



Rural Health Policy Council Member Onboarding Guide

Table of Contents

Welcome and Introduction.....	2
CalRHT Program.....	3
Background.....	3
CalRHT Program Structure and Funding	5
Overview of the RHPC	7
Role of HCAI	7
Council Chair.....	8
Council Members’ Participation.....	9
Contributions	9
Public Transparency	9
Conflicts of Interest	10
RHPC Governance and Operations	10
Meeting Schedule and Format	10
Development of Agendas and Materials.....	11
Meeting Flow and Structure	11
Public Participation.....	11
Expense Reimbursement Guidelines	12

The CalRHT program is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$233,639,308.46 with 100 percent funded by CMS/HHS. The contents are those of CalRHT and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Welcome and Introduction

Welcome to the California Rural Health Policy Council (RHPC or Council). This Guide serves as a supplement to the RHPC charter, providing additional background on California's Rural Health Transformation (CalRHT) Program and practical information to support your participation on the Council. Members are encouraged to review this Guide to support informed discussion and meaningful engagement in the RHPC.

Thank you for your commitment and participation in the RHPC. We look forward to working with you to advance rural health transformation in California.

Sincerely,

Elizabeth A Landsberg
Director
HCAI

CalRHT Program

Background

The federal Health Resources and Services Administration (HRSA) identifies rural areas by county and Census tract. Additional information about the HRSA definition of rural is available on their [website](#), along with an interactive tool to identify if a particular area is designated as rural.

The following description of California's rural areas and the health challenges faced by rural residents was provided in the CalRHT Program application. Please see the CalRHT [Project Narrative](#) for additional information including citations for statistical references.

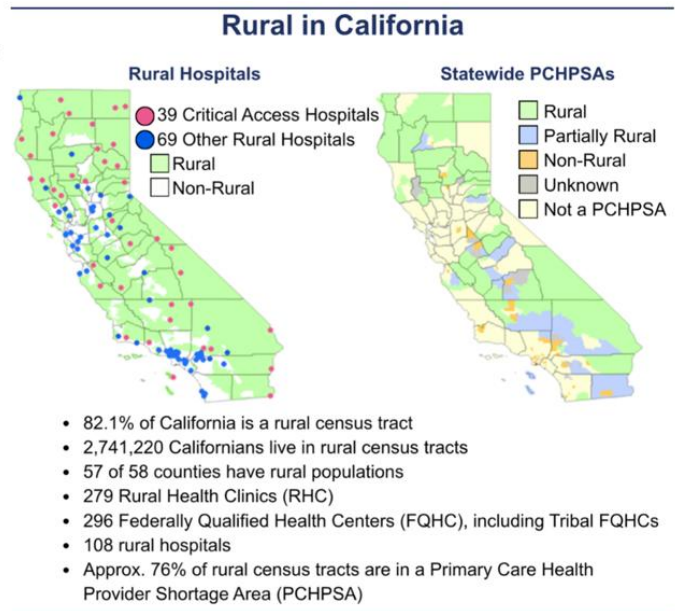
In California, rural areas account for 82.1% of census tracts and include about 2,741,220 residents. Rural populations tend to be older than their urban counterparts, with 26.5% over the age of 65 compared to 15.4% in urban areas. Poverty rates are higher at 15.5% compared to 12.3% in urban areas, and unemployment remains 8.5% higher in rural communities than in urban communities.

Nationally, residents of rural counties face worse health outcomes than residents of urban areas:

- All-cause mortality in rural areas was 20% higher than that of urban areas in 2019.
- The percentages of preventable premature deaths from the five leading causes of death (heart disease, unintentional injury, chronic lower respiratory disease, stroke, and cancer) were higher in rural counties in all years during 2010–2022.
- Percentages of preventable premature deaths in the most rural counties were consistently higher than in the most urban counties.
- As measured by the hospital discharge data from deliveries, the likelihood of severe maternal morbidity and mortality is 9% higher in rural areas than that of urban areas.
- Chronic disease prevalence is consistently higher in rural counties.

Tribal communities, many of which are located in California's most rural and remote regions, face additional barriers to health, economic opportunity, and infrastructure

Figure 1: Snapshot of Rural California



access. California's Tribal communities experience a life expectancy of about 71.8 years, the lowest among racial and ethnic groups in the state, and face higher mortality rates from diabetes, chronic liver disease, and suicide than other Californians. American Indian and Alaska Native (AI/AN) individuals are also two to five times more likely than other racial or ethnic groups to experience serious psychological distress and have the highest percentage of impairment related to mental health challenges.

Californians in rural areas face unique challenges in accessing health care. In 2023, California's overall uninsured rate was 6.4%, while the average uninsured rate in fully rural-designated counties was 10.1%. More than one third of Californians live in areas designated as primary care shortage areas, with particularly acute shortages of obstetrics and gynecology and behavioral health providers in rural regions. Similar access constraints impact behavioral health.

California has a longstanding commitment to addressing these rural health challenges and improving access to care for residents across rural regions of the state. The CalRHT Program is a federal initiative designed to strengthen health care in rural communities where access, workforce shortages, and infrastructure gaps create unique challenges. The California Department of Health Care Access and Information (HCAI), in collaboration with other departments under the California Health and Human Services Agency, is leading the work to implement CalRHT and to align it with other initiatives and activities that support rural healthcare organizations, policies, and programs through investment, engagement, and collaboration.

The California State Office of Rural Health (CalSORH), housed within HCAI, serves as the state's primary focal point for advancing rural health policy, supporting rural health systems, and connecting rural communities with state and federal resources. CalSORH works collaboratively with rural hospitals, clinics, Tribal organizations, local governments, community-based organizations, health plans, and statewide partners to improve access to high-quality healthcare in California's rural and Frontier and Remote (FAR) communities. CalSORH provides technical assistance, convenes stakeholders, supports workforce development efforts, and administers federal and state programs designed to improve rural health infrastructure, financial sustainability, and care delivery.

HCAI oversees longstanding federal rural health programs including the Medicare Rural Hospital Flexibility (Flex) Program, Small Rural Hospital Improvement Program, and Conrad 30 J-1 Visa Waiver Program. Through these initiatives and the launch of CalRHT, HCAI supports rural communities in developing sustainable solutions to address workforce shortages, improve care coordination, expand access to behavioral health and specialty care, strengthen emergency and hospital services, advance health information technology, and improve health outcomes for rural Californians.

The RHPC, established under CalRHT, is an advisory Council to HCAI designed to guide and align HCAI's rural health transformation efforts including:

- Rural workforce recruitment and retention
- Telehealth expansion to deliver evidence-based care closer to home
- Integration of behavioral health, primary, and maternity care

- Financial sustainability of rural providers
- Modern, interoperable, and secure technologies
- Data, quality improvement, and performance measurement

California has historically engaged with rural stakeholders and supported previous statewide health planning and advisory group convenings. These forums helped elevate rural perspectives, identify emerging challenges, and inform policies affecting access to care in rural and FAR communities.

The RHPC re-establishes a statewide forum for rural health stakeholders to collaborate with state partners, elevate emerging issues, and inform strategies that strengthen access to care in rural and FAR communities throughout California. While the RHPC is being established to support CalRHT, its value is expected to extend beyond the federal grant period.

CalRHT Program Structure and Funding

The CalRHT Program builds on existing rural health initiatives to strengthen access, quality, and sustainability across rural and FAR communities. The plan envisions a connected, resilient rural health system that delivers person-centered care through a skilled workforce, modernized infrastructure, and locally responsive partnerships. Additional information about the CalRHT Program can be found on the [HCAI website](#).

The goals of CalRHT are to:

- Improve local access to comprehensive, evidence-based care
- Strengthen and retain a homegrown rural workforce
- Modernize technology, health information exchange, and cybersecurity
- Improve financial stability of rural providers to keep essential services available
- Reduce rural patient travel burden
- Improve maternal and chronic disease outcomes through earlier detection and coordinated management

The program will provide novel and innovative strategies to bring rural and FAR communities the resources and quality health care services they need. CalRHT will:

- **Establish regional hub-and-spoke collaboratives** to create rural primary and maternity regional care collaboratives and partnerships that elevate rural health care by connecting regional hospital system hubs with local healthcare facilities and other providers to improve access to local, high-quality care.
- **Implement evidence-based models** through Extension for Community Healthcare Outcomes (Project ECHO), OB Nest, California Child and Adolescent Mental Health Access Portal (CAL-Map), and Perinatal Psychiatry Access Program (PPAP) to extend workforce capacity and improve quality of care.

- **Leverage technology** that will expand telehealth primary, maternity, specialty and chronic condition care; eConsults; remote patient self-monitoring; and other tailored technology solutions.
- **Expand and support rural workforce capacity** to reduce rural bypass by offering obstetrics training fellowships, and supporting development of Community Health Workers, Licensed Vocational Nurses, doulas, midwives, and other allied health professions.

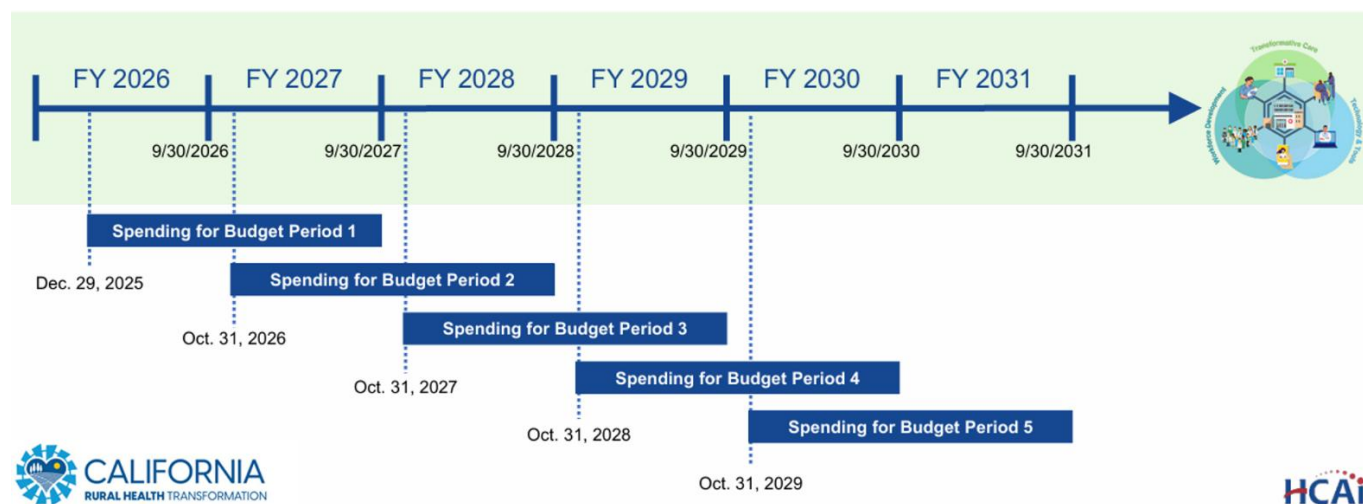
CalRHT will achieve these goals through three major initiatives that will span the five-year project term.

1. **Rural Health Transformative Care Model:** The program will create regional hub and spoke networks anchored by hospital hubs and spokes that include critical access hospitals, clinics, birthing centers, and other providers. Key activities will include shared levels of care and transfer protocols; Project ECHO for chronic disease and primary-specialty care collaboration; family medicine with obstetrics fellowships; OB Nest for prenatal care with remote patient self-monitoring and nursing support; and e-Consult resources and perinatal psychiatry access programs. The program will include targeted transformation payments to support rural hospitals' capacity to transform their systems to support regional delivery of care, complete a telehealth gap assessment for each hub and spoke, and use accelerator partners to incubate workforce, technology, and payment solutions.
2. **Workforce Development:** The program will build a Statewide Workforce Mapping and Planning Tool to identify regional, county, and sub-county workforce needs; strengthen education pathways from high school to Community Colleges, and four-year universities with wraparound supports; expand regional upskilling through Train-the-Trainer programs in maternal health, chronic disease, behavioral health, and telehealth; and grow non-physician roles such as Community Health Workers, nurses, doulas, and midwives. The program will fund pipeline and pathway programs, the expansion of clinical placement and supervision sites, and include retention and relocation incentive payments.
3. **Rural Health Technology and Tools:** The program will modernize infrastructure and connectivity, including Electronic Health Record enhancements, health information exchange, and cybersecurity; operate a Technical Assistance Center that provides implementation support, training and certification, and capabilities assessment; expand collaboration through shared purchases and services; and deploy patient centered tools such as Remote Patient Self-Monitoring that integrate person generated data into clinical workflows.

More information about the initiatives can be found in the [Project Narrative](#).

CalRHT is supported by a five-year federal grant from the Centers for Medicare & Medicaid Services (CMS). California received \$233,639,308 for the first budget period that runs from January to October 2026. CMS will announce each subsequent year's funding on October 31st, of the preceding year. The funds must then be spent by the end of the following fiscal year, as shown below.

Figure 2: CalRHT Budget Period Timeline¹



HCAI's SORH is responsible for overseeing the grant. This role includes:

- Administering day-to-day grant activities
- Regular communication with CMS
- Monitoring and evaluation of grant activities
- Submission to CMS of annual program progress reports, financial reports, and continuation applications to receive funding for each subsequent budget period

Overview of the RHPC

Role of HCAI

HCAI is responsible for implementing the CalRHT Program and will make all final decisions related to CalRHT activities, timelines, and funding. The RHPC is an advisory Council to HCAI. HCAI will consider input and ideas from the RHPC to guide planning and implementation on the major CalRHT initiatives including, but not limited to, the transformative care model, rural workforce development, and the use of technology and tools. Council agendas will be aligned with HCAI timelines related to award funding announcements, policy proposals, and grant reporting so that RHPC input is gathered and can be considered by HCAI as part of the review process.

¹ The California Department of Health Care Access and Information (2026) published a PowerPoint presentation title [California Transformation Program: Spring Webinar](#)

Input from the RHPC will be summarized and shared with HCAI leadership for review and consideration. HCAI will be transparent in how the information provided by the RHPC is integrated into CalRHT implementation and other policies affecting rural health as applicable. All RHPC meeting summaries are public documents and will be posted on the HCAI website.

HCAI also provides the following operational support to the RHPC:

- Quarterly and ad hoc meeting scheduling, logistics, and coordination
- Distributing meeting agendas and materials for member review
- Facilitating RHPC meetings
- Developing meeting summaries and tracking action items
- Maintaining alignment between RHPC activities and broader CalRHT and HCAI rural health program initiatives

If RHPC members need support or have questions related to their participation in the Council, please email CalRHT@hcai.ca.gov.

Council Chair

As a public forum for rural health stakeholders to discuss the CalRHT Program implementation, the RHPC plays an important role in ensuring that CalRHT implementation is reflective of stakeholder input. The RHPC is comprised of a broad group of stakeholders, as described in the Council Charter.

The HCAI's Director of Rural Health Transformation, or their designee, administers the RHPC and serves as Council Chair. In this role, the Chair provides overall leadership, identifies priorities and emerging issues for the RHPC to address and has the authority to convene meetings for the RHPC to provide input on topics or CalRHT activities.

The Chair collaborates internally with HCAI staff to develop meeting agendas and materials. During meetings, the Chair helps encourage balanced participation from members and ensures that Council input is developed through agreed-upon processes. The Chair serves as the primary liaison between RHPC members and HCAI/SORH and identifies areas for improvement so that the RHPC is effective and efficient.

The Chair may determine, in consultation with HCAI leadership, whether subcommittees or ad hoc workgroups are needed to support the RHPC's work. The Chair may assign members to participate in these subcommittees based on their expertise, experience, and interest, and may identify a member to lead or facilitate each subcommittee. Subcommittees may be convened as needed to examine specific issues, provide input, or support implementation activities, and will report back to the full RHPC for discussion and consideration.

Council Members' Participation

Contributions

RHPC members are expected to actively contribute their expertise, experience, and perspectives to inform the Council's discussions, input, and priorities. As advisors to HCAI on the CalRHT Program, members are encouraged to bring both their individual expertise and the broader perspectives of the partners they represent, helping to ensure the Council's discussions reflect a diverse range of experiences and interests. Members should be prepared to review meeting materials, participate in discussions, identify emerging issues affecting rural communities, and provide thoughtful feedback to support the goals of CalRHT and broader rural health priorities.

RHPC members are expected to engage collaboratively and respectfully with fellow members, recognizing the diverse perspectives and experiences represented on the Council. Members should foster constructive dialogue, contribute to consensus-building where appropriate, and approach discussions with a shared commitment to advancing equitable access to high-quality health care for rural Californians.

Members are expected to attend and actively participate in regularly scheduled Council meetings, as well as any special meetings, workgroups, or subcommittee meetings to which they are assigned. Consistent participation by Members or their designees is important to ensure continuity of discussions and effective RHPC operations.

In addition to their participation in meetings, RHPC members serve as ambassadors for rural health within their respective communities, organizations, and partner networks. Members are encouraged to share information about CalRHT initiatives and RHPC activities, gather feedback from the communities and sectors they represent, identify emerging opportunities and challenges, and help ensure that diverse rural perspectives are brought forward to inform HCAI.

Public Transparency

HCAI is committed to public transparency in the administration of the CalRHT Program and the work of the RHPC. HCAI shares information about the CalRHT initiatives through the CalRHT website and will continue to update the website throughout the five-year CalRHT term.

RHPC materials are also shared publicly on the CalRHT website, including meeting agendas, materials, and summaries. HCAI is responsible for ensuring that meeting materials are posted timely.

Although RHPC meetings are not subject to the Bagley-Keene Open Meeting Act, all meetings will be open to the public and HCAI allows individuals to provide comments directly to the Council. Additional information regarding public comment periods can be found in the "RHPC Governance and Operations" section of this Guide.

Conflicts of Interest

RHPC members are expected to conduct themselves in a manner that promotes transparency, integrity, and public trust. Because RHPC members are selected to represent diverse sectors and stakeholder groups involved in rural health, members may have professional, organizational, financial, or other interests that relate to matters discussed by the Council. The existence of such interests does not necessarily constitute a conflict of interest; however, members must disclose any actual or perceived conflicts that could reasonably be viewed as influencing their participation in RHPC discussions.

RHPC members must disclose relevant conflicts of interest upon appointment to the Council and on an ongoing basis as soon as the member becomes aware of the actual or perceived conflict of interest. Disclosures should be routed through the Council Chair or other designated HCAI staff.

Upon disclosure, HCAI will review the nature of the identified conflict and determine the appropriate course of action. The RHPC's role is advisory in nature, and conflict-of-interest reviews will be conducted in a manner that preserves the value of stakeholder expertise while ensuring transparency and public confidence in the Council's role and input. Members shall recuse themselves for deliberations on matters where the member has an actual or perceived personal conflict of interest. Any questions regarding recusal or related requirements should be routed through the Council Chair or other designated HCAI staff.

Members may also be required to disclose certain financial interests by filing Statements of Economic Interest (Form 700). HCAI will communicate filing requirements to RHPC members as needed.

RHPC Governance and Operations

Meeting Schedule and Format

RHPC quarterly meetings will be held in July, October, February, and May. HCAI will communicate specific meeting dates at least 30 days prior to each meeting. RHPC members should communicate known attendance conflicts to CalRHT@hcai.ca.gov as soon as possible and identify the designee that will participate on their behalf as applicable. Prior to each meeting, HCAI will follow-up with all RHPC members to confirm their availability to participate.

RHPC meetings will be held virtually. If in-person meetings are determined necessary by HCAI, details will be sent out two weeks prior with logistical details for attendance. Virtual options will remain available to ensure that participation is accessible for RHPC members and the public. Additional logistics and guidelines are as follows:

- RHPC meetings will be conducted via Zoom.
- Please join from a quiet location with a stable internet connection.
- Please join the meeting at least 5 minutes before the designated start time. HCAI is available for RHPC members who wish to test their audio/video prior to the meeting start.
- Please be visually present and engaged (i.e., camera on) throughout the meeting and use a professional and non-distracting background.
- Please mute your audio when not speaking.

On occasion, ad hoc RHPC meetings may be necessary. Unless otherwise communicated by HCAI, the attendance procedures, participation options, and logistics are the same as regular quarterly meetings.

Development of Agendas and Materials

HCAI develops meeting agendas and materials based on CalRHT decision timelines and priority topics. HCAI will distribute meeting agendas and materials to RHPC members at least 3 business days prior to meetings. RHPC members will be sent electronic copies of meeting materials, and it will also be posted on the HCAI website. RHPC members are expected to review all agendas and materials prior to meetings and come prepared to contribute to discussions. Any questions about meeting materials, or if there are any difficulties accessing materials, please contact CalRHT@hcai.ca.gov.

Meeting Flow and Structure

Quarterly meetings all follow a similar meeting flow and structure:

- Welcome and opening remarks
- Agenda overview
- Presentations and Council discussion
- Summary of input
- Public comment
- Next steps and review of action items
- Adjourn

Public Participation

Dedicated time at each quarterly RHPC meeting is reserved for public comment. HCAI provides information on how the public can participate in Council meetings. The RHPC accepts both written and verbal comments. The meeting facilitator facilitates the public comment period with support from the Council Chair.

HCAI tracks public comments received and provides a summary of the public comments in the broader meeting summary document posted on the HCAI website.

Expense Reimbursement Guidelines

HCAI provides reimbursement for actual and necessary travel expenses incurred in connection with RHPC duties. To request reimbursement, Council members shall complete the necessary forms (see below) and email the completed forms plus all receipts/proof of payment include parking, meals, tolls, etc. to the designated HCAI staff person.

- [STD 204](#) – Payee Data Record: This form is required to be filled out by you (Sections 1-5) to receive payment from the State.
- [STD 261](#) – Request for mileage reimbursement: This form is required *only* if a member is requesting mileage reimbursement related to travel for Council meetings. The current mileage reimbursement rate for personal vehicles is \$0.725 per mile. You will need to provide your starting location.

Once your reimbursement request is received, it will undergo an internal review process at HCAI. When possible, members shall make requests for reimbursement to HCAI before incurring expenses. HCAI processes travel reimbursements following each meeting.

If RHPC members have any questions or require assistance at any point during the reimbursement process, please contact the designated HCAI staff.