

Through this grant, the State will work with rural communities to achieve this vision and develop a durable, data-driven, and locally grounded model that integrates prevention,

technology, workforce development, and strong partnerships. The model will sustain access, improve outcomes, and strengthen financial viability, guided by five interconnected goals that will create a self-sustaining system where the needs of rural residents are at the forefront.

Figure 1. Rhode Island Rural Health Transformation Goals

Goal #1: Make Rural American Healthy Again – Improve the Health of Rural Residents. We will target preventable chronic diseases, behavioral health needs, substance use disorders, maternal and child health, oral health, and root causes of diseases and improve the health outcomes of Rhode Island's rural residents. Recognizing that traditional health care delivery models often fall short in rural areas, we will implement a transformative approach that weaves together community leadership, clinical innovation, and strategic partnerships. We will build on existing infrastructure to develop coordinated, community-based care management programs tailored to each stage of life, meet people where they are, use trusted messengers, and provide ongoing support for managing health. Our strategies for improving outcomes include: (1) establishing an **integrated rural population health infrastructure** that will unite local health providers, community organizations, schools, businesses, and municipal agencies to collaborate on strategies to improve health and well-being; (2) delivering **community-integrated and mobile health services** to bring services directly to rural communities through partnerships with CLCs, schools, and other community-based organizations; and (3) establishing time-limited infrastructure grant program to make one-time investments that expand **access to rural community resources**.

Goal #2: Sustainable Access – Expand Access to Comprehensive, Quality, Low-Cost Care. A central strategy of our RHTP proposal is expanding local access points for urgent, primary, behavioral, and specialty care services. This requires rethinking traditional access points to health care – extending beyond clinics and hospitals – to include the places where rural residents live, work, and congregate, such as schools, libraries, and community centers – and bringing care to their homes. To accomplish this, we will advance several integrated strategies, including: (1) a **rural EMS health access and integration** initiative involving collaboration with community paramedics to provide preventive and follow-up care, improve coordination, and extend essential services to residents in hard-to-reach areas; (2) scaling up **hospital-at-home** services to dramatically expand access to acute hospital care for rural residents by delivering hospital-level services directly in patients' homes; (3) **expanding behavioral health services availability in rural regions** by establishing two 24/7 behavioral health walk-in crisis and stabilization center facilities – one in the south and another in the northwest part of Rhode Island, adding up to four recovery community centers in the rural northern, western, or eastern parts of the State, implementing a substance use disorder (SUD) bridge clinic, and embedding peer navigators in rural EDs; (4) leveraging teledentistry and establishing a special dentistry clinic **to expand dental care availability in rural Rhode Island**; (5) **building capacity for Block Island Health Services (BIHS)** for this geographically isolated community; and (6) **modernizing health care delivery for the Narragansett Indian Tribe** including through equipment upgrades that allow for telehealth and remote patient monitoring.

Goal #3: Workforce Development – Strengthen the Rural Health Care Workforce. A strong and well-supported workforce is essential to improving health outcomes in rural areas, where provider shortages, geographic barriers, and population health needs can create unique

challenges. Building on existing workforce development efforts, we will strengthen and expand a robust, locally grounded rural health care workforce – ensuring that care is accessible, high-quality, and responsive to rural communities' needs. We will develop a **rural workforce program** that cultivates talent from within our rural communities and provides training in rural settings. This includes establishing a Family Medicine residency program with a rural-focused track, expanding financial incentive opportunities for health care workers practicing in rural areas, and strengthening partnerships with educational institutions to enhance training capacity, update curricula, and support individuals at various stages of their health care careers. In addition, we will pursue policies that enable health care practitioners to practice at the top of their licenses, maximizing the reach and effectiveness of the rural health care workforce.

Goal #4: Innovative Care – Accelerate Value-Based and Affordable Care Models. Lasting improvements in access and quality of care for rural residents depend on a financially stable and adaptive health system. To support providers' financial solvency, we will advance comprehensive primary care practice transformation and **support hospitals and primary care practices in transitioning to value-based payment**. This includes preparing providers for successful participation in State-approved quality-linked advanced alternative payment models (APMs) with a focus on primary care capitation and alternative hospital payment models such as global budgets. Support for primary care practices and hospitals will include incentive payments, tailored technical assistance, and a fund to support major investments in clinical infrastructure and operational processes, with the goal of transforming how Rhode Island pays for and delivers primary care and hospital services. Through these activities, we will support providers in identifying and addressing risk factors for closure or service reductions, ensuring they are financially sustainable and able to serve rural communities for generations.

Goal #5: Tech Innovation – Integrate Technology into Rural Practice. Technology is a critical enabler for overcoming geographic barriers and supporting providers in delivering timely, coordinated care. We will launch a **rural health information technology (HIT) modernization program** to strengthen digital and HIT infrastructure across Rhode Island's rural health system. This includes the development and implementation of a cost-effective, secure, and interoperable state-sponsored EHR platform, as well as the creation of a rural HIT infrastructure grant fund. Through this fund, rural providers – including FQHCs, CCBHCs, RHCs, small practices, hospitals, and community-based organizations – will be eligible to apply for funding to upgrade EHRs, implement telehealth platforms, adopt workflow and practice management technologies, and explore and implement responsible use of artificial intelligence (AI), such as for clinical documentation, decision support, or administrative efficiency. By lowering technology barriers and providing shared services, we aim to promote efficient and flexible care, reduce the risk of rural providers closing or being forced to merge with larger health systems due to technology gaps, and empower independent and community-based providers to remain competitive within a modernized rural health ecosystem.

Robust Infrastructure to Support Data-Driven Transformation. To support these five goals, we will strengthen the rural health planning infrastructure to ensure rural communities can continuously assess their needs and measure impact. We will enhance data collection and analysis capacity at EOHHS and RIDOH and develop a **health data and workforce tracking system** to enable strategic resource allocation, outcomes monitoring, and identification of improvement opportunities. The system will include dashboards on the health care workforce, underlying drivers of disease, and health outcomes. Information will be used to support evaluation, policy design, and sustainability.

Program Key Performance Objectives. Upon implementing our RHTP, we commit to achieving the measurable, outcome-oriented objectives that reflect the program's integrated design. These objectives, described in the table below, align with federal rural health priorities, demonstrate accountability for public investment, and ensure that improvements in access, quality, and sustainability are both measurable and meaningful. They represent high-level program goals for Rhode Island's 18 rural communities, supported by initiative-specific outcomes and indicators detailed in *Section 6: Metrics and Evaluation Plan*.

Overall Program Objectives
Make Rural America Healthy Again – Improve the Health of Rural Residents
• Increase provision of primary care well-care services to foster preventive screening and identification and management of chronic illnesses in rural communities. • Increase provision of oral health care for children and adults in rural communities in order to reduce oral health disease prevalence and related medical illness. • Improve residents' access to nutrition information by making nutrition training a Continuing Medical Education requirement for physicians.
Sustainable Access – Expand Access to Comprehensive, Quality, Low-Cost Care
• Expand access to outpatient behavioral health services in rural communities • Improve physical access to necessary services for children and adults with disabilities in rural communities. • Reduce regulatory hurdles to encourage more facility expansion.
Workforce Development – Strengthen the Rural Health Workforce
• Expand the rural primary care clinician workforce. • Increase the number of rural clinical placements for health professional students and residents. • Pursue policies that will allow health care practitioners to practice at the top of their license.
Innovative Care – Accelerate Value-Based and Affordable Care Models
• Increase advanced APM adoption by primary care practices serving rural communities. • Accelerate the adoption of new care models and achieve higher quality care in rural communities through the application of APM incentives with primary care and hospital providers.
Tech Innovation – Integrate Technology into Rural Practice
• Expand rural practice adoption of certified EHRs. • Expand rural practice connection to, and data exchange with, the state's HIE.

State Policy Actions to Maximize and Sustain RHTP Impact. We recognize that policy reforms complement and enhance funding initiatives, creating a sustainable foundation for rural health transformation beyond the program period. The table below outlines Rhode Island's status with respect to the "State Policy Actions Technical Score Factors" in the NOFO.

To maximize the impact of our RHTP investment, by December 2027, we will enact legislation reducing the restrictiveness of our CON laws (C.3), join the PA Compact (D.2), and expand scope of practice for Pharmacists and Dental Hygienists (D.3). Together, these will strengthen our health care workforce capacity and increase access to care. We will also enact legislation by December 2028 requiring nutrition in physician CME, expanding residents' access to nutrition information. We also include data related to the "Rural Facility and Population Score Factors" in *Attachment D.*

Technical Score Factor	Current Status
B.2: Health and Lifestyle	Does not require schools to reestablish the Presidential Fitness Test (0 points).
B.3: SNAP Waivers	Has no pending or approved USDA SNAP food restriction waiver prohibiting the purchase of non-nutritious items and no pending State bill requiring a food restriction waiver be submitted to USDA (0 points).
B.4: Nutrition Continuing Medical Education (CME)	Has no requirement for nutrition CME for physicians as well as no pending State bill requiring nutrition to be included in CME for physicians (0 points).
C.3: Certificate of Need (CON)	Has CON laws that regulate health care facility development and major capital expenditures (25 points) based on the Cicero Institute Report.
D.2: Licensure Compacts	• Passed legislation to join the Interstate Medical Licensure Compact. Currently in the implementation phase (75 points). • Member of the Nursing Licensure Compact (100 points). • Not a member of the EMS Compact (0 points). • Participates in the Psychology Interjurisdictional Compact (100 points). • Has not filed legislation to become a PA Compact member (0 points).
D.3: Scope of Practice	• Has moderate scope of practice for PAs (50 points). • Has full scope of practice for NPs (100 points). • Has restricted scope of practice for Pharmacists (0 points). • Has semi-restricted scope of practice for Dental Hygienists (50 points).
E.3: Short-term, Limited Duration (STLD) Insurance	STLD plans are not restricted in Rhode Island beyond the latest federal guidance (100 points).
F.1: Remote Care Services	Medicaid covers remote care services (100 points).

A Cohesive Vision for Rural Health Transformation Built on Strategic Partnerships. Our transformation plan establishes a cohesive, community-driven vision for rural health, with interconnected goals that build a resilient, sustainable system through strategic partnerships at every level – local, regional, and statewide. Improving health outcomes is supported by expanded access to core services and implementing evidence-based disease prevention, chronic care management, behavioral health interventions and care models, and connections to services

that address upstream drivers of health. We will also ensure that care reaches residents of all ages where they live and work. Strengthening the rural health workforce ensures that care is delivered by local providers who understand and belong to these communities, while technology integration amplifies their reach and effectiveness. Meaningful payment reforms provide the financial stability necessary to sustain these innovations, allowing providers and communities to invest in high-quality, coordinated care.

These goals set forth directly align with the Centers for Medicare & Medicaid Services' (CMS) strategic priorities to build healthier lives through evidence-based prevention, patient empowerment, and greater choice and competition. They are supported by a rural health planning infrastructure that ensures continuous assessment, data-driven decision-making, and ongoing community engagement. We will achieve these goals through strategic policy reforms, and establishment clear program performance objectives that measure progress across health outcomes, access, workforce, payment, and technology domains.

Most importantly, our plan recognizes that rural health care transformation and sustainability cannot depend solely on clinic-based services in a single building. It requires a distributed network – clinicians, emergency responders, community health workers (CHWs), and community partners – all working in coordination to meet residents where they are, with services that address medical, social, nutritional, and functional needs comprehensively. Our initiatives emphasize and incentivize these partnerships, and we have proposed formal structures and funding to support community-led collaboration to inform program implementation.

Section 3: Proposed Initiatives and Use of Funds

Recognizing that traditional health care delivery models often fall short in addressing the unique challenges that rural communities face, we propose 13 transformative initiatives that

reimagine how care is delivered, coordinated, and experienced in these regions. These initiatives not only strengthen access to care but also maximize impact on local economies, supporting rural employment, developing homegrown talent pipelines, and channeling savings from health care investments back into the communities where they are needed. The following describes each of these initiatives, including implementation timelines and high-level outcomes. **At least one outcome for each initiative will be reported at the community level.** *Section 6, Metrics and Evaluation Plan* includes further details on outcomes measurement. More detailed initiative timelines are included in *Attachment D: Other Supporting Materials.*

Initiative 1: Integrated Rural Population Health Infrastructure

<table>
<tr><td colspan="2">Strategic Goal: Make Rural America Healthy Again – Improve the Health of Rural Residents
Use of Funds: A, G, I, H, and K (non-exhaustive).
Technical Score Factors: B.1, C.1, F.1, and F.3 (non-exhaustive).
Key Stakeholders: EOHHS, RIDOH, Department of Labor and Training (DLT); FQHCs; hospitals; behavioral health care providers; community non-profit organizations; home care providers; academic medical institutions; family support programs.
Impacted Counties: 44003, 44005, 44007, 44009
Funding Estimate: $12,362,478</td></tr>
<tr><td>Implementation Stages:
0: Develop implementation framework
1: Issue procurements for Hubs and Networks
2: Select Hubs and Networks; conduct readiness assessments
3: Deliver TA to build Hub and Network capacity; develop community plans
4: Launch phased Hub operations; implement community plans
5: Hubs/Networks fully implemented in all rural regions</td><td>Outcomes:
• Increased percentage of adults who received well-care visits
• Increased percentage of children and adolescents who received well-care visits
• Increased breast cancer screening rate
• Increased cervical cancer screening rate</td></tr>
</table>

Strategy. This initiative establishes a comprehensive population health infrastructure that integrates **Community Clinical Care Hubs (Hubs)** with community-led **Rural Community Health Networks (Networks)** to transform rural health care delivery in Rhode Island. The Hubs will serve as the clinical backbone – providing accessible, integrated care – while the Networks will mobilize local partners and resources to build healthier communities.

Hubs will serve as the clinical foundation of Rhode Island's rural population health infrastructure, delivering accessible, coordinated, team-based care while integrating seamlessly

with community resources. Each Hub will be supported by a third-party intermediary organization responsible for leading the integration and alignment of community–clinical care provision for each respective region. Hubs will support local integration and coordination efforts to address critical barriers to rural health care access – including through coordination with other proposed RHTP initiatives that advance innovative care delivery models, leverage the strategic use of technology, and that address provider shortages, geographic isolation, and fragmentation.

Hubs will expand beyond traditional clinic walls and bring care more directly to rural residents through community-led care coordination, leveraging trusted community infrastructure such as libraries, EMS stations, schools, and CLCs as local access points for care and information. Multidisciplinary care teams will collaborate to deliver integrated primary care, specialty care, behavioral health, oral health, and pharmacy services. There will be targeted efforts to address women's health needs, including breast cancer and cervical cancer screenings, through increased access and care coordination. Care coordination will prioritize individuals with multiple chronic conditions, complex social needs, or patterns of high-cost, preventable acute care utilization. CHWs will be essential members of the care team, coordinating services across clinical and community settings, facilitating referrals, arranging virtual or in-person well-care visits with primary care providers, and addressing barriers such as transportation and social needs. CHWs will not conduct preventive health screenings (such as for breast and cervical cancer). They will coordinate closely with the mobile health network established under Initiative 2 to extend services to residents who cannot easily access fixed sites.

Hubs will implement chronic disease interventions tailored to meet community needs, focusing on accessibility, self-management, and preventive care to reduce chronic disease and make rural America healthy again. These efforts will use a team-based Stepped Care Approach –

an evidence-based model that matches care intensity to patient need, beginning with the least resource-intensive effective intervention and escalating to higher-intensity services as clinically indicated.[2] Hubs will also ensure coordination of integrated behavioral health and SUD services, and mental health and recovery supports, including those established through Initiative 6.

A core feature of Hubs will be the use of HIT and digital tools, described in Initiative 12, to enhance real-time data sharing and extend access to individuals who are homebound or have limited transportation options. These include connection to the statewide health information exchange (HIE) through interoperable systems, investments in telehealth, and remote patient monitoring tools, and leveraging other investments in mobile health services and home-based care established through other RHTP initiatives.

Networks will form the community-based counterpart to the Hubs, bringing together local health care and behavioral health providers, community-based organizations, schools, municipal agencies, businesses, and other local partners to develop coordinated strategies that improve health and well-being. Networks may be regional or town-specific depending on local readiness, resources, and choice. Networks will engage residents directly through community outreach, local needs assessment, asset mapping, and the development and implementation of community improvement plans. In addition, Networks will bolster access to health care in rural communities; promote chronic disease prevention and management, behavioral health, substance use disorder prevention, and prenatal care; and support provider recruitment and retention efforts by engaging with Hubs. Networks will also play a central role in the overall implementation of Rhode Island's RHTP by sustaining ongoing community engagement, generating hyper-local data, monitoring program impact, and fostering connections between providers of health care and social services. Through this structure, rural residents and communities will remain active

partners in planning, implementation, and continuous improvement across all project phases.

Funding will support the creation and operationalization of the Hubs and Networks as an integrated system of rural health delivery. Potential investments may include establishing and equipping Hub sites and community access points to expand rural service capacity; implementing interoperable EHRs connected to the statewide HIE, enabling telehealth, remote monitoring, and population health analytics; supporting team-based care training; building referral and coordination platforms linking health care and social services, and supporting Network-led outreach and engagement; and sustainability and evaluation.

Project Impact. By creating a networked system that bridges clinical care, community-based services, and upstream health determinants, this initiative will improve chronic disease control, reduce unnecessary specialty referrals, improve health outcomes, and build sustainable capacity to address the complex health needs of rural populations across the lifespan.

Sustainability. Elements of these initiatives will sunset throughout the performance period as project milestones are achieved (i.e., site establishment, resolution of access barriers, implementation of electronic medical records, telehealth enablement, and other related initiation costs). Long-term sustainability will be supported by aligning Hubs and Networks with ongoing local and statewide health systems transformation efforts aimed at improving quality, outcomes, and patient experience while reducing preventable costs. All activities and costs will be aligned with existing and emergent funding strategies to maximize impact of RHTP funding, maximize opportunities for sustainability of impactful activities via existing resources, and monitor to prevent duplication and supplantation. Hubs will sustain operations through reimbursement for integrated primary, behavioral, and preventive services under Medicaid, Medicare, and commercial insurance. By aligning with Medicaid Accountable Care Organizations (ACOs) and

leveraging digital health platforms, Hubs will improve care coordination and cost efficiency, ensuring their continued financial viability. Shared data systems, community partnerships, and CHW integration will institutionalize this model as part of the State's rural health delivery framework – allowing it to evolve and scale without reliance on time-limited grant funds.

Rural Networks will be governed and staffed by community-based organizations, providers, and residents who can leverage ongoing funding from public health grants, value-based care arrangements, and local partnerships. Their capacity to conduct needs assessments, manage data, and demonstrate impact will enable them to attract continued investment from municipalities, foundations, and health care. With strengthened data, coordination, and partnership capacity, these Networks will be able to pursue additional public health and value-based funding streams, enabling them to sustain chronic disease interventions. Each funded entity will be required to submit a sustainability plan demonstrating how it will maintain operations and absorb future costs beyond the grant period, ensuring that the community and clinical partnerships established during the five-year Cooperative Agreement continue to strengthen and evolve.

Initiative 2: Rural Community-Integrated and Mobile Health Services.

<table>
<tr><td colspan="2">Strategic Goal: Make Rural America Healthy Again – Improve the Health of Rural Residents
Use of Funds: A, C, D, E, F, G, H, J, and K (non-exhaustive).
Technical Score Factors: B.1, B.2, C.1, F.1, and F.3 (non-exhaustive).
Key Stakeholders: RIDOH; Office of Healthy Aging (OHA); Women, Infants and Children (WIC) local agencies; Olmstead Advisory Group (OAG); rural school districts; FQHCs; dental providers; Rhode Island Quality Institute (RIQI).
Impacted Counties: 44003, 44005, 44007, 44009
Funding Estimate: $7,621,380</td></tr>
<tr><td>Implementation Stages:
0: Develop implementation framework; identify target CLCs/schools
1: Procure for CLC/school telehealth work and mobile services
2: Select contractors
3: Launch CLC/school services/training; deploy mobile services
4: Expand CLC/school services/training and mobile services deployment
5: CLC/school enhancements/training and mobile units fully launched/scaled</td><td>Outcomes:
• Increased population served by new mobile units
• Increased utilization of telehealth in schools
• Increased percentage of adults 18-64 who received at least one preventive dental service in Westerly and New Shoreham
• Increased percentage of children 0-17 who received at least one well-care visit in Westerly and New Shoreham</td></tr>
</table>

Strategy. We will enhance capacity and programming at eight rural **CLCs** that serve as multipurpose hubs providing education, workforce development, and health programs. Currently under construction in seven rural regions and expected to be complete by 2026, CLCs offer centralized, accessible spaces for residents of all ages to participate in wellness, education, and employment programming. This initiative will establish dedicated telemedicine spaces with the necessary technology – such as audiovisual equipment, digital stethoscopes, electrocardiogram (EKG) machines – and supported by trained personnel to assist residents in accessing and navigating virtual visits. Additional programming could include exposure to disability-serving professions, lifestyle interventions such as pediatric weight management, maternal and infant health supports including childbirth and breastfeeding education, and fall prevention programs.

Schools can also act as central hubs for coordinated medical, behavioral, and social supports that enhance academic achievement, reduce chronic absenteeism, and build long-term workforce resilience. To advance this role, we will enhance and expand our partnerships with **schools** to function as integrated health access points for students' health – providing combination of on-site and telehealth services that address physical and behavioral health needs, as well as tailored supports and services for students with disabilities. This approach includes strengthening professional development and technical capacity to provide mental health literacy for school staff, virtual consultation systems linking schools to behavioral health experts, and coordinated referral pathways to community providers for higher-level care. Telehealth infrastructure improvements will ensure secure, private visits and real-time coordination with health care providers, allowing schools to monitor and respond to student needs while linking families to broader community-based services to meet non-clinical care needs.

Complementing these community-embedded services, a **coordinated rural mobile health**

network will bring preventive and primary care directly to communities. Mobile dental services will deliver comprehensive oral health care – including exams, cleanings, sealants, fluoride treatments, and restorative care – to children, older adults, and individuals with disabilities across regions identified as having limited provider access. Mobile outreach and telehealth will provide well-visits, screenings, and chronic disease management, with real-time tele-consultations to specialists as needed. A mobile nutrition unit will deliver comprehensive nutrition and maternal-child health services – leveraging and expanding upon existing Women, Infants, and Children (WIC) infrastructure – to reach low-income families with enrollment assistance, nutrition counseling, breastfeeding support, health screenings, and referrals to social and clinical services. Each mobile unit will integrate with the state HIE to enable coordinated care, data sharing, and follow-up across community, school, and clinical settings.

Project Impact. This initiative will expand access to health services by leveraging trusted community spaces and a coordinated mobile health network to bring care directly to rural residents. These will serve as mobile extensions of the Clinical Care Hubs (Initiative 1) providing services and care transitions that connect directly to Hub care coordination teams.

Sustainability. Our strategy for sustaining this initiative focuses on embedding these services within existing education and community systems, aligning them with ongoing state and federal funding mechanisms, and ensuring that local partners assume long-term ownership of implementation. The RHTP will build on state and local investments that already guarantee at least five years of CLC programming, expanding those commitments to include preventive health, telehealth, and behavioral health services. Funding for ongoing operations will be supported through a combination of federal grant funds and local education and municipal budgets. For school-based programs, we will institutionalize behavioral health and telehealth

services by integrating them into FQHC-school district partnerships and professional development systems supported by the Department of Education (RIDE), thus sustaining them through district level system changes.

The coordinated mobile health network will be incorporated into Rhode Island's existing public health and health care infrastructure. The individual expanded mobile programs will be operated through established organizations that already receive ongoing reimbursement through Medicaid, private insurance, and federal nutrition programs. Following the grant period, participating provider organizations will maintain mobile services and equipment through a combination of new third-party reimbursements, public health contracts, and expanded community partnerships.

Initiative 3: Expanding Access to Rural Community Resources

<table>
<tr><td colspan="2">Strategic Goal: Make Rural America Healthy Again – Improve the Health of Rural Residents
Use of Funds: D and J (non-exhaustive).
Technical Score Factors: B.1 (non-exhaustive).
Key Stakeholders: EOHHS; RIDOH; Governor's Commission on Disability; RI Commission on the Deaf and Hard of Hearing; BHDDH; Department of Children, Youth, and Families (DCYF); rural providers; health-promoting organizations.
Impacted Counties: 44003, 44005, 44007, 44009
Funding Estimate: $5,900,000</td></tr>
<tr><td>Implementation Stages:
0: Develop implementation framework
1: Issue procurements for contractor for training and equipment
2: Select contractors, conduct needs assessment, and finalize training design
3: Begin equipment installations, launch virtual training
4: Continue installations and annual training updates
5: Complete installations; integrate maintenance and training into operations</td><td>Outcomes:
• Increased number of medical or community-based facilities equipped with accessible equipment
• Increased number of health care and community providers trained on disability-competency training
• Decreased percentage of elderly Medicaid members and Medicaid members with a non-behavioral health disability reporting significant difficulty in accessing services
• Increased percentage of elderly Medicaid members and Medicaid members with a non-behavioral health disability reporting community spaces as accessible following physical and procedural upgrades</td></tr>
</table>

This initiative complements and strengthens the broader effort to establish the Hubs and Networks. Leveraging these community resources is insufficient if they remain physically inaccessible. Our community listening sessions revealed that rural persons with disabilities and

older adults experience significant barriers to physically accessing health care and health-promoting spaces. These barriers include lack of ramps, adjustable equipment, or sensory-friendly environments in medical offices, community centers, and recreational facilities.

Strategy. We propose to conduct structured accessibility assessments of participating health care providers and community spaces; fund and install accessibility enhancements, including one-time purchases of adjustable exam tables, wheelchair-accessible scales, automatic doors, ramps, and adaptive exercise equipment; deliver in-person and virtual training modules on disability-competent care, and effective communication strategies; and develop a virtual training series and guide for providers and community organizations.

Project Impact. Making rural health care clinics and community spaces accessible will ensure more residents – particularly individuals with disabilities and older adults – fully benefit from transformative investments made through other initiatives.

Sustainability. Following the grant period, sustainability will be achieved through integration of accessibility audits and training into ongoing EOHHS provider quality improvement programs, adoption of virtual training series as a continuing education module for health care providers, and partnerships with community foundations and local businesses to maintain and expand accessibility infrastructure.

Initiative 4: Rural EMS Health Access and Integration

<table>
<tr><td colspan="2">Strategic Goal: Sustainable Access – Expand Access to Comprehensive, Quality, Low-Cost Care
Use of Funds: A, D, E, F, G, H, and J (non-exhaustive).
Technical Score Factors: B.1, C.1, C.2, D.1, E.1, and F.1 (non-exhaustive).
Key Stakeholders: RIDOH; Brown University Health, Department of Emergency Medicine; Local EMS agencies and volunteers; BIHC; Westerly Hospital; RIQI; municipal governments.
Impacted Counties: 44003, 44005, 44007, 44009
Funding Estimate: $8,398,503</td></tr>
<tr><td>Implementation Stages:
0: Conduct EMS needs assessment; develop implementation framework
1: Issue procurements for EMS modernization, MIH-CP, and EMS Academy</td><td>Outcomes:
• Decreased EMS response time (minutes)
• Increased percentage of individuals with at least one well-care (preventive) visit resulting from EMS</td></tr>
</table>

2: Select contractors; begin facility planning 3: Launch MIH-CP/EMS Academy operations; complete equipment upgrades 4: Expand MIH-CP and Academy training; finalize EMS readiness 5: All sub-projects fully launched and scaled	• Increased number of trainees that complete the EMS Academy • Decreased rate of potentially avoidable ED visits/1000

Strategy. EMS are among our most trusted and far-reaching health resources, serving even the most isolated rural and island communities. Historically viewed primarily as an emergency response and transport service, we will transform EMS into a fully integrated, patient-centered extension of the health care system, delivering preventive, urgent, and follow-up care directly in the community to improve outcomes and reduce ED reliance.

We will scale Rhode Island's successful **Mobile Integrated Health–Community Paramedicine (MIH-CP)** program to all rural towns, enabling specially trained EMS clinicians to provide in-home preventive and post-acute care. MIH-CP teams can function as mobile extensions of Clinical Care Hubs, providing in-home well-visits, assessments, and chronic disease monitoring. They will also support the Rural Hospital-at-Home Program (Initiative 5) by providing rapid response capabilities and daily monitoring services for patients receiving acute hospital care at home.

This transformation will be sustained by a stronger, better-trained EMS workforce. We will establish a new **State EMS Academy**, co-located with the existing State Fire Academy in the rural community of Exeter, that will serve as a permanent foundation for rural EMS education. The EMS Academy will conduct targeted recruitment, provide simulation-based instruction, and offer specialized certifications in mental health and community-based care. It will coordinate with the Rural Workforce Program (Initiative 10) to ensure that both career and volunteer providers have access to consistent, high-quality training, and to create pipeline programs introducing individuals to emergency medical careers.

Modernized EMS equipment and technology will further elevate care quality and

efficiency. We will work with local EMS agencies to upgrade monitors, digital decision-support tools, and advanced communication systems that will enhance coordination across hospitals, EDs, and community providers. We will also implement **targeted enhancements for remote island communities** such as Block Island and Prudence Island, including infrastructure investments in marine transport, paramedic training and volunteer support.

Project Impact. Together, these efforts will redefine what it means to deliver health care in rural Rhode Island. The MIH-CP pilot has already demonstrated its value in preventing avoidable emergency visits, improving chronic disease management, and connecting high-need individuals to ongoing care.[3] Expanding it to all rural towns will ensure that every community benefits from this proven, cost-effective approach. The EMS Academy will develop the next generation of clinicians and help to stabilize a workforce that has long struggled with recruitment and retention challenges. Equipment and technology improvements will allow EMS teams to transmit patient data in real time, ensure safer and more efficient transports, and strengthen readiness for complex emergency and trauma cases. Targeted EMS investments in rural islands, which face unique challenges of distance and weather, will ensure year-round, advanced life support capacity, and guarantee high-quality emergency and pre-hospital care for residents and visitors alike. This initiative will position EMS as a cornerstone of rural health transformation—one that delivers care where people are, when they need it most.

Sustainability. This initiative ensures long-term sustainability by embedding training, workforce development, and operational improvements within existing state and local systems. RHTP funds will support the development and scaling of infrastructures that can be sustained through existing payment mechanisms. The new State EMS Academy will be supported by course tuition, certification fees, and state resources. Training programs for delivering mobile

services, along with mental health training designed to prepare and support the workforce, will become part of ongoing EMS education, ensuring a skilled and resilient workforce. We will also explore establishing APMs that reimburse for MIH-CP services, ensuring long-term support for preventive and in-home care. Municipalities and hospitals will assume maintenance of upgraded equipment and facilities through regular budgets, ensuring continued service delivery. These measures establish a self-sustaining, community-based EMS network that strengthens access and continuity of care across Rhode Island's rural and island regions.

Initiative 5: Rural Hospital-at-Home Program

<table>
<tr><td colspan="2">Strategic Goal: Sustainable Access – Expand Access to Comprehensive, Quality, Low-Cost Care
Use of Funds: B and G (non-exhaustive).
Technical Score Factors: E.1, and F.1 (non-exhaustive).
Key Stakeholders: Hospitals and health systems serving rural residents; physicians and advanced practice providers; paramedics and EMS agencies; community health workers; remote monitoring specialists
Impacted Counties: 44003, 44005, 44007, 44009
Funding Estimate: $16,207,933</td></tr>
<tr><td>Implementation Stages:
0: Develop scope of work for hospital-at-home program
1: Execute subaward agreement
2: Conduct hospital readiness assessments; initiate Medicaid engagement
3: Launch initial hospital-at-home pilots; draft Medicaid state plan amendment (SPA)
4: Expand services; finalize and implement payment models
5: Fully scale program; integrate into hospital operations and budgets</td><td>Outcomes:
• Decreased rate of hospital inpatient admissions related to COPD, pneumonia, cellulitis, and soft tissue infections for Medicaid and commercial patients
• Increased patient satisfaction, as reported by patients receiving hospital-at-home services
• Increased number of patients receiving hospital-at-home services
• Launch of new reimbursement model for hospital-at-home services in Medicaid and commercial markets</td></tr>
</table>

Strategy. This initiative aims to strengthen access to acute and post-acute care services in rural communities by establishing a scalable home-based hospital care model that delivers safe, high-quality acute-level hospital care in patients' homes as a substitute for traditional inpatient admission. This evidence-based model reduces travel burden for rural residents, increases effective hospital capacity, improves patient satisfaction, and reduces costs while maintaining or improving clinical outcomes.[4] It is particularly well-suited to rural areas where patients face longer travel distances to hospitals, hospitals struggle with low utilization and financial

sustainability, patients prefer to remain in their communities near family support, and aging populations with complex medical needs desire to age in place.

This initiative will focus on conditions appropriate for home-based acute care, such as chronic obstructive pulmonary disease (COPD) exacerbations; pneumonia (community-acquired, low severity); cellulitis and soft tissue infections; and stable post-operative monitoring. Clinical teams will include physicians, nurse practitioners, registered nurses, paramedics, CHWs, and remote monitoring specialists coordinated through a centralized hub. It will leverage enhanced EMS capabilities established through Initiative 4 and integrate with Hub care coordination systems from Initiative 1 to deliver hospital-level care in patients' homes, supported by the HIT infrastructure from Initiative 12 for remote monitoring and clinical oversight.

Project Impact. Hospital-at-home programs can improve hospital finances by allowing them to maintain access to acute care reimbursement without the high overhead associated with maintaining additional hospital beds for patients receiving the hospital-at-home services. Several studies have shown lower costs and higher patient satisfaction with hospital-at-home services compared to inpatient care.[5] They also enable hospitals to serve patients who might otherwise travel to urban facilities, retaining revenue within the community.

Sustainability. We will pursue Medicaid and commercial payer participation to establish a sustainable reimbursement model for hospital-at-home services. This may include inclusion of hospital-at-home in the Medicaid State Plan as a covered acute care modality, prospective per-episode or bundled payment methodologies tied to quality and outcome metrics, or value-based incentives for hospitals that transition eligible admissions to home-based care.

Initiative 6: Expanding Behavioral Health Services Availability in Rural Regions

Strategic Goal: Sustainable Access – Expand Access to Comprehensive, Quality, Low-Cost Care
Use of Funds: G, H, J, and K (non-exhaustive).
Technical Score Factors: B.1 and C.1 (non-exhaustive).

<table>
<tr><td colspan="2">Key Stakeholders: Governor’s Council on Behavioral Health, Governor’s Overdose Task Force, BHDDH, CCBHCs, outpatient behavioral health and SUD providers, hospital EDs, and advocacy groups (e.g., Mental Health Association, NAMI).
Impacted Counties: 44005, 44007, 44009
Funding Estimate: $9,289,637</td></tr>
<tr><td>Implementation Stages:
0: Conduct needs assessment and develop site selection criteria
1: Issue procurements; identify partner hospitals
2: Select contractors
3: Launch CSC, RCC, bridge clinic, and addiction consult services
4: Expand services and strengthen coordination across sites
5: Full launch and scale rural behavioral health service network</td><td>Outcomes:
• Decreased rate of behavioral health ED visits/1000 – stratified by mental health and substance use disorder diagnosis
• Increased rate of outpatient behavioral health visits/1000
• Implementation of new behavioral health and crisis stabilization and recovery community centers in targeted regions
• Increased number of patients served by new behavioral health and crisis stabilization and recovery community centers by year, following implementation</td></tr>
</table>

Strategy. We will establish one (rather than two) **24/7 behavioral health and crisis stabilization center (Center)** in one rural area of Rhode Island – to be determined based on resident need – which will provide continuous, community-based crisis and stabilization services for adults 18 and older. Using evidence-informed practices, the **Center** will offer behavioral health screening, triage and diagnostic assessment, psychoeducation, medication initiation, withdrawal management, recovery planning, peer support, and care coordination. They will be walk-in/drop-off sites that connect individuals to immediate and long-term recovery supports.

In addition, two (rather than four) new **recovery community centers (RCCs)** will be created in northern, western, or central rural regions of Rhode Island, determined through analysis of opioid overdose and EMS data. RCCs will operate using evidence-informed peer recovery supports practices to promote long-term recovery and build community recovery capital.[6] Services will include overdose prevention education, recovery support groups, treatment referrals, health screenings, and employment and education supports.

The crisis stabilization **Center** and **RCCs** will be complemented by evidence-based addiction medicine specialist care services at four hospitals in Rhode Island that serve rural patients. This will ensure high quality substance use treatment is available and incorporated into

care for patients admitted to the hospital for any reason, and also for those cared for in the ED including post-overdose and in the outpatient setting. This multimodal approach will include working with hospitals and addiction medicine-board certified specialist health care providers to establish inpatient consult services in addiction medicine, including withdrawal management for admitted patients. It will include an **SUD bridge clinic** that will operate as a low-barrier, walk-in urgent care site offering evidence-based SUD treatment in a rural hospital setting for patients aged 16 and older – including those who are pregnant or postpartum. **Peer navigators** will be embedded in bridge clinics to facilitate care linkage with primary care, substance use treatment, and behavioral health services from the hospital including the bridge clinic, inpatient and emergency departments (EDs). They will also connect, as necessary, with Hubs (Initiative 1) to coordinate delivery of clinical and social supports, as well as to schools (Initiative 2) to support youth experiencing behavioral health crises and connect families to ongoing services.

Project Impact. This initiative will expand mental health, SUD, and crisis intervention services across rural regions, ensuring residents have timely, community-based support while also enhancing recovery supports statewide. It will improve engagement in SUD treatment, linkage to long-term recovery supports, and strengthen community recovery capacity.

Sustainability. Following initial start-up investment with RHTP funds, we will transition operational costs for the crisis stabilization center, RCCs and SUD bridge clinic to ongoing reimbursement mechanisms, including Medicaid State Plan and managed care arrangements that support crisis and community-based services. The peer navigator program will be sustained through hospital-based billing for peer recovery services.

Initiative 7. Strengthening Rural Oral Health Delivery Through Innovation and Integration

Strategic Goal: Sustainable Access – Expand Access to Comprehensive, Quality, Low-Cost Care
Use of Funds: A, E, F, G, and J (non-exhaustive).
Technical Score Factors: B.1, C.1, E.1 and F.1 (non-exhaustive).

<table>
<tr><td colspan="2">Key Stakeholders: BHDDH, Eleanor Slater Hospital (ESH), contracted dental providers, OAG
Impacted Counties: 44003, 44005, 44007, 44009
Funding Estimate: $1,804,744</td></tr>
<tr><td>Implementation Stages:
0: Develop implementation framework and conduct needs assessment
1: Issue procurements for teledentistry and Zambarano
2: Select contractors; begin technology and facility prep
3: Complete upgrades; implement dentist and ED staff training
4: Launch virtual dental triage and phased Zambarano operations
5: Fully launch and scale virtual dental triage and Zambarano dental center</td><td>Outcomes:
• Decreased rate of non-injury, dental-related ED visits/1000
• Decreased number of Medicaid patient transfers to urban or out-of-state facilities for dental procedures
• Increased number of ESH outpatient dental center visits
• Increased percentage of Medicaid children and adults with a disability who received a dental visit</td></tr>
</table>

Strategy. This initiative expands both immediate and long-term dental capacity across rural Rhode Island through two coordinated strategies. The first is a virtual triage system that connects patients presenting with dental issues, either before or upon arrival at the ED, to licensed dental professionals via tele-dentistry. Patients experiencing dental pain or problems can call a dedicated hotline, connecting directly to licensed dental professionals. Using real-time video and guided self-assessments, clinicians will evaluate patient needs, provide guidance, and schedule care in appropriate clinical settings. For patients who do present to EDs with dental complaints, ED staff will connect them via tablet or telemedicine cart to the virtual dental triage team.

The second component involves transforming the existing dental facility at Eleanor Slater Hospital's (ESH) Zambarano campus into a specialized, fully accessible outpatient dental care center. As a long-term acute care hospital with expertise managing patients with complex medical conditions, ESH is uniquely positioned to provide high-quality, safe dental care for populations that most dental practices cannot accommodate. These include individuals requiring sedation due to severe anxiety or behavioral health conditions, or individuals with disabilities who would benefit from extended appointment times and specialized communication approaches. The center will be staffed by a multidisciplinary team trained in trauma-informed and sedation dentistry and will serve as a consultation and training resource for other providers.

Strategic facility upgrades will improve accessibility, infection control, and patient flow. The clinic will also function as a statewide consultation training and resource for other dental and medical providers. Rural dentists encountering patients with complex needs can consult the center's specialists for guidance on treatment planning, behavior management, or other issues.

Project Impact. This initiative will improve oral health and reduce the high number of unnecessary ED visits for dental complaints, which are common in areas with few dental providers.[7] It will also enhance provider capacity across the state through consultation and training, creating a sustainable network of dental care capable of treating individuals with complex needs which will reduce transfer of rural residents to other urban areas or other states.

Sustainability. Ensuring the long-term viability of these dental initiatives relies on financial stability, workforce development, and community integration. The virtual triage program will achieve sustainability by integrating with existing care systems and value-based payment models that reward appropriate care and demonstrate costly ED visits. Its scalable, interoperable tele-dentistry platform can also support other rural telehealth needs – the same infrastructure enabling virtual dental triage can facilitate telepsychiatry consultations, tele-dermatology, or remote chronic disease monitoring, spreading technology costs across multiple applications and increasing overall value. By Years 4-5, the ESH dental care center will be sustainable as it begins billing Medicaid for services, supplemented by disability-focused grants, consultation fees, and potential partnerships with dental schools for specialized clinical rotations.

Initiative 8: Building Capacity for Block Island Health and Human Services

Strategic Goal: Sustainable Access – Expand Access to Comprehensive, Quality, Low-Cost Care
Use of Funds: A, D, E, and F (non-exhaustive).
Technical Score Factors: B.1, B.2, C.1, C.2, D.1 and E.2 (non-exhaustive).
Key Stakeholders: BIHS, New Shoreham Health and Human Services; New Shoreham EMS and Public Safety; Thundermist Health Center, academic medical centers, RIDOH, BHDDH
Impacted Counties: 44009
Funding Estimate: $2,731,826

Implementation Stages:	**Outcomes:**
0: Develop integrated implementation framework across program components 1: Execute subaward agreement 2: Select contractors for upgrades and installations 3: Begin infrastructure, EMS, and aging-in-place improvements 4: Launch expanded community programs and PACE operations 5: Fully implement and scale all programs and infrastructure upgrades	• Launch of Program of All-Inclusive Care for the Elderly (PACE) on Block Island • Increased percentage of New Shoreham residents, age 65+, who received at least one well-care visit during the year • Increased number of medical residents assigned to / enrolled in the Rural Medicine Education Program on Block Island • Increased number of home-based services delivered to people on Block Island through the Community Medicine Program

Block Island (Town of New Shoreham), Rhode Island, located 12 miles offshore in the Atlantic and home to the State's only RHC, faces challenges that distinguish it from any other rural community. Block Island has approximately 1,100 year-round residents, but during peak summer months, the daily population surges to over 30,000 – a more than 25-fold increase driven by tourists, seasonal homeowners, and day-trippers. The island's geographic location and dramatic seasonal swings in population require a comprehensive, place-based approach.

Strategy. This initiative incorporates elements of multiple other initiatives to meet the needs of Block Island including Hub concepts from Initiative 1, enhanced EMS capabilities from Initiative 4, HIT infrastructure from Initiative 12, and workforce development from Initiative 10. At the center of this effort, BIHS will expand its Community Medicine Program to deliver home-based, preventive (well-care), and follow-up care for elderly and chronically ill residents. Integrating EMS, nursing, and public safety partners, the program will improve access to well-care visits and reduce hospitalizations through coordinated, home-centered care. This initiative also aims to establish the island's first PACE in partnership with BIHS, the Town of New Shoreham, and PACE Rhode Island, while expanding a Community Health and Aging-in-Place Program to build wellness, transportation, and social support capacity through employment of a full-time CHW and accessible facilities. To promote health, BIHS will enhance local food storage and distribution through a Nutrition and Chronic Disease Prevention Program, ensuring

reliable access to healthy foods year-round. Workforce capacity will be advanced through a Rural Medicine Education Program with Thundermist, an FQHC. The program will place residents in Block Island and collaborate with academic institutions to train medical, Physician Assistant (PA), and Nurse Practitioner (NP) students in rural, emergency, and community-based care. Finally, BIHS and the Block Island Volunteer Rescue Squad will modernize technology, facilities, and EMS infrastructure.

Project Impact. Expected impacts include reductions in off-island medical transports and preventable hospitalizations, improved continuity of care for elderly and chronically ill patients, and expanded local workforce capacity – ensuring the island's health network remains strong.

Sustainability. The Community Medicine and PACE model will be sustained through established Medicare and Medicaid reimbursement. BIHS will collaborate with the town to sustain the CHW role. The Rural Medicine Education Program will continue through tuition revenues, and EMS and facility infrastructure modernization represent strategic one-time capital investment.

Initiative 9: Modernizing Health Care Delivery for the Narragansett Indian Tribe

<table>
<tr><td colspan="2">Strategic Goal: Sustainable Access – Expand Access to Comprehensive, Quality, Low-Cost Care
Use of Funds: C, E, F, H, and J (non-exhaustive).
Technical Score Factors: B.1, C.1, D.1, F.1, F.2, and F.3 (non-exhaustive).
Key Stakeholders: Narragansett Indian Tribe; Narragansett Indian Health Center; DLT; EOHHS; RIDOH
Impacted Counties: 44003, 44005, 44007, 44009
Funding Estimate: $964,655</td></tr>
<tr><td>Implementation Stages:
0: Develop implementation framework modernization/workforce initiatives
1: Execute subaward agreement
2: Select contractors; begin recruitment for Tribal Health Award Program
3: Launch telehealth, workforce training, and incentive programs
4: Continue optimization and workforce integration
5: Fully launch and scale modernization, telehealth, and workforce programs</td><td>Outcomes:
• Increased NIHC telehealth service volume
• Increased NIHC CHW and behavioral health aide service volume
• Number of new health infrastructure/equipment installations at NIHC
• Increased NIHC behavioral health service volume (office and telehealth)</td></tr>
</table>

The Narragansett Indian Health Center (NIHC) delivers primary, behavioral, and community health services to Narragansett Indian Tribal members in southern Rhode Island. Yet access to dental, specialty, and diagnostic care remains limited due to transportation barriers, outdated infrastructure, and incomplete integration of tribal health data within statewide systems. Specialty care coverage for tribal members is currently very limited, underscoring the need for expanded local capacity. Because tribal health programs operate independently, from state-funded facilities, a dedicated initiative is necessary to address the Narragansett Indian Tribe's (Tribe) needs.

Strategy. Through the RHTP, EOHHS will partner with the Tribe to modernize infrastructure, strengthen workforce capacity, and enhance care coordination. This initiative will deploy digital diagnostic tools, remote patient monitoring, and EHR-integrated equipment to improve early detection, chronic disease management, and data accuracy. This includes installing secure telehealth systems to expand remote access to care, along with new diagnostic and monitoring technologies such as portable ultrasound and ECG devices, connected home monitors, and point-of-care testing systems. Facility upgrades will further enhance care delivery through the addition of a handicap-accessible transport van, dental IT modernization, UV-C air filtration, updated power and water systems, and installation of a Hyperbaric Oxygen Therapy unit for wound care. The Tribe will also implement a Tribal Health Award Program, offer sign-on and retention incentives, and coordinate with the State to train CHWs and behavioral health aides to strengthen local capacity and ensure continuity of care.

Project Impact. Training programs and recruitment incentives will strengthen local capacity and ensure continuity of care. Additionally, expanded outpatient and telebehavioral health services will address substance use, anxiety, and depression in coordination with state and

local behavioral health partners.

Sustainability. The infrastructure and equipment upgrades funded through RHTP—digital diagnostic tools, telehealth systems, facility improvements, the hyperbaric oxygen therapy unit—become permanent NIHC assets maintained through IHS operational budgets and third-party billing revenues. Once established, these enhanced capabilities will enable NIHC to bill Medicaid, Medicare, and private insurance for expanded services (telehealth visits, advanced diagnostics, specialized wound care), generating incremental revenue that offsets maintenance costs and supports sustainability.

Initiative 10: Rural Workforce Program

<table>
<tr><td colspan="2">Strategic Goal: Workforce Development – Strengthen the Rural Health Workforce
Use of Funds: E (non-exhaustive).
Technical Score Factors: D.1 (non-exhaustive).
Key Stakeholders: EOHHS; RIDOH; DLT; Office of the Postsecondary Commissioner (OPC); RIDE; Thundermist Health Center; higher education institutions; rural health and behavioral health providers; dental and oral health providers.
Impacted Counties: 44003, 44005, 44007, 44009
Funding Estimate: $24,817,865</td></tr>
<tr><td>Implementation Stages:
0: Develop implementation framework for incentives/placements/mentorships
1: Execute subaward agreement for residency program; issue procurements for workforce development programs
2: Select contractors and launch recruitment and enrollment
3: Begin mentorship, training, and incentive program delivery
4: Expand participation and continue incentive disbursements
5: Institutionalize program and transition oversight to partners</td><td>Outcomes:
• Increased number of rural primary care physicians
• Decreased vacancy rate among rural providers
• Increased number of rural clinical placements for health professional students and residents
• Increased number of individuals obtaining training and credentials for jobs in rural settings</td></tr>
</table>

This initiative seeks to build a stable, skilled rural health workforce by expanding clinical training, strengthening education-to-employment pathways, supporting career advancement, and providing targeted recruitment and retention incentives. It creates the workforce foundation that enables other RHTP initiatives to succeed.

Strategy. To attract clinicians to rural practice, we will **expand rotations and field experiences** for medical, NP, and PA students in community-based settings, including FQHCs and behavioral health clinics. Embedding trainees in these environments fosters familiarity with

rural practice and encourages long-term commitment. **Financial incentives** – including hiring bonuses, relocation stipends, and retention payments – will support both clinicians and essential frontline staff such as Certified Nursing Assistants (CNAs), home health aides, and CHWs, making rural employment more competitive and sustainable.

Partnerships with educational institutions and workforce development agencies will enhance training capacity and align curricula with employer needs. Initiatives like Rural Healthcare Career Awareness, expanded rural high school career and technical education health care tracks, adult pre-employment training, continuing education and professional development, and hiring incentives for paraprofessionals will enhance the pipeline into rural health careers. A **centralized clinical placement system** will streamline student placements, help rural providers host trainees more efficiently, and ensure that education meets rural communities' needs.

For long-term retention, we will implement **continuing education programs** that connect new providers with experienced rural practitioners. These programs will cover team-based care, integrated behavioral health, culturally responsive and trauma-informed approaches, and chronic disease management. Specialized behavioral health certificate training will further strengthen home-based care providers' skills. These programs build confidence, reduce burnout, and help sustain a resilient workforce through structured professional development and peer learning.

Finally, **community-based residency programs** will create a durable pipeline of rural physicians and dentists. The **Thundermist Family Medicine Residency program** includes placements on Block Island to prepare residents to deliver comprehensive care in rural settings. A new **dental residency program** will expand access to oral health care through community health centers and mobile services.

Project Impact. These coordinated strategies not only address immediate staffing gaps but

also build the long-term capacity needed to meet the evolving health care needs of rural Rhode Island communities. By integrating recruitment, training, mentorship, and clinical placements with financial incentives and educational support, this initiative fosters a sustainable, adaptable, and multidisciplinary rural health workforce. Embedding trainees in these communities fosters familiarity with rural practice and encourages long-term commitment.

Sustainability. This initiative creates permanent educational partnerships that will continue well beyond the RHTP. Medical, PA, and nursing programs will integrate rural rotations into their curricula supported by institutional training budgets. High school career pathways programs will be sustained through state education funding. We will strategically phase recruitment and retention incentives to support early workforce stabilization as the pipeline matures.

Five Year Workforce Service Commitments Strategy. The State of Rhode Island will use RHTP funds to strengthen and stabilize the rural clinical workforce through a coordinated, multi-pronged strategy designed to expand access to care, reduce turnover, and grow a sustainable pipeline of clinicians serving rural communities. Given Rhode Island's small geographic size, constrained health care infrastructure, and workforce shortages, this approach is intentionally flexible while remaining fully aligned with federal requirements.

In accordance with the NOFO and RHTP FAQs promulgated on October 28, 2025, the State will apply the statutory five-year service commitment requirement to individuals who attain additional abilities, certifications, or degrees that enable a career in rural health care, or who receive a direct monetary benefit such as a recruitment or retention incentive. Non-degree or one-time training programs will generally be exempt unless deemed critical to meeting rural workforce needs. Program-specific service requirements, including any exceptions, will be clearly documented in written agreements.

Rhode Island's compliance verification strategy will vary by program type and funding mechanism. Monitoring tools may include contractual agreements, promissory notes, structured service obligation documents, periodic employment verification, and tracking of licensure, certification, or workforce participation status. For programs tied to direct monetary incentives or post-credential clinical advancement, the State will incorporate recoupment provisions requiring repayment for failure to fulfill service commitments, with pro-rated recovery permitted in cases of partial completion. Limited exceptions, such as family leave, serious illness preventing practice, or death, will be explicitly defined. The State may also establish a workforce governance structure to review unique circumstances on a case-by-case basis to ensure fairness while maintaining program integrity.

RHTP workforce initiatives span multiple entry points along the clinical workforce continuum. For example, the Behavioral Health Certificate Training program will provide rural home care workers with clinical competencies necessary to support patients with behavioral health conditions. This initiative strengthens the workforce pipeline and enables agencies to meet Rhode Island's Behavioral Health rate enhancement requirements. Because home care professionals serve clients statewide throughout the year, including rural residents whose assignments may shift based on patient need, the State's service commitment approach for this program will focus on continued licensure, active employment within the home health industry, and verified workforce participation rather than strict geographic placement. For participants receiving RHTP-supported training tied to expanded clinical credentialing, compliance may be demonstrated through documentation of maintained licensure and ongoing employment in home health or community-based care settings/

The Rural Family Medicine Residency Program, including placements at Thundermist and Block Island, will treat residency training as active rural service, as residents provide supervised care to rural populations throughout their training period. Because residents are already serving rural communities during the residency years, the State's approach to the five-year requirement will recognize this period as contributing toward the statutory service expectation. As a result, participants will generally owe a defined post-graduation service period (anticipated to be approximately two years) following completion of residency if they received RHTP-supported benefits. Post-residency service obligations will be formalized through promissory agreements and may be fulfilled in rural settings or in practices demonstrably serving rural patients. While flexibility will be allowed for completion across eligible sites, including out-of-state locations serving rural populations, enforceable documentation and employment verification requirements will ensure alignment with the statutory five-year intent.

Direct recruitment and retention incentives will apply the full five-year service commitment requirement. These incentives target hard-to-fill rural clinical positions and represent direct monetary benefits to the individual clinician. Employers must document recruitment difficulty and provide justification for the proposed incentive. Recipients will enter into contractual agreements that clearly outline a five-year service obligation, defined employment terms, verification requirements, and recoupment provisions if the obligation is not fulfilled or if CMS determines funds must be recovered. Compliance will be verified through periodic employment verification with the hiring entity, supported by contractual documentation maintained by the State. Payments may be structured in installments tied to verified service milestones to reinforce accountability and alignment with the statutory requirement.

Additional initiatives include professional development and continuing education programs delivered through RIDOH and partner entities to ensure clinicians remain current in clinical guidelines and emerging care models. Hands-on workforce training programs, implemented in collaboration with the Department of Labor and Training and other partners, will support CNAs, CHWs, and other essential personnel in developing practical entry-level health care skills. Because Rhode Island's small size necessitates shared infrastructure, participants may train or work in hospital or urban-based settings while still serving rural populations. Accountability for such roles will focus on active licensure, workforce participation, and service to rural patient populations rather than strict geographic placement when facilities represent the sole available resource in the state.

Oversight and coordination will be led by EOHHS as the responsible agency for RHTP implementation and monitoring. The Office of Primary Care and Rural Health and other subject-matter experts will provide technical guidance and operational support, leveraging experience administering workforce programs such as the State Loan Repayment Program. The EOHHS Workforce Transformation Program will provide additional administrative capacity for managing complex, multi-layered workforce initiatives. RHTP workforce programs will prioritize rural-serving providers and safety-net facilities, including FQHCs, CCBHCs, and free clinics, while permitting participation by urban-based providers when a meaningful proportion of their patient population resides in rural communities.

All payments and funding disbursements will be tied to verified program activities and measurable outcomes, including completion of training, attainment of certifications, and fulfillment of service commitments. The State will conduct duplication-of-funding assessments to ensure RHTP funds do not supplant or duplicate other funding sources. Recovered funds from

unmet service obligations, if applicable, will be reinvested in allowable RHTP workforce activities in consultation with the CMS Project Officer.

Through this structured yet adaptable framework, Rhode Island will apply the five-year service requirement in a consistent, enforceable, and transparent manner. This approach ensures that RHTP investments translate into measurable, long-term rural workforce capacity while maintaining accountability, flexibility, and full alignment with CMS guidance.

Initiative 11: Supporting Hospitals and Primary Care in Value-Based Payment Transition

<table>
<tr><td colspan="2">Strategic Goal: Innovative Care – Accelerate Value-Based and Affordable Care Models
Use of Funds: D, I, and J (non-exhaustive).
Technical Score Factors: B.1, C.1, and E.1 (non-exhaustive).
Key Stakeholders: Office of the Health Insurance Commissioner (OHIC); EOHHS; hospitals, primary care providers, other rural provider partners (including CCBHCs), Rhode Island Health Center Association (the HRSA-designated state primary care association representing FQHCs and other providers); Hospital Association of Rhode Island; Care Transformation Collaborative – Rhode Island (CTC-RI)
Impacted Counties: 44001, 44003, 44005, 44007, 44009
Funding Estimate: $32,273,525</td></tr>
<tr><td>Implementation Stages:
0: Develop implementation framework for TA and Transformation Funds
1: Complete performance agreements with hospitals; begin incentive payments; issue procurements for TA and transformation funds
2: Select contractors and launch transformation fund solicitations
3: Begin TA, and award initial grants
4: Transition to performance-based payments; continue TA and grants
5: Integrate APM oversight and best practices into ongoing governance</td><td>Outcomes:
• Increased State-approved APM adoption by primary care providers serving patients in rural areas
• Increased State-approved APM adoption by hospitals serving patients in rural areas
• Increased State-approved APM incentives earned by primary care practices serving patients in rural areas
• Increased State-approved APM incentives earned by hospitals serving patients in rural areas</td></tr>
</table>

Strategy. The RHTP – in concert with Rhode Island's participation in the federal AHEAD (Achieving Healthcare Efficiency through Accountable Design) Model and ongoing efforts to advance ACOs and other advanced APMs – presents a key opportunity to transform payment and delivery systems. Through APMs, we will promote multi-payer alignment, integrate behavioral health and address upstream drivers of health while managing costs and improving population outcomes. To accelerate adoption of APMs, we will implement three complementary strategies.

The first, **Hospital and Primary Care Incentive Payments for APM Reporting and**

Performance, will incentivize strengthening reporting capabilities to allow for successful participation in quality-linked advanced APMs by paying for reporting in starting in Year 1. Starting in FY28 Q2, the program will transition to a pay-for-performance model, rewarding hospitals and primary care practices that serve significant rural populations for success on cost and quality metrics in the context of State-approved advanced APMs; this timing aligns with federal AHEAD Model implementation. We will develop a process for approval of advanced APMs to ensure incentives support participating in meaningful payment reforms. Approved APMs will be Health Care Payment Learning and Action Network Category 3b or 4 – models that include shared financial risk elements and links payments directly to quality performance.

The second strategy is a **Targeted Technical Assistance (TA) Program.** It will engage one or more qualified contractors to deliver comprehensive TA tailored to each hospital and primary care practice's needs during the transition to State-approved quality-linked hospital and primary care advanced APMs. The contractor(s) will provide both individualized and group-based TA focused on improving operational performance and financial management, and supporting care delivery transformation. TA activities may include identification and implementation of internal operation changes and efficiency improvement projects; identification of capital projects or other investments; improving cost accounting and data analytics capabilities, particularly for hospitals undertaking global budgets and primary care practices participating in primary care capitation models; staff training on value-based care; support for accurate and timely cost and quality reporting; identification of cost and quality improvement opportunities; and facilitating peer learning collaboratives to share best practices. For primary care practices, this will also include support for improving Advanced Primary Care competencies and achieving Patient-Centered Medical Home status. Final TA plans for hospitals and primary care practices will be informed

by a detailed needs assessment of each participating hospital and cohort of participating primary care practices, and will ensure sustained technical and operational capacity to function effectively under quality-linked advanced APMs.

The final component, the **Hospital and Primary Care Transformation Funds**, will provide direct financial support for strategic projects that help eligible providers implement value-based care. Eligible uses include allowable capital expenditures, supplies, equipment, staffing, and programmatic activities that advance care delivery innovation, efficiency, and community integration. Example investments may include (but are not limited to): minor renovation of physical spaces to provide innovative care (e.g., ED or primary care practice renovations to support behavioral health provider co-location); development of partnerships among rural provider types (e.g., engaging CCBHCs or rural social service providers); or pilots of innovative care models with a clear post-RHTP sustainability plan. Proposals for HIT-related projects will be considered separately through Initiative 12, Rural HIT Modernization Program.

Funding will be awarded through a competitive grant process prioritizing rurality (including location and the extent to which the hospital/practice serves rural patients), safety net status (including DSH percentage and, where applicable, Medicare designation for hospitals and clinic type, e.g., FQHC status, for primary care practices), readiness for transformation, and alignment with State goals for rural health system modernization. Eligible applicants will include hospitals and primary care practices that demonstrate a commitment to implementing sustainable delivery and payment reforms via commitment to participating in State-approved quality-linked advanced APMs, including those offered under AHEAD.

Project Impact. This initiative will support the financial sustainability of hospitals and primary care practices that serve rural communities by enabling their successful participation in

advanced APMs. The quality incentive payments and shared savings they generate from reduced preventable hospitalizations and improved chronic disease management will create new revenue streams. Beyond provider level gains, this transformation will improve population health, and result in shifting of care to high-quality, lower cost settings.

Sustainability. We will sustain this initiative by embedding hospitals and primary care practices in long-term State-approved advanced APMs, including the AHEAD Model. The Hospital and Primary Care Incentive Payments for APM Reporting and Performance, coupled with targeted TA, will build lasting expertise in financial management, data analytics, and care redesign, enabling hospitals and primary care practices to operate effectively under advanced APMs without continued grant support. The Transformation Funds will provide one-time capacity-building investments for infrastructure, efficiency, and care transformation projects that create ongoing savings or align with new payment incentives. After initial implementation, we will integrate advanced APM oversight and performance monitoring into AHEAD governance and Medicaid quality infrastructure. We will continue to refine payment models and TA offerings using lessons learned from the TA and Transformation Fund projects.

Initiative 12: Rural Health Information Technology Modernization Program

Strategic Goal: Tech Innovation – Integrate Technology into Rural Practice **Use of Funds:** C, D, and F (non-exhaustive). **Technical Score Factors:** B.1, F.1, F.2, and F.3 (non-exhaustive). **Key Stakeholders:** Rural Providers (such as CCBHCs, FQHCs, RHCs, rural hospitals, rural practices, and other community-based organizations); State Government Agencies (Department of Administration (DOA), EOHHS, RIDOH,); RIQI/RHIO; Tech Industry **Impacted Counties:** 44003, 44005, 44007, 44009 **Funding Estimate:** $16,766,993

Implementation Stages:	**Outcomes:**
0: Conduct HIT needs assessment and define governance for grant funds 1: Develop EHR design, issue procurements, and grant eligibility criteria 2: Select contractors and grant fund administrator	• Increased number of rural practices adopting the state-sponsored EHR • Increased number of rural practices that transition from a non-certified to certified EHR • Increased number of new health

3: Launch EHR implementation and first grant awards 4: Continue EHR implementation and grant disbursement 5: Fully implement EHR and fully disburse grant awards	infrastructure/digital tools installations • Increased number of new interfaces established to the State's HIE or to RIDOH

Strengthening rural health care in Rhode Island requires ensuring that every provider has the right tools, technology, and equipment to deliver high-quality, efficient, and coordinated care. Many small and rural practices face barriers to maintaining up-to-date systems and medical technology due to high costs, limited staffing, and technical complexity. To close the gaps, we propose to implement a **Rural HIT Modernization Program** to embed interoperable, sustainable, and practice-ready technology solutions directly into rural care settings, and provide the technological backbone that will facilitate and connect other RHTP initiatives.

Strategy. A cornerstone of the program will be a **state-sponsored EHR solution** designed for rural providers. By aggregating demand across multiple rural practices, the State can negotiate substantially reduced per-user costs, leveraging volume discounts unavailable to individual practices. The State – or a contracted vendor – would be responsible for the complex technical and compliance aspects of EHR selection, contracting, and ongoing management. This includes ensuring the system meets all federal meaningful use requirements, HIPAA security standards, and state-specific reporting mandates. The system will be pre-configured with necessary reporting feeds to RIDOH, participating health plans, and the State's HIE.

The initiative will also establish a **rural HIT infrastructure grant fund** to catalyze strategic investments in HIT and digital health tools that strengthen rural providers' capacity to deliver coordinated, efficient, and accessible care. Built on partnership rather than prescription, this initiative will work directly with rural providers to identify their most pressing needs, and support them in identifying practical, sustainable technology solutions that fit their local context. This approach ensures that technology investments are meaningful, feasible, and aligned with both local priorities and statewide transformation goals, while advancing CMS's aim of

improving quality, safety, and efficiency through the adoption and use of CMS-certified health information technology in accordance with standards set by CMS in the Promoting Interoperability Program (PIP) and the recently announced Interoperability Framework.

The grant fund will operate through three structured mini-grant categories: 1) equipment for currently billable services, 2) achievable and targeted software upgrades aligned with PIP goals, and 3) innovation and AI tools that do not otherwise fit with the other categories. For equipment grants, providers may request telehealth equipment, remote monitoring devices, or rated solutions tied to billable services and aligned with State-defined clinical priorities. For software-upgrade grants, funds will support enhancement to existing systems – not full conversions – such as population health modules, patient management applications, or other features that promote Interoperability Framework goals, with expectations for disbursement based on meeting implementation milestones. For innovation and AI grants, providers will propose concrete, evidence-supported tools such as scribe software or clinical-decision support modules with clearly defined outcomes that they will report back to the State.

The State will directly oversee the program, including developing criteria for uses of grant funds, developing and issuing the call for grant applications, evaluating grant applications and making final award decisions, and monitoring implementation. Issuing numerous small awards aims to ensure place-specific needs are addressed individually – rather than with a “one size fits all” approach – and consequently the State will procure a consultant organization through a single over-arching contract for this program, which will provide both HIT-related technical assistance and financial administration. A contracted organization can operate more quickly and nimbly than the State in issuance of multiple small awards, minimizing bureaucratic delays in operationalizing this work; furthermore, pairing disbursement of funds with technical assistance

will promote sustainability and uptake. Coordinated technical assistance will include needs assessments with the rural providers to ensure identified tech solutions fit workflows, assisting providers with developing their mini-grant applications, and support in the implementation of the approved projects. Awards will be made based on state-defined criteria and priorities such as alignment with the State's RHTP goals; rurality and rural service commitment; HIT readiness and implementation capacity; interoperability and care coordination impact; and evidence of effectiveness, efficiency, and quality improvement. To prevent duplication, staff will review applications from other initiatives (e.g., Block Island and EMS equipment requests) before issuing awards. Where other initiatives fund specific equipment for defined programs, the HIT infrastructure grant will prioritize complementary or standalone technology needs for rural health that may not be addressed elsewhere.

Project Impact. Equipping providers with an interoperable EHR will reduce administrative burden, facilitate care coordination and continuity, streamline data exchange, and ensure rural providers can fully participate in APMs and population health programs. The infrastructure grants will allow providers to acquire technology and digital tools that can help them streamline workflows, deliver telehealth and telemonitoring services, and modernize care delivery.

Sustainability. This one-time technology investment will free practice capacity, allowing providers to deliver more on direct care. Grant-funded equipment and tools will enable long-term efficiency gains and reduce reliance on ongoing funding. Practices will pay a low-cost subscription to the state-sponsored EHRs that provides access to interoperable, fully supported systems and ensure affordable, sustainable operations beyond the grant period.

Initiative 13: Rural Health Data and Workforce Tracking System

Strategic Goal: Make Rural America Healthy Again – Improve the Health of Rural Residents **Use of Funds:** E, F, and G (non-exhaustive). **Technical Score Factors:** B.1, F.2 (non-exhaustive).

<table>
<tr><td colspan="2">Key Stakeholders: State Government Agencies (DLT, EOHHS, RIDOH, Office of Data Analysis and Evaluation, OHIC); Networks and Hubs; RIQI
Impacted Counties: 44001, 44003, 44005, 44007, 44009
Funding Estimate: $1,000,000</td></tr>
<tr><td>Implementation Stages:
0: Conduct system inventory and develop implementation framework
1: Define enhanced data and dashboard specifications; issue procurements for expansion work
2: Select contractors; begin system enhancements
3: Launch pilot of expanded workforce data and tracking system
4: Scale expanded system and finalize dashboards
5: Fully implement enhanced data and tracking systems</td><td>Outcomes:
• Expand functionality of existing workforce data hub
• Completed assessment of priorities for workforce recruitment efforts using workforce data hub output
• Number of completed community health data profiles
• Enhanced performance monitoring dashboards with data stratified by geography</td></tr>
</table>

This initiative focuses on developing integrated data systems that track upstream drivers of health, coordinate care between community-based and clinical providers, and inform investments in preventive and non-clinical interventions. We will implement an enhanced rural health data and workforce tracking system (data hub) to strengthen resource alignment, guide targeted interventions, and measure progress toward improved health outcomes and cost-effective care.

Strategy. We will create a standardized data system to identify and track opportunities for upstream health improvements at the community and individual levels. The system will help facilitate Z Code utilization across Rhode Island health care settings or otherwise capture actionable data to improve care coordination, service provision, and address upstream drivers of health at the community-level. A centralized Community Health Needs Assessment (CHNA) repository will help community partners standardize data practices, improve quality, reduce duplication, and enable analysis of patients' long-term health. Individualized community data profiles will map local provider capacity and highlight opportunities to address upstream drivers of health across all 18 rural towns. In parallel, we will develop a comprehensive statewide health care provider tracking system to accurately assess workforce distribution across rural and non-rural regions. We will also enhance existing system performance dashboards to track comparative outcomes more effectively for rural and non-rural populations. The new dashboard

will allow geographic stratification of health data to monitor the impact of rural health initiatives, inform ongoing planning and resource allocation, and support evidence-based adjustments to care delivery based on provider capacity and location.

Project Impact. The rural health data and workforce tracking system responds to a longstanding priority identified through Rhode Island's Health Care System Planning Cabinet, which has consistently emphasized the need for robust workforce data to inform strategy health systems investments and policy decisions. It will support optimization provider allocation, helping to "right-size" care delivery and strengthen rural health capacity. This will enhance local and state health planning, identifying areas where investments in workforce capacity and targeted interventions can maximize impact, improve outcomes, and reduce costs. Dashboards will enable community-level evaluation of progress toward RHTP strategic goals, including reductions in chronic disease prevalence, improved care coordination, and increased health system efficiency. It will also support reporting requirements, and contribute to evaluation of RHTP initiatives.

Sustainability. The rural health data and workforce tracking system is designed as permanent state infrastructure that will continue operating and providing value beyond the RHTP period. All data systems developed through this initiative will be transferred to the EOHHS Office of Data Analysis and Evaluation and RIDOH Office of State Health Planning, with maintenance costs absorbed into these agencies' regular operating budgets. These offices already maintain similar data infrastructure, making integration of these systems a natural extension of existing capabilities rather than new standalone programs requiring dedicated funding.

Initiative Integration and Synergies

Our 13 RHTP initiatives form an interconnected ecosystem rather than standalone projects. Each initiative has been intentionally structured to reinforce and amplify the others, creating

synergies that multiply impact and promote long-term sustainability. Three foundational initiatives provide the core infrastructure: (1) Workforce development (Initiative 10) builds the rural talent pipeline to staff Hubs, mobile services, EMS, and behavioral health centers; (2) HIT modernization (Initiative 12) provides the technological backbone, enabling data exchange and care coordination across all initiatives; and (3) Data and workforce tracking (Initiative 13) establishes the measurement framework that guides implementation and demonstrates value.

Three initiatives form service delivery platforms: (1) Networks and Hubs (Initiative 1) are the central organizing structure for rural health services; (1) Community-integrated and mobile health services (Initiative 2) extend care into communities; and EMS integration (Initiative 4) transforms emergency services into a preventive care platform.

The remaining initiatives expand access to specific services or populations. Access to community resources (Initiative 3) ensures the community spaces where other initiatives operate are physically accessible. Hospital-at-Home (Initiative 5) leverages EMS and Hub infrastructure. Similarly, behavioral health expansion (Initiative 6) integrates with Hubs for warm handoffs. The oral health initiative (Initiative 7) addresses dental access gaps. The Block Island and Narragansett Indian Tribe initiatives (Initiatives 8 and 9) integrates multiple RHTP strategies and applies them to the unique contexts of these communities.

Value-based payment transitions (Initiative 11) align financial incentives with the integrated, team-based, prevention focused care by helping providers adopt State-approved advanced APMs, including AHEAD models, recognizing that transformation cannot sustain itself on fee-for-service reimbursement.

Section 4: Implementation Plan and Timeline

We will implement the RHTP across five budget periods from federal fiscal year (FY) 2026

through FY 2031. Figure 2 shows the phased approach to launching and scaling the overall program and each initiative, ensuring coordinated rollout, stakeholder engagement, and progress monitoring aligned with the program's strategic goals. It also outlines our timeline for implementing the policy actions discussed above. Detailed, initiative-specific implementation plans and timelines, organizational charts, and resumes of key staff, Ana Novais and Manuel Ortiz, are provided in the *Attachment D: Other Supporting Materials*.

Figure 2: Overall Program and High-Level Initiative Implementation Timeline

Gantt Chart Key					
Stage 0	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**

	FY26			**FY27**				**FY28**				**FY29**				**FY30**				**FY31**			
	Q2	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Overall Program Wide Implementation and Evaluation																							
Establish project leadership and staffing structure																							
Develop detailed work plans and procurement strategy																							
Finalize evaluation framework, research questions, and logic model																							
Finalize stakeholder engagement plan																							
Execute subaward agreements																							
Introduce legislation for policy actions **(2026 legislative session)**																							
Select and contract with independent evaluator																							
Select and contract with communications vendor																							
Collaborate with evaluator on mixed-methods design and baseline data																							
Enact legislation for policy actions **(by June 2027 and December 2028)**																							
Conduct ongoing governance and stakeholder meetings																							
Implement policy actions **(by December 2027)**																							
Implement evaluation plan and conduct reporting																							
Conduct annual review and refinement of initiatives																							
Finalize initiative deliverables and evaluation summaries																							
Develop sustainability and transition plans																							
Disseminate comprehensive evaluation report and report outcomes																							
Initiatives																							
1. Integrated Rural Population Health Infrastructure																							
2. Rural Community-Integrated and Mobile Health Services																							
3. Expanding Access to Rural Community Resources																							
4. Rural EMS Health Access and Integration																							
5. Rural Hospital-at-Home Program																							
6. Expanding Behavioral Health Services Availability in Rural Regions																							
7. Strengthening Rural Oral Health Delivery Through Innovation and Integration																							
8. Building Capacity for Block Island Health and Human Services																							
9. Modernizing Health Care Delivery for the Narragansett Indian Tribe																							
10. Rural Workforce Program																							
11. Supporting Hospitals and Primary Care in Value-Based Pmt Transition																							
12. Rural Health Information Technology Modernization Program																							
13. Rural Health Data and Workforce Tracking System																							

Program Governance. The Rhode Island Executive Office of Health and Human Services (EOHHS) will lead RHTP implementation. EOHHS is a cabinet-level agency reporting directly to the Governor and serves as the single State Medicaid agency and implementation lead for AHEAD. As the coordinating body for the organization, finance and delivery of services across multiple departments – including RIDOH, DCYF, BHDDH, and the Department of Human Services (DHS) – EOHHS is well-positioned to drive a transformative, system-wide initiative to strengthen and sustain Rhode Island's rural health infrastructure. EOHHS will oversee all aspects of the Cooperative Agreement, including overall project governance, alignment with CMS and Center for Medicare and Medicare Innovation (CMMI) requirements, reporting, and evaluation.

The governance framework for the RHTP builds on Rhode Island's longstanding record of successful interagency collaboration and proven capacity for efficient planning, management, evaluation, and stakeholder engagement – demonstrated most recently through the successful implementation of pandemic relief funding and successful cross-sector initiatives (e.g., implementation of CCBHCs and development of Rhode Island's AHEAD Model). The structure is designed to streamline implementation and ensure coordination, accountability, and transparency – with direct weekly decision points managed jointly by the Executive Committee and Project Management Teams.

- **Executive Committee.** Comprised of designated Governor's Office staff, the EOHHS Secretary Richard Charest and Assistant Secretary Ana Novais, the RIDOH Director, the Health Insurance Commissioner, the Office of Management and Budget (OMB) Director, and the DOA Director, this body will provide overarching oversight, policy direction, and strategic alignment with statewide priorities.
- **Interagency Leadership Team.** Comprised of Cabinet members and their senior staff, and

Governor's Office staff, this team will serve in an advisory capacity to promote coordination, alignment, and effective resource utilization across agencies. The team, led by Assistant Secretary Novais, will support communication and collaboration on implementation activities, ensuring consistency with state priorities while informing decision-making by the Executive Committee and Project Management Team. As specific initiatives are developed, targeted workstreams may be established to leverage subject matter expertise and ensure effective execution. Participating entities include BHDDH, DCYF, DHS, EOHHS, OHA, Office of Veterans' Services (OVS), OHIC, DLT, RIDE, RIDOH, OMB, OPC, and the DOA.

- **Project Management Team.** The Team will be led by the EOHHS Project Director (to be hired), with Manuel Ortiz, Director of the Office of Rural Health and Primary Care serving in an interim capacity. This team will oversee day-to-day operations, grant management, communications, and evaluation activities, ensuring timely progress toward program goals and compliance with Cooperative Agreement requirements. Jennifer Pate is the EOHHS Authorized Organizational Representative.
- **Rural Stakeholder Advisory Committee.** Comprised of patients, residents, rural-based organizations and provider institutions – including rural CCBHCs, FQHCs, Indian Health providers, tribal leadership, and leaders of Rhode Island's CLCs – this committee will be convened in coordination with the Leadership Team to ensure rural stakeholders have an active role in the planning and implementation of the project. This advisory committee will build on Rhode Island's Health Care System Planning Cabinet efforts to support integration and sustainability of successful strategies. The team will monitor changes to costs, quality, outcomes, and patient experience that can inform reinvestment and sustainability of

successful grant strategies.

The Executive Committee has met weekly throughout the development of the grant application and will continue to do so during the initial months after funds are awarded to monitor early milestones. Meetings will transition to a bi-weekly cadence throughout the five-year project period. The Leadership Team will meet monthly to ensure alignment with the Governor's strategic priorities, the Health Care System Planning Cabinet goals, and other statewide initiatives; track progress towards milestones; assess impact; and provide overall guidance to the team.

As with prior large-scale projects, this governance structure will be memorialized through memoranda of understanding between the Governor's Office and the state agencies. EOHHS will assign oversight of specific initiatives to appropriate state agencies or community partners through subawards and competitive procurement. For example, BHDDH will lead the development of new behavioral health access points in rural areas; RIDOH will manage the expansion of rural EMS services across the 18 targeted towns; and the Rhode Island Health Center Association (RIHCA) will oversee the allocation of funds to FQHCs involved in multiple initiatives. Details on sub-awardee responsibilities are outlined in the *Budget Narrative*.

Staffing Plan. We will dedicate 17.5 Full-Time Employees (FTE) to ensure effective implementation and oversight of this program, led by Interim RHTP Director Manuel Ortiz. The EOHHS core team will include a Deputy Director, Finance Director, two Project Managers, an Evaluation Manager, a Communications Specialist, and a Procurement Specialist, ensuring robust fiscal management, operational efficiency, and performance monitoring. Five partner state agencies – RIDOH, BHDDH, OHIC, RIDE and DLT – will each hire one Project Manager and one Finance staff member (totaling 10 FTEs) to oversee and coordinate implementation within

their respective areas of work. Additional contractual staff will be engaged for program implementation. This cross-agency RHTP Project Management Team will meet weekly and be responsible for the program's day-to-day administration, including fiscal and program oversight, milestone tracking, impact assessment, and communication with CMMI within the Cooperative Agreement. As outlined in *Section 6, Metrics and Evaluation Plan*, EOHHS will also procure a qualified professional evaluation organization to conduct a rigorous, independent assessment of program outcomes and impact.

Risk Management. We will implement a proactive and structured risk mitigation plan to ensure that the RHTP achieves its intended outcomes on time, within scope, and in compliance with federal requirements. We will analyze data from performance dashboards, financial reports, and community feedback quarterly to identify early warning signs of risk and opportunities for improvement. The Project Management Team will share findings with partners to inform mid-course corrections, technical assistance priorities, and sustainability planning. We will evaluate each risk by likelihood and impact on implementation and outcomes to determine what course corrections we need to take. Any high-priority risks or deviations from implementation milestones will be elevated to the Executive Committee. If significant implementation delays occur, EOHHS will re-sequence project timelines while preserving scope and outcomes.

Section 5: Stakeholder Engagement

We have conducted extensive stakeholder engagement, in-person and virtually, throughout the proposal development process, engaging with hundreds of Rhode Islanders. We hosted two statewide virtual Community Listening Sessions, and held three hybrid Listening Sessions across the State: on Block Island, in southern Rhode Island (Washington County) and in northern Rhode Island (town of Burrillville). We also presented at more than 20 public meetings and community

forums, including the HSPC and Advisory Council, Governor's Council on Behavioral Health, Children's Cabinet, Primary Care Physician Advisory Committee, EOHHS Workforce Stakeholder Meeting, Olmstead Action Team, RIDOH Maternal Health and Oral Health programs, and the Rhode Island HIT Steering Committee.

We also launched an online Community Feedback Request to collect written input on rural communities' health needs and project ideas. This effort generated over 300 formal survey responses and numerous additional emailed submissions. Outreach and promotion for the Listening Sessions and survey reached approximately 1,200 individuals.

Our robust engagement process has built strong alignment and broad-based support for the proposed initiatives. Stakeholders – including health systems, community-based organizations, behavioral health providers, advocacy groups, and local government partners – have expressed a shared commitment to advancing rural health transformation. This is evidenced by the letters of commitment and support included in *Attachment D: Other Supporting Materials*, demonstrating tangible, cross-sector readiness to participate in and sustain the proposed efforts.

Looking ahead, we will sustain this engagement framework through the Rural Health Stakeholder Advisory Committee, described in the previous section, which will convene regularly to provide input to both the EOHHS Independent Advisory Council (IAC) and to the Health Care System Planning Cabinet. These bodies will coordinate to ensure alignment with ongoing statewide priorities and to maintain a transparent, collaborative implementation process.

Section 6: Metrics and Evaluation Plan

We will implement a comprehensive, mixed-methods evaluation framework to assess the implementation, effectiveness, and impact of the RHTP. The evaluation will measure program implementation processes, outputs, outcomes, and population-level impacts across all initiatives

to ensure accountability, support continuous improvement, and maintain alignment with federal performance and quality objectives. Our evaluation will seek to answer the core research questions outlined in Figure 3.

Figure 3. Evaluation Research Questions

- Are RHTP initiatives being implemented as planned?
- How do contextual and other factors influence implementation?
- What is the impact of RHTP on health system infrastructure, service availability, care delivery, and the root causes of disease in rural settings?
- What is the impact of RHTP on quality of care, health outcomes, community health, and patient experience in rural communities?

Evaluation Framework. We will partner with a qualified organization to evaluate the impact of the RHTP. The evaluator will provide independent oversight, methodological expertise, and data analysis to ensure an objective and rigorous evaluation process. During the planning stage of the program, we will identify the process for selecting an evaluator and collaborate with the selected organization to finalize the evaluation design. We will cooperate with any CMS-led evaluation or monitoring activities.

As part of the evaluation design, and in collaboration with the selected evaluator, we will establish processes for data collection, measurement, and analyses; approaches to reporting and dissemination of learnings; and protocols for data management and quality control. Collectively we will infuse primary care, behavioral and mental health, maternal and child health, oral health, rural health, and health economic subject matter expertise into the evaluation approach, data collection and analysis activities, and interpretation of findings. We intend to use a mixed methods approach that includes the following three components:

- **Quantitative analyses** to assess programs activities' impact on health care quality, outcomes, service utilization, expenditures, and community health.
- **Qualitative analyses** through stakeholder interviews and other methods to capture stakeholder perspectives and program implementation experience.

- **Process evaluations** to examine implementation barriers and facilitators, effectiveness of initiative implementation, and contextual factors that influence program performance.

Performance Measures and Outcomes. Our initiative-specific metrics align with Rhode Island's RHTP goals and strategies, focusing on access, service utilization, quality and health outcomes, workforce, and program implementation. We identified the selected measures based on overall program goals and objectives, improvement opportunities in rural Rhode Island, and data availability. The table below summarizes each initiative's metrics, including baselines, targets, expected time frames for observing change, data sources, and data update frequency. Baseline data availability reflects the accelerated timeline for the NOFO response; for metrics derived from existing data sources and analyses, we established baselines and targets. However, for many metrics – particularly those measuring new services or programs that do not yet exist, baseline values are necessarily zero or to be determined during the planning phase. Targets will also be determined as baseline data becomes available. Unless otherwise noted in the table, all outcomes will be measured at the community level, and where appropriate and feasible in comparison to non-rural communities within the State.

Initiative Outcome Measures				
Metric	**Baseline**	**Targets and Observation Period**	**Data Source**	**Data Update Frequency**
Initiative #1: Integrated Rural Population Health Infrastructure				
% of adults who received well-care visits	35.3% for Westerly and New Shoreham. 44.1% for 18 Towns.	Increase by 1 percentage point annually following program implementation	RI's All-Payer Claims Database (APCD)	Annually
% of children and adolescents who received well-care visits	53.8% for Westerly and New Shoreham. 62.6% for 18 Towns.	Increase by 1 percentage point annually following program implementation	APCD	Annually
Breast cancer screening rate	TBD	Increase by 1 percentage point annually following program implementation	APCD	Annually

Cervical cancer screening rate	TBD	Increase by 1 percentage point annually following program implementation	APCD	Annually
Initiative #2: Rural Community-Integrated and Mobile Health Services				
Population served by new mobile units	0	Rhode Island expects the population to be served by mobile units to increase from 0 starting in Year 4 followed by a steady level of volume thereafter	EOHHS	Annually
Utilization of telehealth in schools	TBD	Increase starting in Year 4	APCD	Annually
% of adults 18-64 who received at least one preventive dental service in Westerly and New Shoreham	49.5% in 2024	Increase by 1 percentage point annually following program implementation	APCD	Annually
% of children 0-17 who received at least one well-care visit in Westerly and New Shoreham	53.8% in 2024	Increase by 1 percentage point annually following program implementation	APCD	Annually
Initiative #3: Expanding Access to Existing Rural Community Resources				
# of medical or community-based facilities equipped with accessible equipment	TBD	Increase starting in Year 2	EOHHS	Annually
# of health care and community providers trained on disability-competency training	TBD	Increase starting in Year 2	EOHHS	Annually
% of elderly Medicaid members and Medicaid members with a non-behavioral health disability reporting significant difficulty in accessing services	TBD	Decrease following program implementation	Medicaid survey data	Annually
% of elderly Medicaid members and Medicaid members with a non-behavioral health disability reporting community spaces as accessible following physical and procedural upgrades	TBD	Increase following program implementation	Medicaid survey data	Annually
Initiative #4: Rural EMS Health Access and Integration				
EMS response time (minutes)	TBD	Decrease following program implementation	RIDOH	Quarterly
% of individuals with at least one well- care (preventive) visit resulting from EMS	40.4% for Westerly and New Shoreham. 48.2% for 18 Towns	Increase by 1 percentage point annually following program implementation	APCD	Annually
# of trainees that complete the EMS Academy	TBD	Increase starting in Year 4 followed by a steady level of volume thereafter	MIH-CP Program	Annually
Rate of potentially avoidable ED visits/1000	TBD	Decrease following program implementation	APCD	Annually

Metric	Baseline	Targets and Observation Period	Data Source	Data Update Frequency
Initiative #5: Rural Hospital-at-Home Program				
Rate of hospital inpatient admissions related to COPD, pneumonia, cellulitis, and soft tissue infections for Medicaid and commercial patients	TBD	Decrease following program implementation	APCD	Annually
Patient satisfaction, as reported by patients receiving hospital-at-home services	TBD	Patients receiving hospital-at-home services report high satisfaction following program implementation	RHTP Survey Data	TBD
# of patients receiving hospital-at-home services	TBD	Increase following program implementation	APCD	Annually
Launch of new reimbursement model for hospital-at-home services in Medicaid and commercial markets	N/A	Executed contract with the State's largest Medicaid insurer (NHPRI) and the largest commercial insurer (BCBSRI) by Year 3	EOHHS, OHIC	TBD
Initiative #6: Expanding Behavioral Health Services Availability in Rural Regions				
Rate of behavioral health ED visits/1000 – stratified by mental health and substance use disorder diagnosis	TBD	Decrease by 1 percentage point annually following program implementation	APCD	Annually
Rate of outpatient behavioral health visits/1000 (office and telehealth)	TBD	Increase by 1 percentage point annually following program implementation	APCD	Annually
Implementation of new behavioral health and crisis stabilization center and recovery community centers in targeted regions	N/A	Implementation begins in Year 3 and centers are fully launched and scaled in Year 5	RI EOHHS	N/A
# of patients served by new behavioral health and crisis stabilization center and recovery community centers by year, following implementation	N/A	Increase starting in Year 3	APCD	Annually
Initiative #7: Strengthening Rural Oral Health Delivery Through Innovation and Integration				
Rate of non-injury, dental-related ED visits/1000	TBD	Decrease following program implementation	APCD	Annually
# of Medicaid patient transfers to urban or out-of-state facilities for dental procedures	TBD	Decrease following program implementation	Medicaid claims data	Annually
# of ESH outpatient dental center visits	N/A	Increase starting in Year 5	Medicaid claims data	Annually
% of Medicaid children and adults with a disability who received a dental visit	TBD	Increase by 1 percentage point annually following program implementation	Medicaid claims data	Annually
Initiative #8: Building Capacity for Block Island Health and Human Services				
Launch of PACE on Block Island	N/A	Operations begin in Year 4 and are fully launched and scaled in Year 5	RI EOHHS	N/A

Metric	Baseline	Targets and Observation Period	Data Source	Data Update Frequency
% of New Shoreham residents, age 65+, who received at least one well-care visit during the year	TBD	Increase by 1 percentage point annually following program implementation	APCD	Annually
# of medical residents assigned to / enrolled in the Rural Medicine Education Program on Block Island	TBD	Increase starting in Year 4	Thundermist, academic institutions	Annually
# of home-based services delivered to people on Block Island through the Community Medicine Program	N/A	Increase starting in Year 4	Block Island Health Services	Annually
Initiative #9: Modernizing Health Care Delivery for the Narragansett Indian Tribe				
NIHC telehealth service volume	TBD	Increase starting in Year 4	NIHC	Annually
NIHC CHW and behavioral health aide service volume	TBD	Increase starting in Year 4	NIHC	Annually
# of new health infrastructure/equipment installations at NIHC	N/A	Installations begin in Year 2	NIHC	Annually
NIHC behavioral health service volume (office and telehealth)	TBD	Increase starting in Year 4	NIHC	Annually
Initiative #10: Rural Workforce Program				
# of rural primary care physicians	117 PCPs located in rural towns (2024)	Increase by 1% annually following program implementation	State Data Management System	Annually
Vacancy rate among rural providers	TBD	Decrease following program implementation	Survey of large outpatient providers	Annually
# of rural clinical placements for health professional students and residents	TBD	Increase starting in Year 3	Centralized clinical placement system	TBD
Increased number of individuals obtaining training and credentials for jobs in rural settings	TBD	Increase starting in Year 2	DLT, RIDE	Annually
Initiative #11: Supporting Hospitals and Primary Care in Value-Based Payment Transition				
State-approved APM adoption by primary care providers serving patients in rural areas	N/A	Increase starting in Year 3	OHIC	TBD
State-approved APM adoption by hospitals serving patients in rural areas	N/A	Increase starting in Year 3	OHIC	TBD
State-approved APM incentives earned by primary care practices serving patients in rural areas	N/A	Increase; 75% of eligible incentives earned by primary care practices in Year 2	OHIC	TBD
State-approved APM incentives earned by hospitals serving patients in rural areas	N/A	Increase; 75% of eligible incentives earned by hospitals in Year 2	OHIC	TBD

Metric	Baseline	Targets and Observation Period	Data Source	Data Update Frequency
Initiative #12: Rural HIT Modernization Program				
# of rural practices adopting the state-sponsored EHR	0	Increase starting in Year 2	EOHHS	TBD
# of rural practices that transition to a certified EHR	0	Increase starting in Year 2	RIQI/ RHIO	TBD
# of new health infrastructure/ digital tools installations	0	Increase starting in Year 2	EOHHS	TBD
# of new interfaces established to State's HIE or RIDOH	0	Increase starting in Year 4	RIQI/RHIO, RIDOH	TBD
Initiative #13: Rural Health Data and Workforce Tracking System				
Expand functionality of existing workforce data hub	N/A	Data hub enhancements begin in Year 3 and finalized in Year 4	EOHHS	N/A
Assessment of priorities for workforce recruitment efforts using workforce data hub output	N/A	Assessment completed in Year 1	EOHHS	N/A
# of completed community health data profiles	0	18 community health data profiles completed in Year 2	EOHHS	N/A
Performance monitoring dashboards with data stratified by geography	N/A	Dashboards are enhanced with geographic stratification in Year 3	EOHHS	N/A

Section 7: Sustainability Plan

We are committed to ensuring that the investments made through the RHTP create lasting change in rural health care that persist beyond the funding period. With the RHTP, we will bolster rural provider networks, capacity, and relationships, implement evidence-based care models and health programming, expand data capabilities to identify what is working and scale best practices across regions, and adopt APM models that achieve savings. These strategies are self-sustainable and will create lasting impact. Additionally, we will transition to ongoing funding sources, embedding programs into standard operations, and demonstrating value that justifies continued investment, and integrating lessons learned into state policy and practice.

Financial Sustainability. Many of the RHTP investments represent one-time infrastructure costs that establish the foundation for rural health transformation. These investments – such as the Hubs, mobile health services, and expanded services delivered through schools – create the physical, technological, and organizational capacity needed to sustain operations over time. Once

established, funding for services delivered through these programs will transition to ongoing financing through established reimbursement mechanisms, including Medicaid, Medicare, and commercial payer coverage. For some programs like SUD Bridge Clinics and behavioral health crisis centers, we will also leverage existing state and federal block grants to maintain operations. Local municipalities will assume responsibility for maintaining and operating capital assets – such as infrastructure upgrades to CLCs and EMS equipment – through local appropriations and cost-sharing agreements.

Our value-based payment support initiative (Initiative 11) also represents a critical element of the RHTP sustainability strategy. Community Clinical Care Hubs (Initiative 1) can sustain their team-based care coordination, CHW programs, and integration of behavioral health only if primary care APMs reward this comprehensive approach rather than paying only in-person clinician visits. Hospitals can maintain Hospital-at-Home programs (Initiative 5) and support EMS-based community paramedicine (Initiative 4) only if advanced APMs provide financial flexibility to deliver care in appropriate settings rather than maximizing inpatient admissions.

Program and Operational Sustainability. RHTP initiatives will embed robust data collection and performance monitoring systems through the State HIE, rural data dashboards, and evaluations. These tools will enable continuous quality improvement, resource optimization, program refinement, and demonstration of impact. In addition, programs are intentionally designed to build on and enhance the work of existing entities – FQHCs, hospitals, EMS agencies, and community organizations – ensuring alignment, reducing redundancy, and ensuring that RHTP functions are fully integrated into these organizations' standard operating procedures over time. Networks will maintain local engagement and continue community-driven planning, ensuring that solutions remain responsive to local needs.

Workforce Sustainability. A skilled and locally rooted workforce is fundamental to sustaining our rural health transformation. Staff trained through RHTP initiatives (e.g., EMS transformation, behavioral health, and clinical care hubs) will remain embedded within their respective health systems, community-based organizations, and municipal agencies, continuing to deliver enhanced, high-quality services for years to come. Ongoing workforce development will be supported through programs such as the EMS Academy and provider competency training modules, sustained through tuition and certification fees, and incorporated into existing continuing education and licensure requirements, creating a durable workforce pipeline.

Infrastructure Sustainability. As mentioned previously, capital investments, including mobile clinics, equipment, and upgraded facilities are designed for long-term use and maintained through local partner and organization budgets. Digital infrastructure investments, such as telehealth platforms, remote patient monitoring systems, and interoperable health records, will be sustained by the provider organizations. These infrastructure investments are expected to yield measurable returns on investment that will strengthen provider organizations' long-term financial positions. By increasing care efficiency and improving population health management these assets will help rural providers achieve shared savings, quality incentives, and performance-based payments under Medicaid, Medicaid, and commercial payer arrangements. As these financial benefits accrue, provider organizations will be positioned to reinvest a portion of those savings into maintaining and upgrading their physical and digital infrastructure.

Integration of Lessons Learned into State Policy. We will systematically capture and integrate RHTP lessons learned into ongoing State health policy through multiple mechanisms. We will incorporate successful RHTP models into Medicaid through State plan and waiver amendments. Insights from workforce initiatives will guide regulatory and licensing reforms that

enable clinicians to practice at the top of their license. For health system planning and oversight, RHTP data and outcomes will inform long-term implementation and align payer policies to incentivize participation in value-based care and price transparency for patients. We will pursue statutory and regulatory changes to remove barriers to affordable, high-quality care and seek appropriations for proven RHTP models that improve efficiency, quality, and outcomes. We will also integrate rural health infrastructure into the State's broader economic development strategy, recognizing that access to care is foundational to community vitality and business growth.

Conclusion

Rhode Island's RHTP represents a comprehensive, strategic approach that reflects the State's health care priorities to improve comprehensive, low-cost care and address the health care challenges facing our rural communities. Through 13 interwoven initiatives and a vibrant governance and community engagement process, we will build health infrastructure connecting rural residents to preventive care, chronic disease management, and behavioral health services in community settings; create a locally-driven, sustainable rural health network improving operational efficiency, clinical quality, and financial stability through collaboration and shared resources; invest in and strengthen FQHCs as anchors of rural primary care; establish strong rural-urban partnerships expanding specialty access through telehealth, e-consults, and rotating clinics while maintaining local care delivery; develop a robust rural health workforce through residency programs, recruitment support, and high school career pathways; and transform payment models from volume to value, focusing on higher quality, better outcomes, and lower costs for patients.

Endnotes

See *Attachment E: Endnotes* for references.