Application is currently under review with CMS.
The final activities and budget may change pending CMS award decisions.

Rural Health Needs and Target Population

Rural California is geographically expansive with significant areas and populations that are addressed in this application. The state covers 155,779 square miles and is home to 39,538,223 residents; rural areas account for 82.1% of census tracts and include about 2,741,220 residents.[ii] These population and land-area characteristics provide the geographic context for the sections that follow, which describe target populations and present the specific criteria and data used to define rural areas.

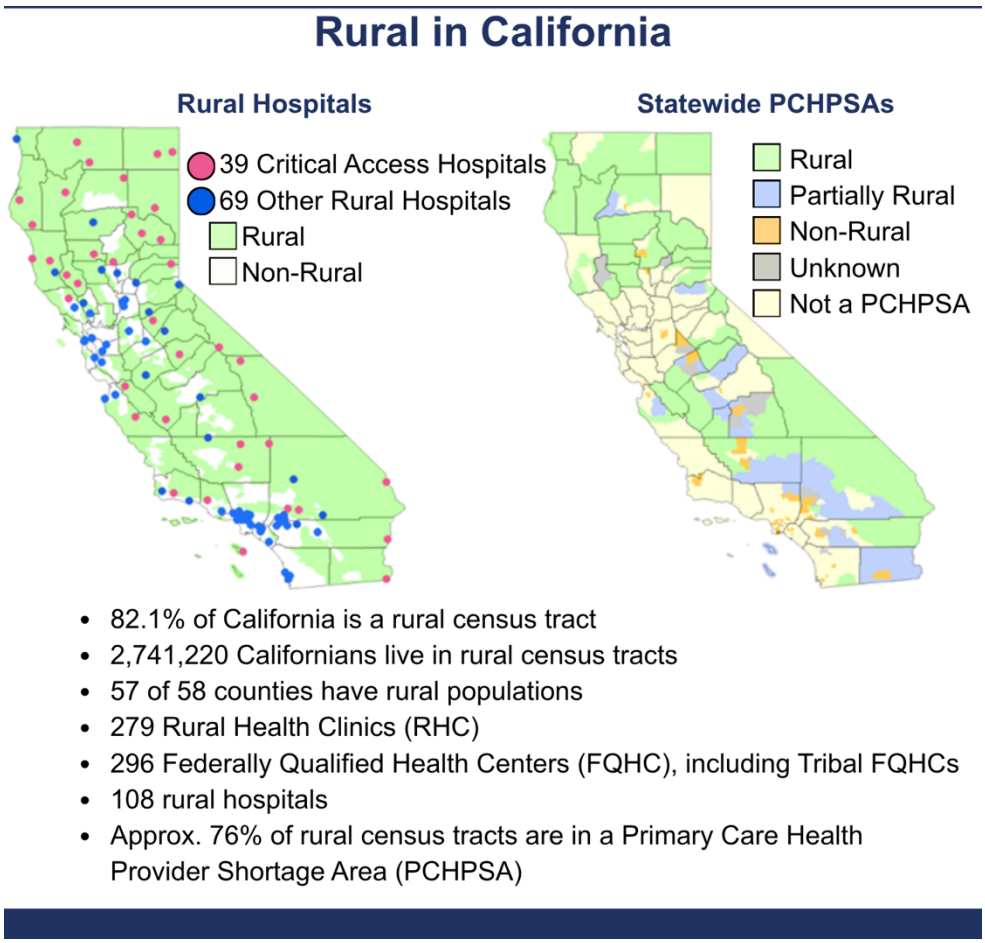


Figure 1 Snapshot of Rural in California Maps and Quick Facts:[i]

Demographics and Socioeconomic Conditions

Rural Californians face distinct demographic and socioeconomic realities. 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.[iii] Tribal communities, many of which are in California's most rural and remote regions, face additional barriers to health, economic opportunity, and infrastructure access.[iv] In rural areas, employment centers on agriculture, government, health and social services, retail, and manufacturing. Across rural counties, educational attainment is concentrated at the high school level. On average, 27% of adults hold a high school diploma, 16% hold a bachelor's degree, and 9% hold a graduate degree. County-level figures vary considerably, ranging from 18%-40% for high school graduates, 10-25% for bachelor's degree holders, and 3-20% percent for those with graduate degrees.[v]

Health Outcomes

A recent statewide analysis revealed that chronic conditions and injuries accounted for over 75% of deaths in California in 2016. Roughly 40% of California adults report having at least one of five chronic conditions: serious psychological distress, high blood pressure, heart disease, diabetes, or asthma. Millions of these adults have multiple chronic conditions to manage at the same time.[vi] Among Californians with Original Medicare, roughly two-thirds live with high blood pressure or high cholesterol, and beneficiaries commonly have four co-occurring chronic conditions.[vii] Chronic disease prevalence is consistently higher in rural counties. Diabetes, obesity, hypertension, and tobacco use occur at higher rates compared to urban populations, with diabetes prevalence estimated to be 9% to17% higher in rural areas nationally.[viii] Many California Tribes are located in isolated, medically underserved regions where chronic diseases

such as diabetes, hypertension, and heart disease occur at significantly higher rates than among the general population.[ix]

Nationally, all-cause mortality in rural areas was 20% higher than that of urban areas in 2019.[x] The percentages of preventable premature deaths from the five leading causes of death (heart disease, unintentional injury, chronic lower respiratory disease (CLRD), 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.[xi] 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. Access to hospital-based and community-based obstetrical care in rural areas declined during 1995-2015, which may have affected pregnancy outcomes.[xii] According to the most recent data available, the number of rural hospitals providing labor and delivery services declined from 2004 through 2018, and more than half of rural counties did not have such services in 2018.[xiii]

Health Care Access

Access to care is a central challenge. 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.[xiv] Rural California covers 82.1% of census tracts and includes over 2.7 million residents across 57 of 58 counties. Care is delivered through 279 Rural Health Clinics (RHCs), 296 Federally Qualified Health Centers (FQHCs, including Tribal sites), 26 Indian Health Service (IHS) clinics, and 108 rural hospitals, yet approximately 76% of rural census tracts fall under a Primary Care Health Provider Shortage Area (PCHPSA)

designation.[xv] In 2023, California's overall uninsured rate was 6.4%, while the average uninsured rate in fully rural-designated counties was 10.1%.[xvi] [xvii] California is home to numerous maternity care deserts, defined as counties lacking maternity care hospital resources, birth centers offering obstetric care, or obstetric providers, including the Federal Office of Rural Health Policy (FORHP) defined rural counties of Trinity, Madera, Lassen, Calaveras, Alpine, Sierra, Colusa, and Glenn.[xviii] [xix] As a result, patients commonly travel an additional 20 to 40 miles or more for essential care. Transportation challenges compound these barriers. Among rural households, 5% have no vehicle and 18% are car deficit, particularly in the Central Valley and Imperial Valley, and where public transportation exists it is often limited or demand response, further constraining timely access.[xxxxi]

These same access constraints apply to behavioral health. Certified Community Behavioral Health Clinics (CCBHCs) are a proven model for delivering comprehensive, integrated behavioral health services in underserved areas, but California's CCBHC network is small and unevenly distributed. As of September 1, 2025, there are 22 CCBHC entities statewide, 11 of which operate in Los Angeles County, with one entity each in Alameda, Marin, Orange, Sacramento, San Diego, San Francisco, Santa Barbara, Santa Clara, and Shasta counties, and two organizations (HealthRIGHT 360 and Pacific Clinics CA) operating multi-county or statewide programs (Technical Score Factor A.2).[xxii] That concentration in urban and some coastal counties means many rural counties continue to lack nearby CCBHC capacity, reinforcing the need to address geographic distribution, transportation, and broadband barriers so behavioral health services are accessible to rural residents.

Because geographic, provider, and transportation constraints are structural, state policy tools help determine whether and how services reach rural communities. Certificate of need (CON) rules, participation in interstate licensure compacts, and scope of practice frameworks all affect facility siting, workforce mobility, and the use of telehealth. The following table is a snapshot of California's current certificate of need status, scope of practice frameworks, and participation in selected licensure compacts.

Table 1 - California's Current Certificate of Need, Licensure Compacts and Scope of Practice Status

Certificate of Need: California has no CON or CON-equivalent statutes limiting market entry in the measured categories.[xxiii]
Interstate Medical Licensure Compact status: California is not participating and has no status.[xxiv]
Nurse Licensure Compact status: California has no pending NLC legislation.[xxv]
EMS Compact status: California is not a member state.[xxvi]
Psychology Interjurisdictional Compact status: California is a non-PSYPACT state with no active legislation.[xxvii]
Physician Assistant Compact status: California has no legislation filed. California expanded scope of practice in 2025.[xxviii] PAs ratio 1:4 to 1:8 PA to supervising physician ratio.[xxix]
Scope of practice for Physician Assistants: California is rated Moderate. [xxx]
Scope of practice for Nurse Practitioners (NPs): California is a Restricted Practice state for NP licensure. [xxxi] NP expanded scope after meeting supervision requirements.[xxxii]
Scope of practice for Pharmacists: California has an overall score of 5; drug administration laws are "innovation ready" level 2; laboratory testing has "barriers to innovation in place" level 0; independent prescribing scores "improvement needed" level 3. California expanded scope of practice in 2025.[xxxiii]
Scope of practice for Dental Hygienists: California permits local anesthesia under direct supervision, allows dental hygienists to supervise dental assistants for tasks within the hygiene scope, provides direct Medicaid reimbursement, allows dental hygiene treatment planning within the hygiene scope, permits sealants in public health settings without prior dentist examination, and allows direct access to prophylaxis in public health settings.[xxxiv]

Rural Facility Financial Health

California's 108 rural community hospitals, including 39 Critical Access Hospitals (CAHs), operate under severe financial strain. In 2023, 58.6% of rural hospitals reported negative operating margins. Average operating margins for rural hospitals were –0.7% compared to +0.8% for non-rural hospitals.[xxxv] Since 2005, at least eight rural hospitals have closed, and dozens more are considered at immediate or long-term risk. Service

line reductions, the elimination or downsizing of specific hospital or clinical services, have been widespread, with more than 20% of rural hospitals eliminating labor and delivery services between 2011 and 2021.[xxxvi] Utilization and patient volumes remain low and reveal significant seasonal variation, with small and rural hospitals averaging an occupancy rate of 58.2% in 2022.[xxxvii]

Target Populations and Priority Geographies

The California Rural Health Transformation (CA-RHT) program will target the over 2.7 million rural residents throughout the state, with a focus on high-need geographies that demonstrate the most persistent health and infrastructure gaps. Priority populations include rural families; pregnant and postpartum women and infants in counties with minimal obstetric services or classified as maternity care deserts; residents of health professional shortage areas; Tribal and agricultural communities; older adults; individuals with chronic health conditions; and rural households without reliable broadband or transportation access. Program emphasis will focus on rural Californians living in counties with a high burden of chronic disease; limited access to primary, maternity, and specialty care; and reliance on geographically isolated hospitals with constrained resources.

Geographically, the CA-RHT program will focus on program delivery across state-designated Medical Service Study Areas (MSSAs), Health Resources and Services Administration (HRSA)-defined rural and frontier areas, Primary Care Health Professional Shortage Areas (PCHPSAs) within all rural communities, with early assessment and implementation in counties identified as having the greatest need. MSSAs are predefined rational service areas recognized by HRSA and used to

determine HPSAs. Program activities will be offered to all rural hospitals, rural health clinics, rural community health centers, community-based organizations, behavioral health facilities, and Tribal clinics with carefully designed opt-in model(s), activities, and grant opportunities promoting a scalable statewide approach to rural health transformation. 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.[xxxviii] 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.[xxxix] In California, a significantly greater proportion of American Indians with asthma (51%) report having an exacerbation, proportionately more American Indians experience heart disease than other ethnic minorities.[xl] These findings are consistent with national statistics that show American Indians and Native Alaskans have the highest asthma prevalence compared to any other population.[xli] To address these disparities, the CA-RHT program will dedicate a minimum of five percent of its overall budget to support the participation of Tribal clinics and health centers in the Transformative Care Model. Tribal partners have been

Figure 2 California Map of Rural Tribal Health Facilities

consulted during the program's development and will continue to partner in ongoing consultations to guide the program implementation.

Digital Health and Infrastructure

Persistent disparities in digital infrastructure within rural communities in California continue to hinder access to healthcare, particularly in the areas of telehealth and electronic health record (EHR) adoption. Although telehealth use rose significantly statewide between 2019 and 2020, adults in rural areas remained less likely to use telehealth than those in urban regions.[xlii] Many rural counties maintained or increased California Medicaid telehealth use post-2020; however, these communities continue to face barriers such as limited reliable broadband coverage and high technology costs, with implementation expenses reaching up to $50,000 and annual fees exceeding $60,000.[xliii] Medicaid reimburses all four telehealth modalities: live video, store and forward, remote patient self-monitoring, and audio only, although some limits may apply. In 2019, the California Legislature passed AB 744, establishing reimbursement parity for telehealth services in the commercial (non-Medicaid) market.[xliv] Professional requirements include no participation in licensure compacts that would allow for practicing across state lines and a patient consent requirement. For Federally Qualified Health Centers (FQHCs), both originating and distant sites for live video are explicitly allowed; store and forward and audio only are reimbursed; and FQHCs may bill the Prospective Payment System rate for telehealth. State resources include Medicaid administered by the California Department of Health Care Services (DHCS) and the California Telehealth Resource Center *(Technical Score Factor F.1.)*.[xlv] According to the CMS Outcomes Based Assessment (OBA) methodology, California's reporting of full

Transformed Medicaid Statistical Information System (T-MSIS) data is classified as "Does not meet OBA targets" as of June 30, 2025. Specifically, California passed the critical priority criterion but failed at least one target in the high priority and or expenditures data content categories. California is one of eleven state Medicaid agencies with this result (N=11) *(Technical Score Factor F.2.)*.[xlvi]

While California has achieved widespread EHR adoption, there is tremendous variance in the quality and functionality of the EHRs. Not all systems function effectively for the organizations that use them, and many smaller or community-based providers still lack the interoperability and support needed to use EHRs efficiently. The heterogeneity of EHR platforms makes the integration and interoperability between physician offices, clinics, community resources, hospitals, and payers a key problem to address. Federal initiatives beginning with the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act and the Meaningful Use program, followed by the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) and the Promoting Interoperability program, accelerated the adoption of electronic health records nationwide. However, rural providers have continued to face challenges with both implementation and effective use.[xlvii] A 2025 analysis found that 74% of urban physicians used certified EHRs compared with 64% of rural physicians, underscoring ongoing disparities in adoption and interoperability.[xlviii] In California, these federal efforts laid the groundwork for the state's Data Exchange Framework and related initiatives designed to strengthen interoperability and health information exchange, particularly among smaller hospitals, provider groups, and community-based organizations that remain at a digital disadvantage.[xlix] Although nearly all family

physicians statewide now use EHRs, the small group of non-adopters is concentrated among independent rural practices with limited funding, staffing, and technical resources. These challenges limit the ability of rural providers to exchange data, participate in coordinated care, and leverage statewide health information networks. Addressing these gaps will require expanded support for interoperability infrastructure, workforce training, and system integration.

Rural Health Transformation Plan: Goals and Strategies

The California Department of Health Care Access and Information (HCAI) has developed the California Rural Health Transformation (CA-RHT) program plan as required by 42 U.S.C. 1397ee(h)(2)(A)(i), a statewide strategy to strengthen access, quality, and sustainability across rural and frontier communities to improve health outcomes. The plan envisions a connected, resilient rural health system that delivers person-centered care through a skilled workforce, modernized infrastructure, and locally responsive partnerships.

The CA-RHT program outlines a comprehensive framework to strengthen rural health delivery through coordinated, data-informed action. The program funding directly supports the following CMS strategic goals while remaining consistent with approved funding uses:

Make rural America healthy again: Projects will support rural health innovations and new access points to promote preventative health and address root causes of diseases by using evidence-based, outcomes-driven interventions to improve disease prevention, chronic disease management, behavioral health, prenatal care, and birthing outcomes.

Sustainable access: The CA-RHT program will help rural providers become long-term access points for care by improving efficiency and sustainability. With RHT Program support, rural facilities work together, or with high-quality regional systems, to share or coordinate operations, technology, primary and specialty care, and emergency services.

Workforce development: The CA-RHT program will attract and retain a highly skilled health workforce by strengthening retention and relocation opportunities and recruiting individuals from rural communities to pursue health careers. The initiatives will enable rural clinicians to practice at the top of their license and broaden the provider mix to meet local needs. Allied health professionals, community health workers, doulas, midwives, pharmacy technicians and individuals will be trained to help patients navigate the healthcare system.

Innovative care: The CA-RHT program will spark the growth of innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements, by developing and implementing payment mechanisms that incentivize providers to reduce health care costs, improve quality of care, and shift care to lower cost settings.

Tech innovation: The CA-RHT program will foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients. CA-RHT projects will support access to remote care, improve health information exchange, strengthen cybersecurity, and invest in emerging technologies.

The vision, goals, strategies, and objectives presented in the following sections are organized by proposed initiative areas, reflecting the program’s integrated approach to

advancing access, quality, workforce capacity, and infrastructure modernization. Each initiative aligns with federal transformation aims and statewide priorities, establishing a clear roadmap for implementation, performance measurement, and sustainable impact across California's rural and frontier communities.

The following illustration visually maps the plan. At the center is a regional hospital functioning as the hub, with spokes that include telehealth, e-Consults, birthing centers, Federally Qualified Health Centers, smaller hospitals and clinics, at-home care, and community partners. Together they enable person-centered care delivered by a skilled workforce, supported by modern infrastructure and locally responsive partnerships.

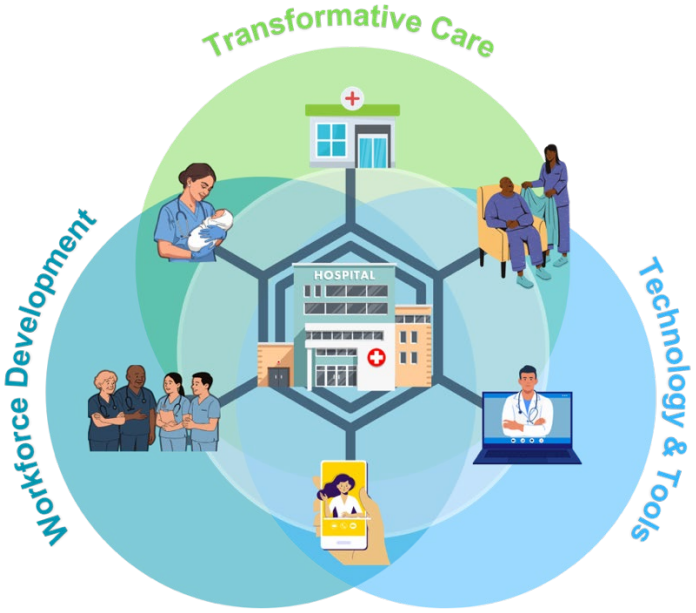


Figure 3 Hub-and-Spoke Illustration of Interconnected Initiatives: Transformative Care Model (1), Workforce Development (2), Technology & Tools (3)

The CA-RHT program vision is a connected, resilient rural health system in which every rural and frontier Californian, across rural counties and Tribal communities, can access timely, person-centered primary, maternal, specialty, chronic condition, and behavioral

health care close to home, supported by a sustainable workforce, modern technology and data infrastructure. The CA-RHT program is guided by commitments to put Tribal nations and high-need communities first. The program will develop regional coordination and partnerships, apply evidence-based care, deploy tools that work in low resource settings, and align sustainable payment to fund local readiness and health care services.

Regional partnership will take shape as an integrated network that shares information through health information exchange event notifications, common dashboards, and clinical case conferences; offer joint training through Extension for Community Healthcare Outcomes (ECHO) clinics, team based simulations, and perinatal drills; coordinate services with one call transfers and referral Service Level Agreements supported by rotating specialist clinics; and pool purchasing for telehealth and technology that empowers coordinated care, consumer remote patient self-monitoring devices, cybersecurity, and revenue cycle management. Participants include hospitals as hubs, and FQHCs, Rural Health Clinics (RHCs), Tribal health programs, county Behavioral Health (BH) agencies, alternate birth centers, rural hospitals, community-based organizations (CBOs), and local health jurisdictions as spokes. The program's governance will reflect community priorities through engagement with each TCM region, with HCAI as the lead agency and the Rural Health Policy Council (RHPC) as an advisory body that will be guided by a shared charter for transparent performance reporting.

Workforce development is being built around a Statewide Workforce Mapping Tool to identify gaps by county, sub-county, and MSSA and by role, paired with education

pathways from high school to community college to 4-year universities with wraparound supports such as stipends and transitional housing. Regional upskilling will use Train-the-Trainer models in maternal care, BH integration, chronic disease, and telehealth, with career lattices from Certified Nursing Assistant (CNA) or technician to Licensed Vocational Nurse (LVN), Registered Nurse (RN), and Nurse Practitioner (NP), Physician Assistant, and pharmacist-led chronic care. The program expands non-physician roles including Community Health Workers (CHWs) for perinatal and chronic disease, doulas, midwives, LVNs, and entry-level BH providers. It expands and strengthens clinical training and rotations within rural facilities and supports family medicine with OB fellowships supported by faculty sharing across sites. The program seeks to improve retention through relocation and retention bonuses tied to service commitments, developing shared staffing pools across facilities, and funding clinical precepting and supervision time.

To improve rural provider financial stability, the CA-RHT program pairs transformation payments for strategically placed hospitals to support their participation in the initiatives with service optimization. The CA-RHT program will conduct a national and state landscape assessment to evaluate evidence-based, financially sustainable rural payment models across primary care, maternity, and hospital services and identify the operational, workforce, technology, and financial capabilities needed for rural facilities to successfully participate in value-based care driven by CA-RHT program's targeted transformation investments. Facilities will optimize their services by supporting the transition of low-volume inpatient services to outpatient or telehealth-enabled pathways while preserving emergency readiness and growing their already successful service

lines; likewise, their portfolio will shift appropriate care to lower-cost sites with guardrails to protect community access.

State data show standalone rural hospitals, including critical access hospitals, face multiple ongoing risks. Key pressures include low patient volume, high travel-clinician (locums) costs, patient bypass to urban centers, aging infrastructure, limited capital, widespread obstetric closures, lower telehealth use and EHR interoperability, persistent obstetric and behavioral health shortages, the emergence of maternity care deserts, and long travel times to the nearest birth hospital. The CA-RHT program will address the causes through the activities within the proposed initiatives. These include:

- Evaluation of rural pathways to value-based payment.
- Regionalization to avoid duplicative costs and coordinate transfers.
- Workforce relocation and retention pathways to reduce dependence on locums.
- Technology-enabled reach, leveraging telehealth, e-Consults and technology that empowers clinicians to keep appropriate care local.
- Achieving clinical quality and patient experience improvements to retain patients locally leading to shorter consumer wait times, expedited local labs and imaging, and avoiding preventable delays for specialty consultations.

Program Key Performance Objectives: Refer to section Metrics and Evaluation and Additional Attachment 4. Workplan and Timeline for details.

Proposed Initiatives and Use of Funds

The California Rural Health Transformation (CA-RHT) program includes three interrelated initiatives designed to achieve the goals in Section 71401 of Public Law 119-21 and the CMS-RHT-26-001 Notice of Funding Opportunity. Together, they form a comprehensive strategy to expand access, strengthen the workforce, and modernize infrastructure in rural and frontier communities, each aligned with authorized uses of funds and sustainability requirements.

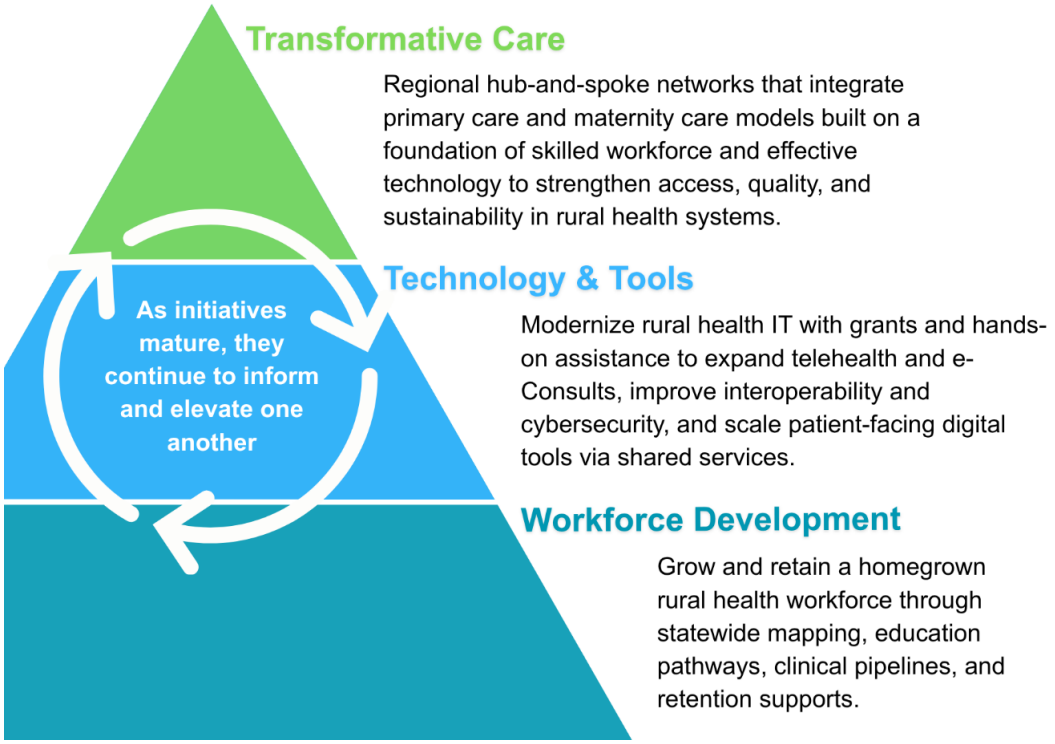


Figure 4 Illustration of California's Rural Health Transformation Program Proposed Initiatives.

Initiative: The Rural Health Transformative Care Model Initiative (1)

Description: The Rural Health Transformative Care Model (TCM) Initiative expands access, strengthens the rural workforce, evaluates payment structures, and deploys integrated telehealth solutions to deliver evidence-based care closer to home. Rural communities across California face challenges in accessing high-quality primary,

maternity, specialty and chronic condition care. For families and older adults in rural and frontier California, a routine prenatal visit, chronic disease follow-up, or advanced imaging appointment can require hours of travel. When rural communities lose access to local outpatient primary and maternity services, patients must travel farther or forgo care altogether, leading to delayed diagnoses, unmanaged chronic conditions, and preventable complications that drive avoidable hospitalizations and maternal complications. To address these challenges, TCM improves rural access by implementing evidence-based models of care through regional hub-and-spoke continuums of care, supported by workforce and technology investments that will reduce rural bypass, upskill workforce and improve outcomes. TCM leverages two models of behavioral health integration within primary care and maternity care, to strengthen care coordination, reduce avoidable costs and advance whole person outcomes to build sustainable, community cased models of comprehensive care. This initiative also develops community-based roles such as Community Health Workers (CHWs), midwives and doulas to expand the rural health workforce and improve access to care. This coordinated approach will expand local access that improves early detection and treatment in primary and maternity care, increase timely diagnosis, strengthen chronic disease management, support aging in place, and promote long-term financial stability for rural hospitals.

Strategic Objectives

1. **Establish Regional Hub-and-Spoke Networks:**

The hub-and-spoke model creates a structured, scalable way to deliver high-quality care across dispersed and resource-limited communities. In rural settings, primary care,

maternity care, and chronic disease management suffer from limited specialty access, workforce shortages, and fragmented infrastructure. By providing strategic governance and elevating evidence-based clinical practice, this model positions rural communities to maintain essential services and deliver modern, patient-centered care that improves outcomes.

The TCM will anchor regional hospital “hubs” with 24/7 specialty and referral capacity and connect them to local “spokes”, such as critical access hospitals, community clinics, FQHCs, rural health clinics, Tribal health centers, and telehealth nodes, that will provide patients their routine care close to home while maintaining seamless access to higher-acuity or specialty services when needed. The TCM structure will support continuity and coordination of care, reduce unnecessary transfers and rural outmigration, and leverage technology (e.g., telehealth, remote monitoring, e-Consults) to extend the reach of specialists and strengthen local provider capacity. This model aims to:

- Lift up outpatient nodes, such as telehealth, remote patient self-monitoring and consumer-facing technologies that empower consumers and CHWs, helping extend the network’s reach into communities and homes. The use of consumer-facing mobile-app-based technology with prevention-based programs will target chronic disease conditions, link patients to clinical teams, and promote healthy habits for patients.[I]
- Enable the network to apply evidence-based levels of care to guide rural hub-and-spoke systems with a shared, evidence-based framework for service capabilities and patient transfers.

- Support accelerator partners to function as innovation hubs within the model, incubating new workforce strategies, novel regional partnerships, technologies, and innovative payment solutions that can be scaled across rural areas to strengthen rural care delivery.

2. Implement Evidence-Based Care Models:

By deploying evidence-based models across primary care, maternity care, chronic disease, and specialty domains, the TCM's rural hub-and-spoke regional networks will expand access, strengthen provider capacity, and deliver high-quality, patient-centered care close to home. Key program activities include:

- Use Project ECHO (Extension for Community Healthcare Outcomes) to develop chronic disease management and primary-specialty care models that apply tele-mentorship and case-based learning. These approaches upskill rural clinicians in specialty care and improve local care management capacity.
- Strengthening maternity care by implementing the OB Nest model, which reduces in-person visits through virtual nurse contacts and home monitoring. This model enhances patient satisfaction, reduces maternal stress, maintains care quality, and avoids compromising maternal or neonatal outcomes. [li]
- Integrating behavioral health consultation tools such as the Perinatal Psychiatry Access Program (PPAP), the California Child and Adolescent Mental Health Access Portal (Cal-MAP),[lii] and other available perinatal psychiatry access programs.[liii] These resources enable spokes to offer behavioral health e-Consult services, giving pediatricians, primary care providers, obstetricians, and other practitioners access to timely consultation from behavioral health specialists.

3. **Evaluating Rural Pathways to Value Based Payment:**

   To ensure that rural health care providers, who often lack the infrastructure, staffing, and financial stability to engage in current value-based and innovative payment models, are not excluded from national payment reform, the CA-RHT program will conduct a national and state-level assessment of the payment reform landscape. This assessment will evaluate existing and emerging rural payment models across primary, maternity, chronic condition, specialty care, and hospital services. The analysis will focus on value-based programs with demonstrated potential to influence patient and provider behavior in rural settings. It will examine the feasibility of long-term financial self-sustainability. A core output of this work will be the identification of specific operational capabilities, workforce configurations, technology infrastructure, and financial systems that rural facilities need to successfully engage in innovative payment models. This assessment will serve as both a feasibility analysis and a blueprint to guide targeted investments under the broader rural TCM initiatives. These investments may include, but are not limited to, transformative support for hospitals and accelerator hub-and-spoke partners.

4. **Expand and Support Rural Workforce Capacity:**

   To reduce rural bypass and strengthen the capacity of local providers, TCM addresses critical workforce shortages in primary, maternity and specialty care by expanding the utilization of doulas, midwives, and perinatal CHWs; implementing clinician upskilling programs and family medicine obstetric fellowships; and deploying Project ECHO and OB Nest programs. These efforts expand local capacity, relieve provider strain, improve satisfaction, and increase access to high-

quality, comprehensive care close to home. To further support population health, whole-person care, and reduce access barriers, key program activities include:

- Integrating behavioral health into primary and maternal care through clinician Train-the-Trainer programs.
- Offering obstetric training fellowship opportunities to family medicine physicians and advanced practitioners to train in obstetric care.
- Supporting the development of CHWs, LVNs, doulas, midwives, entry level health providers, and other allied health professionals will strengthen frontline care and improve access, quality, and continuity of services.
- Incentivizing allied health professionals including nurses, pharmacy technicians, and emergency medical service personnel to pursue CHW training that enhances collaborative care for chronic conditions, care coordination, and transport support.
- Leveraging entry-level and allied roles to build skills aligning with system priorities like telehealth and remote monitoring, integrating these capabilities into clinical workflows.

5. Create a Digital "Nervous System" of Telehealth Components:

The TCM regional network relies on telehealth components to create a digitally integrated "nervous system" for rural health. This system enables real-time specialty access, e-Consults, remote patient self-monitoring and workforce extension, supporting evidence-based models such as Project ECHO, OB Nest, Cal-MAP and PPAP. Each hub-and-spoke site will undergo a gap assessment to identify the existing telehealth resources and determine what additional tools or capabilities are needed to function

effectively as a TCM partner. Some sites may require hardware such as tablets for videoconferencing; others may need only software. Certain locations may need critical maternal care equipment–such as neonatal warmers or neonatal resuscitation carts–while others may benefit from evidenced-based checklist protocols and critical care equipment for managing conditions like hypertensive disorders and post-partum hemorrhage.

6. Transformative Payments:

The success of the TCM networks will depend on the collaboration and incorporation of rural hospitals, many of which face high fixed costs such as 24/7 emergency services, on-call coverage, aging infrastructure, and low patient volumes. These factors contribute to razor-thin margins and chronic financial strain. Workforce shortages and reliance on costly travel doctors and nurses further increase expenses, while limited capital availability, service-line closures, and delayed payments from health plans elevate the risk of insolvency. TCM Transformative Payments will support these vital regional collaborations and partnerships. Key program activities include:

- Provide Transformative Payments to strategically important rural hospitals that will commit to implementing feasible TCM components as a condition of receiving the funds.
- Provide Transformative Payments to financially distressed rural hospitals located in strategically important areas for building hub-and-spoke care networks and the effective delivery of regional care. For example, based on their recent trends in management and operational performance, certain rural hospitals may only be capable of participating in CA-RHT program initiatives if they receive initial funding to

build their internal capacity for developing and adopting changes to incorporate the most feasible TCM components for their hospital. This proposal offers upfront funding to distressed rural hospitals, paired with a five-year transformation plan modeled on the federal RHTP goals to implement financial solvency strategies. HCAI proposes to work with these organizations through the CA-RHT program to examine root causes of financial instability and support the hospitals in implementing targeted reforms (e.g., modernizing billing, adopting sustainable staffing models, reducing rural bypass, and strengthening community partnerships) to address systemic vulnerabilities and support their successful participation in the regional care network.

- CA-RHT will not use cooperative agreement funds for provider payments (Category B) for the provision of health care items or services. Instead, Transformative Payments are strategic investments that support and enable rural hospitals to implement TCM components and strengthen their operational resilience.
- Under the CA-RHT program, as a condition of receiving funds, awardees will commit to implementing TCM components that are most feasible and impactful for their community's health needs. Prior to disbursing Transformative Payments, HCAI will confirm that the hospital can identify feasible TCM components that it can begin to implement during the first two years. In addition to an applicant's commitment to achieving CA-RHT goals, the feasibility of any applicant will be determined through a comprehensive regional community gap assessment; a review of the applicant's management and operations; and the participant's willingness to enter a formal contract that monitors Transformative Payments with site-specific performance

metrics and award monitoring. This assessment will identify existing site resources, clinical expertise, and other relevant capabilities that can be leveraged to participate in and support a regional care network. The TCM needs assessment will include an evaluation of Workforce and Technology and Tools initiatives. HCAI will flow down federal requirements – including those related to permissible uses of funds, subaward monitoring, financial reporting, and compliance – in all agreements with subrecipients of Transformative Payment awards. Oversight of these awardees will be further aided by their ongoing collaboration with HCAI and its contractors providing regional care network support to the participating hospitals, clinics, and other network partners.

Summary of the Rural Health Transformative Care Model Initiative

The following connects the Initiative's overarching goal to implementation, use of funds, technical scoring, key partners, outcome measures, workplan milestones, statewide impact, and budget references.

Main strategic goal: Make Rural America Healthy Again. Expand access to comprehensive, evidence-based primary, maternity, chronic condition, and specialty care in rural communities through interconnected hub-and-spoke networks that promote patient safety and quality; improve patient outcomes; strengthen local capacity; identify local partners for accelerator partnerships; and advance long-term collaborative sustainability.

Use of funds: A. Prevention and Chronic Disease, C Consumer tech solutions, D. Training and Technical Assistance, E. Workforce, F. IT Advances, G. Appropriate Care Availability, I. Innovative Care, H. Behavioral Health, K. Fostering Collaboration

Technical score factors: B.1 Population Health Clinical Infrastructure, C.1 Rural Provider Strategic Partnerships, D.1. Talent recruitment, F.1 Remote Care Services, F.2 Data Infrastructure, F.3 Consumer-facing tech.

Key stakeholders: Rural and Critical Access Hospitals, Federally Qualified Health Centers, Rural Health Clinics, Independent Clinics, Birth Centers, Academic Medical Centers, Community Based Organizations, Behavioral Health programs, Tribal Health Programs, California Department of Healthcare Services, Local Health Jurisdictions, and Health Plans.

Outcomes:

- Improved access to care as evidenced by increasing the percentage of rural patients receiving primary, maternity, specialty, or chronic disease services.
- Expanded local access to maternity care leading to earlier detection and treatment of complications with measurable reductions in preventable maternal complications.
- Expanded workforce capacity through training and support of rural providers through CHW programs, fellowships, or Project ECHO participation.
- Increased telehealth utilization as evidenced by the number of e-Consults completed or virtual visits for chronic, maternity and specialty care.
- Stabilized rural hospitals and clinics through reduced rural hospital bypass and improved workforce retention.
- Maintained and expanded access to local service delivery by leveraging telehealth via network partnerships.

Workplan References:

A1.1 Procure support for hub and spoke assessment, design, and training; A1.2 Develop baseline assessment of capabilities and capacity; A1.3 Develop transformation payment program; A1.4 Establish Hub & Spoke Accelerators; A1.5 Provide support for implementing OB Nest, Project ECHO model, PPAP and Cal-MAP, as needed, within participating regions; A1.6 Expand and support rural workforce capacity; A1.7 Expand non-physician clinical roles; A1.8 Launch Train-the-Trainer Program; A1.9 Establish digital “nervous system”; A1.10 Evaluate rural pathways to value based care; and, A1.11 Develop rural payment model options

Impacted counties: Statewide, will impact all rural counties

Refer to additional details on funding and budget in the budget narrative section.

Initiative: The Rural Health Workforce Development Initiative (2)

The Rural Health Workforce Development Initiative will drive lasting rural transformation by building a sustainable, locally rooted health workforce. The program will invest in connecting students to pathway programs, develop early exposure to health careers for K-12 students, create connections for high school students to health care careers, and strengthen partnerships with community colleges and 4-year universities campuses to prepare students for health careers in rural California. With a focus on Tribal, rural and frontier communities, the program’s incentives, mentoring, and continuing education will support current providers while establishing long-term pathways for students and new professionals to train and remain in their communities. The goal is to grow and sustain a capable, community-based health workforce in rural and frontier California, enabling access to high-quality care through coordinated, data-informed planning; community engagement; career pathways; and strategic training, relocation, and retention.

The workforce initiatives within the CA-RHT program will incorporate a 5-year service commitment in a rural area to individuals who attain additional abilities or certifications and degrees needed to fulfill a career in a rural health care setting. Failure to meet this obligation will result in a breach of the award terms, necessitating the recoupment of awarded funds by the CA-RHT program.

Strategic Objectives

1. **Establish a Statewide Workforce Mapping and Planning Tool:**

   The initiative aims to develop a dynamic data platform to map existing rural and frontier workforce supply, identify demand trends, and pinpoint county-level capacity gaps across licensed professionals and allied health roles. The findings of this workforce mapping and planning tool will allow California to target the activities outlined in this proposal to the unique needs of California's rural communities. Key program activities:

   - A dynamic statewide workforce mapping and planning platform maps supplied by county and Medical Service Study Area will track demand trends, and pinpoint capacity gaps across licensed clinicians and allied health roles. The findings will guide the strategic targeting of activities to the distinct needs of rural and frontier communities, including Tribal communities.
   - Core functions of the workforce planning and mapping platform will include identifying workforce needs at the county and community level; surfacing opportunities for targeted funding of training and professional pathway initiatives to address maldistribution; aligning education and training programs

with projected workforce demand; and defining the workforce mix needed in each community so facilities can optimize services and access.

2. **Strengthen Training Pathways and Clinical Placement Networks:**

The CA-RHT workforce initiative will focus on creating a lasting pipeline of rural students entering health professions careers and building pathways for them to remain and practice in California's rural communities. The initiative will establish a coordinated regional approach to fund pipeline programs for K-12 students that incorporates partnerships with local school systems, colleges, and rural health facilities with a clear intent to strengthen the long-term impact of CA-RHT funds. These pipeline programs will connect high schools, community colleges, universities, hospitals, and clinics to create learning opportunities for students, expand regional training capacity in rural areas including clinical rotations, and practicum opportunities for health professionals. Emphasis is placed on meeting communities where they are and partnering to address unique workforce challenges at the county and regional levels. Key program activities:

- Connect local students from high schools, community colleges, and 4-year colleges through career education and counseling, tutoring, mentorships, and internships to build students' awareness about health related professions and prepare students to succeed in future health workforce training or education programs. These pipeline programs will include wrap around support for students to ensure that these opportunities are accessible to students from all rural communities.

- Expand opportunities for individuals pursuing health careers, or currently in entry level health professions, to receive scholarships, stipends, upskilling, or apprenticeships that will help individuals find their preferred right-fit training and education program that also meets the workforce needs of communities in rural counties and regions.
- Develop a clinical placement network to connect health profession students (e.g., RNs, AA, BS and MS degree level health professions) with rural facilities, including Tribal clinics. This network will create opportunities for students to gain increased access to rural health training and will allow local rural colleges and training programs to have consistent and reliable clinical opportunities for their students in rural counties and regions.

3. Retention and Relocation:

The CA-RHT program will keep talent in rural communities and make relocation practical when needed through wrap around supports that strengthen stability and fit. The program funding will focus on the needs of facilities within the participating regions. Allowable uses include retention and relocation bonuses tied to service commitments, regional shared staffing pools across facilities to maintain access, and practical assistance such as temporary housing for staff who are relocating or sustaining service in rural areas with a high need for those professions. These actions will reduce the time to fill priority roles; improve multi-year retention and average tenure; and stabilize community anchored teams that deliver whole person care close to home.

Key activities and actions:

- Funds awarded within this initiative will focus on supporting regional collaborations of rural facilities to ensure coordination of services across the community and sharing of funds between organizations of varying sizes and resources. The funds will focus on rural facility needs, including Tribal clinics. Support includes facilities' use of funds for retention and relocation bonuses for providers who commit to the 5-year service obligation.
- The regional collaboration required for facilities to access the retention and relocation funds will foster shared staffing pools and coordinated scheduling across rural sites in the TCM regions to ensure that the network has clinically appropriate community coverage and an optimal workload.
- Grow training capacity and rural training rotations in rural facilities; funding will also support onboarding, precepting, practical assistance, temporary housing, and the supervision of students to increase rural facilities' capacity to offer licensure and or certificate-mandated supervision time for providers that are in greatest need for that region or community.
- Participating organization performance is tracked through time to fill for priority roles, multi-year retention, average tenure, and the share of paid rotations converting to employment, and findings guide continuous improvement.

Summary of the Rural Health Workforce Development Initiative:

The following connects the Initiative's overarching goal to implementation, use of funds, technical scoring, key partners, outcome measures, workplan milestones, statewide impact, and budget references.

Main strategic goal: Workforce Development. Build and sustain a homegrown rural health workforce through coordinated planning, training, and retention so every community in rural California can access high-quality care close to home.

Use of funds: A. Prevention and Chronic Disease, D. Training and Technical Assistance, G. Appropriate Care Availability, E. Workforce Development and Recruitment, H. Behavioral Health, K. Fostering Collaboration

Technical score factors: B.1 Population Health Clinical Infrastructure, C.1 Rural Provider Strategic Partnerships, D.1 Talent Recruitment and Training, F.1 Remote Care Services (Telehealth Workforce Integration)

Key stakeholders: Community Colleges, High Schools, Colleges, Universities, Rural Hospitals, Federally Qualified Health Centers, Rural Health Clinics, Alternate Birth Centers, Community Based Organizations, California Department of Health Care Services, Tribal Health Programs, Behavioral Health Providers and programs, Area Health Education Centers, Professional Associations, and Local Workforce Development Boards

Outcomes:

- Improved recruitment and retention of rural clinicians and allied health professionals as evidenced by an increased number of licensed and certified health workers in rural areas.
- Reduced vacancy rates and improved retention rates as illustrated by reduction in time to hire.

- Expanded workforce capacity to deliver telehealth and e-Consult services as measured by number of e-Consults completed or virtual visits for chronic, maternity and specialty care.

Reference to Workplan:

A2.1 Launch workforce mapping tool; A2.2 Conduct readiness assessments of hub and spoke organizations; A2.3 Establish career pathways grant; A2.4 Establish rural clinical placement support; A2.5 Develop organization-based retention and relocation program
Impacted counties: Statewide, will impact all rural counties

Refer to additional details on funding and budget in the budget narrative section.

Initiative: The Rural Health Technology & Tools Initiative (3)

The Rural Health Technology & Tools Initiative will equip rural health providers with the technical capacity necessary to strengthen clinical care and improve efficiency. This initiative will advance California's rural health care providers' ability to deliver high-quality primary, maternity, and specialty care and support the TCM and Workforce Development initiatives by modernizing technology systems and infrastructure. Through grant funding and expert technical assistance, the initiative will provide opportunities for regional collaboration and learning; utilize innovative strategies to empower consumers to engage in their health care; and enable regional networks to leverage collective purchasing agreements and shared management of technology services. The initiative will address rural disparities in telehealth utilization and access to timely health data enabling communities to benefit from high-quality, affordable, and coordinated care while strengthening clinical integration and financial stability.

Strategic Objectives

1. **Technology Infrastructure Enhancement:**

   Expand access to and optimize the technical systems rural providers need to participate in effective regional care models.

- Conduct an in-depth assessment of established regional hub-and-spoke networks participating in TCM to identify the technology systems, tools, and practices that enable their success. This includes evaluating existing telehealth platforms, e-Consult tools, health information exchange, interoperability and cybersecurity solutions, screening tools, population health and revenue cycle systems, as well as identifying persistent technology or workflow gaps that limit efficiency or scalability. Accelerator partnerships will undergo the same assessment.
- Perform an assessment of rural regions to determine baseline readiness, cybersecurity, and capacity to effectively participate in TCM, including telehealth platforms, e-Consult tools, health information exchange, interoperability and cybersecurity solutions, screening tools, population health and revenue cycle systems, as well as identifying persistent technology or workflow gaps that limit efficiency or scalability.

2. **Grant Funding:**

   Implement a multi-year technology grant program to expand technology access and adoption among TCM participants and other rural providers. This program will fund or provide tools and systems essential for participation in TCM and identified as needed in the assessment period. This may include modernizing EHR systems, practice management, screening tools, and population health systems, accessing

telehealth and e-Consult platforms, optimizing interoperability and improving revenue cycle management. This grant program will prioritize sites based on readiness, geographic need, and existing infrastructure gaps, with a focus on solutions that enhance care coordination and long-term sustainability.

3. **Technical Assistance:**

   Develop a Rural Technical Assistance Center (RTAC) that provides expert advice and hands-on, on-site support to TCM participants and other grantees. The RTAC will support improved access to technology and tools, which may include EHR and practice management enhancements, telehealth and e-Consult adoption, health information exchange, data exchange, revenue cycle management improvements, and cybersecurity fortifications.

   - Identify barriers and optimize workflows and technologies to address timely access to care, including facilitating prior authorizations, and improving revenue cycle capture.
   - Provide access to technical and program management expertise for TCM participants and other grantees, including technology planning, implementation support, project coordination, vendor management, and other technical assistance, including hands-on and on-site when appropriate.
   - Support training and certification to develop and sustain local expertise and self-sufficiency in data access, privacy, and security.
   - Support the overarching success of TCM, Workforce, and Technology & Tools Initiatives through progress measurement, learning, and diffusion.

4. **Expand Regional Collaboration:**

Leverage the RTAC to coordinate efforts to reduce technology costs and staffing burden for rural providers by creating opportunities for group purchasing, shared management of technological services, and shared service development.

- Convene regional partners, including TCM participants and other grantees, to identify shared technology needs and provide guidance on group purchasing and shared service opportunities.
- Promote technology adoption within and across rural regions.
- Assess group procurement or shared service models that reduce costs and/or expand access to interoperable health IT tools for rural facilities.
- Engage vendors to streamline EHR onboarding, manage shared licenses, and provide ongoing support for rural and regional partners.

5. Technology and Tools to Empower Consumers:

Promote development and adoption of technologies and tools that empower individuals to participate in their health care.

- Promote development of accessible digital tools and technologies that empower rural patients.
- Educate consumers and promote the use of tools and technologies that allow them to monitor their health, self-report to their providers, access their own health information, helping patients relay timely information to their providers and feel more empowered in their care. Promote adoption by rural health care providers, of technologies that allow patients to access and obtain a copy of their health information.

- Leverage the RTAC to facilitate collaboration among rural health care providers to integrate patient self-reported and self-monitoring information into their workflows.

Summary of the Rural Health Technology & Tools Initiative:

The following connects the Initiative's overarching goal to implementation, use of funds, technical scoring, key partners, outcome measures, workplan milestones, statewide impact, and budget references.

Main strategic goals: Innovative Care. Enable California's rural providers to deliver consistently high-quality and comprehensive care by modernizing technology and improving access to health information, collaborating on successful strategies, and strengthening clinical integration and financial stability across primary, maternity, and specialty services. Tech innovation. Foster adoption of modern, interoperable, and secure technologies that enable efficient care delivery and expand access to digital health tools for rural facilities, providers, and patients. Projects will expand telehealth and e-Consult, improve data sharing and interoperability, strengthen cybersecurity, and invest in emerging technologies through grants, shared services, and the Rural Technical Assistance Center.

Use of funds: A. Prevention and chronic disease, C. Consumer tech solutions, D. Training and technical assistance, F. IT Advances, G. Appropriate Care Availability, J. Capital Expenditures and Infrastructure, K. Fostering Collaboration

Technical score factors: B.1 Population health clinical infrastructure, C.1 Rural provider strategic partnerships, F.1 Remote care services, F.2 Data infrastructure, F.3 Consumer-facing tech

Key stakeholders: Rural Hospitals, Community Health Centers, Health Center Control Networks (HCCN), Rural Health Clinics, Primary Care Practices, Tribal Health Providers, California Department of Health Care Services, Local Health Jurisdictions, and Health Plans.

Outcomes:

- Improved health information exchange and interoperability as measured by the increased number of rural hospitals and primary care providers reporting data exchange capabilities.
- Increased telehealth utilization as evidenced by increased number of e-Consults completed or virtual visits for chronic, maternity and specialty care.
- Enhanced cybersecurity and data privacy as measured by grantees reporting completed standardized security risk assessments and data managed by a technology with sustained cybersecurity certification.
- Increased utilization of patient portals to access patients' own health records as measured by grantees reporting patient visits to portals.

Reference to Workplan:

A3.1 Create the Rural Technical Assistance Center (RTAC); A3.2 Conduct assessments of hub and spoke organizations participating in TCM; A3.3 Conduct statewide readiness assessments; A3.4 Design technology and tools grant program; A3.5 Expand regional collaboration; A3.6 Conduct and support technology training and certification

Impacted counties: Statewide, will impact all rural counties

California does not currently anticipate spending in Category B. If, over the course of implementation, a TCM participant proposes an innovative concept that would

meaningfully elevate rural health care delivery, California would review the proposed provider spending and, with counsel from CMS under the auspices of the Cooperative Agreement, seek CMS approval prior to incurring any Category B expenditures. Any potential Category B investments would be subject to needs identified in rural regions following assessments and HCAI's review of proposals received and would not exceed the allowable spending cap. The state anticipates limited but meaningful spending in Category J, and any funding in this category will remain within the 20% cap of the total award, as outlined in the NOFO. Where the proposed initiatives reference "infrastructure," this is predominantly digital infrastructure to support interoperability, telehealth capabilities, and health information exchange, rather than bricks-and-mortar capital projects. Consistent with 2 CFR 200.1, some of these digital infrastructure investments and clinical care equipment will meet the federal definition of "equipment" (tangible property, including information technology systems, with a useful life of more than one year and a per-unit cost at or above the applicable capitalization threshold). All Category J expenditures, including qualifying equipment purchases, will comply with 2 CFR Part 200 and applicable state requirements, supported by clear policies, strong performance-based subaward agreements, and regular programmatic and fiscal monitoring of subrecipients. HCAI will maintain internal controls to ensure costs are allowable, reasonable, and allocable, and will use data-driven quality improvement and transparent reporting to CMS to promote accountability and sustained impact. *Refer to additional details on funding and budget in the budget narrative section*.

Implementation Plan and Timeline

California's Rural Health Transformation (CA-RHT) program will be implemented over five years through a data-informed strategy focused on strengthening primary, maternity, and specialty care, expanding the rural workforce, and modernizing digital infrastructure. Regional data, including county-level health outcomes, hospital service availability, and labor and delivery unit closures, will guide prioritization of expansion and targeted resource allocation. Program implementation will be coordinated through a statewide partnership led by HCAI in collaboration with DHCS, California Department of Public Health (CDPH), HCAI's State Office of Rural Health, and the Office of Tribal Affairs. Coordination will also include Tribal governments and Indian Health Service (IHS) area offices, academic institutions, rural hospitals and clinics, and community-based organizations.

A dedicated CA-RHT Implementation Team will oversee program management, fiscal administration, partner coordination, performance tracking, and CMS reporting. California will identify the most effective strategies to leverage CA-RHT investments to improve primary, maternity, and specialty care, strengthen the rural health workforce, and advance technology that supports care delivery closer to rural and frontier communities. The Implementation Team will collaborate with all impacted stakeholders and provide targeted support for Tribal partners throughout implementation of the proposed strategies.

Baseline and Rationale

California faces persistent challenges with rural health accessibility. Chronic disease prevalence, such as diabetes and hypertension, is consistently higher in rural counties, as-is all-cause mortality, and preventable premature deaths.[liv] Maternal mortality is also

higher in rural communities where, among rural California women, 43% live more than 30 minutes from the nearest alternate birth hospital, compared to 6.2% in urban areas.[lv] At the same time, financial pressures have compounded long-standing challenges that rural hospitals and providers face related to workforce shortages, aging infrastructure, and limited-service integration. related to workforce shortages, aging infrastructure, and limited-service integration.

The California Rural Health Transformation (CA-RHT) implementation will begin with targeted investments state-wide, in rural and frontier counties with the greatest service and access gaps, further guided by county-level mapping of maternity care access and workforce shortages conducted by the California Department of Health Care Access and Information (HCAI). This approach supports a strategic rollout sequence focused on early impact, measurable progress, and long-term stability across rural regions.

The CA-RHT's initiatives are designed to support the whole person needs of every rural Californian including their primary, maternal, chronic disease, specialty, and behavioral health care needs. At present, California has complementary funding dedicated to addressing behavioral health care across the state. This funding includes expanding the behavioral health workforce serving Medicaid members, expanding the number of behavioral health and substance use disorder treatment facilities, and redesigning the public behavioral health and Medicaid delivery system to implement innovative approaches to address the unique needs of Californians, including rural communities. The CA-RHT behavioral health initiatives will not duplicate these existing programs. Instead, the CA-RHT program will focus on activities that expand the skills of primary care, maternal health, and allied health providers to support the behavioral health needs

of their patients and use technology to expand access to behavioral health services. The program will augment the skills and training of primary and maternal care clinicians and providers to offer integrated primary and behavioral health care.

Initiative-Specific Milestone Types

Cross-Initiative Coordination and Monitoring

All three initiatives will align with shared statewide milestones and will be implemented in stages consistent with the CMS-recommended framework (Stages 0-5) as outlined in the implementation plan and timeline. The California Department of Health Care Access and Information (HCAI) will convene technical workgroups focused on primary, maternity, chronic condition, and specialty care rural workforce, and digital infrastructure to track cross-initiative progress and coordinate implementation adjustments. Regular progress reports submitted to CMS will include updates on milestone achievement, data trends, challenges encountered, and mid-course corrections. Program-wide timeline and CMS staging (0-5) framework are illustrated in the following table. For more details not captured in this section, see Additional Attachment 4. Workplan and Timeline, Budget Narrative & corresponding SF-424A.

Reporting Intervals and CMS Coordination

The team will utilize the following mechanisms to report back and coordinate with CMS: Regular CMS touchpoints; quarterly KPI dashboards; annual NCC with progress and financial reporting. The fiscal team will also provide spend-down verification to ensure prior year funds are fully expended by the end of the subsequent fiscal year.

Governance and Project Management

Lead agency: The California Department of Health Care Access and Information (HCAI) will serve as the lead department and will host an inter-agency steering group with relevant sibling departments who play a part in the development and implementation of these initiatives. HCAI will convene designees from the California Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the Emergency Medical Services Authority, and California Health and Human Services Agency regularly. The Rural Health Policy Council with representatives of interagency and regional-to-local stakeholders will convene quarterly.

Key Personnel by Role

Project Leadership will be provided by the California Rural Health Transformation (CA-RHT) Project Director and Principal Investigator, 1 FTE. The Project Director provides leadership, strategy, governance, vendor and payer alignment, and milestone sign-off across initiatives. In addition, CA-RHT will benefit from direct involvement by HCAI executives including the Chief Deputy Director, Chief Medical Officer, and Chief Data Officer who will help ensure the CA-RHT initiatives have the departmental resources, support, and alignment necessary to succeed.

As currently proposed, the CA-RHT Program will be supported by a team of 28 FTEs from HCAI as well as consultants and contractors. The specific personnel, consultant, and contractor roles are detailed in the Budget Narrative. Staff resources from HCAI's Office of Health Workforce Development (OHWD) and State Office of Rural Health (SORH) will support CA-RHT through assisting with rural policy development and analysis. Members of the grants management unit will lead the proposed grant funding opportunities to support CA-RHT. Additional support from the communications staff will

coordinate stakeholder outreach including with Tribal partners. Other HCAI business units will provide supporting resources and knowledge, including:

Research and Evaluation - Assist with evaluation of grant program scoring criteria and outcome measures.

Office of Health Facility Loan Insurance - Administer provider transformation payments for CA-RHT and provide support for financial stability measures.

Office of Clinical Innovation - Provide physician/clinician subject matter knowledge to support the Transformative Care Model development and implementation.

Office of Information Services - Support rural health data modeling and evaluation and provide technology support for the new program.

Office of Administrative Services - Provide accounting and general administrative support for program budgets, contracts, and payments.

Hiring Timeline

In Q1 FY26, program managers and analyst roles will be posted following the hiring of the PD to meet the Stage 1 requirement that the project plan is created and staff are assigned.

Decision-making and Coordination

Program reporting and decision-making will follow the CA-RHT program organizational chart. Decisions made by the steering committee and advisory council will be documented in action logs, and any issues requiring escalation will follow the risk and mitigation strategies outlined in the workplan and respective committee and council charters.

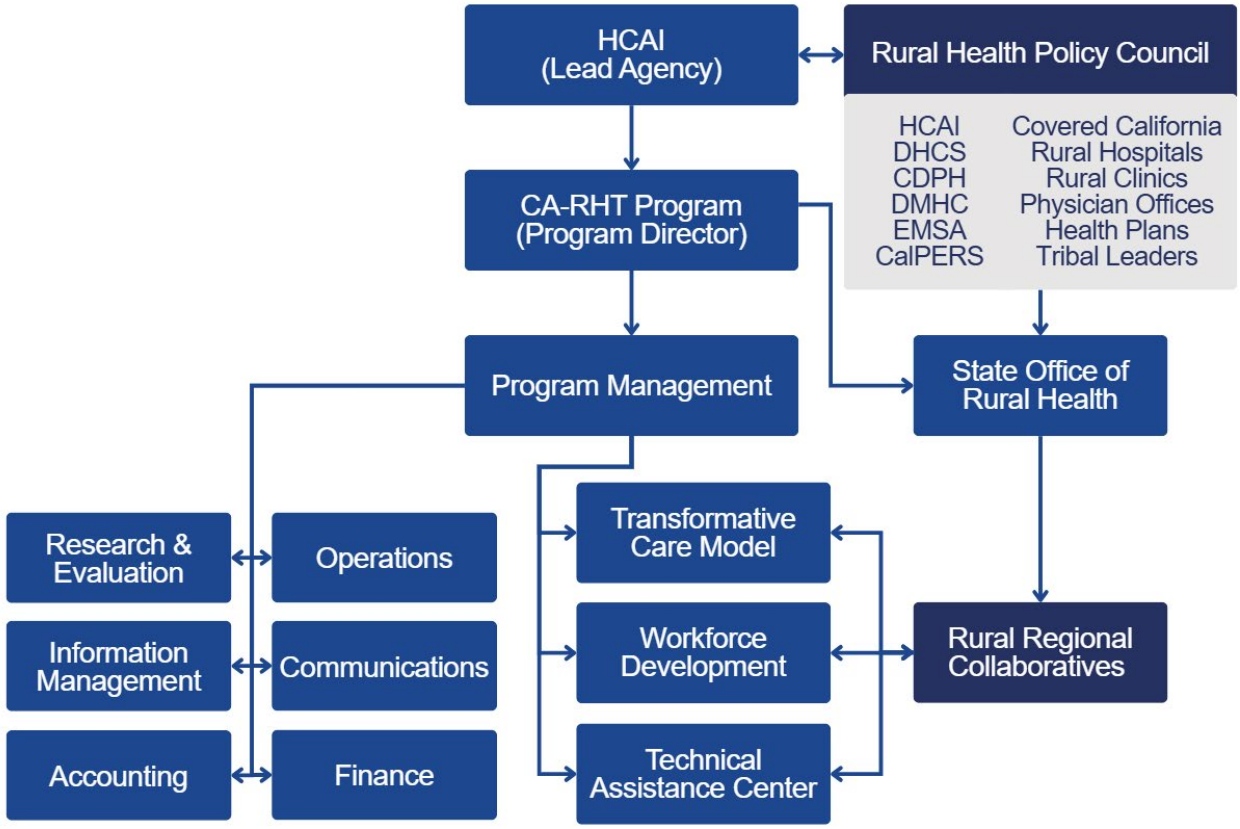


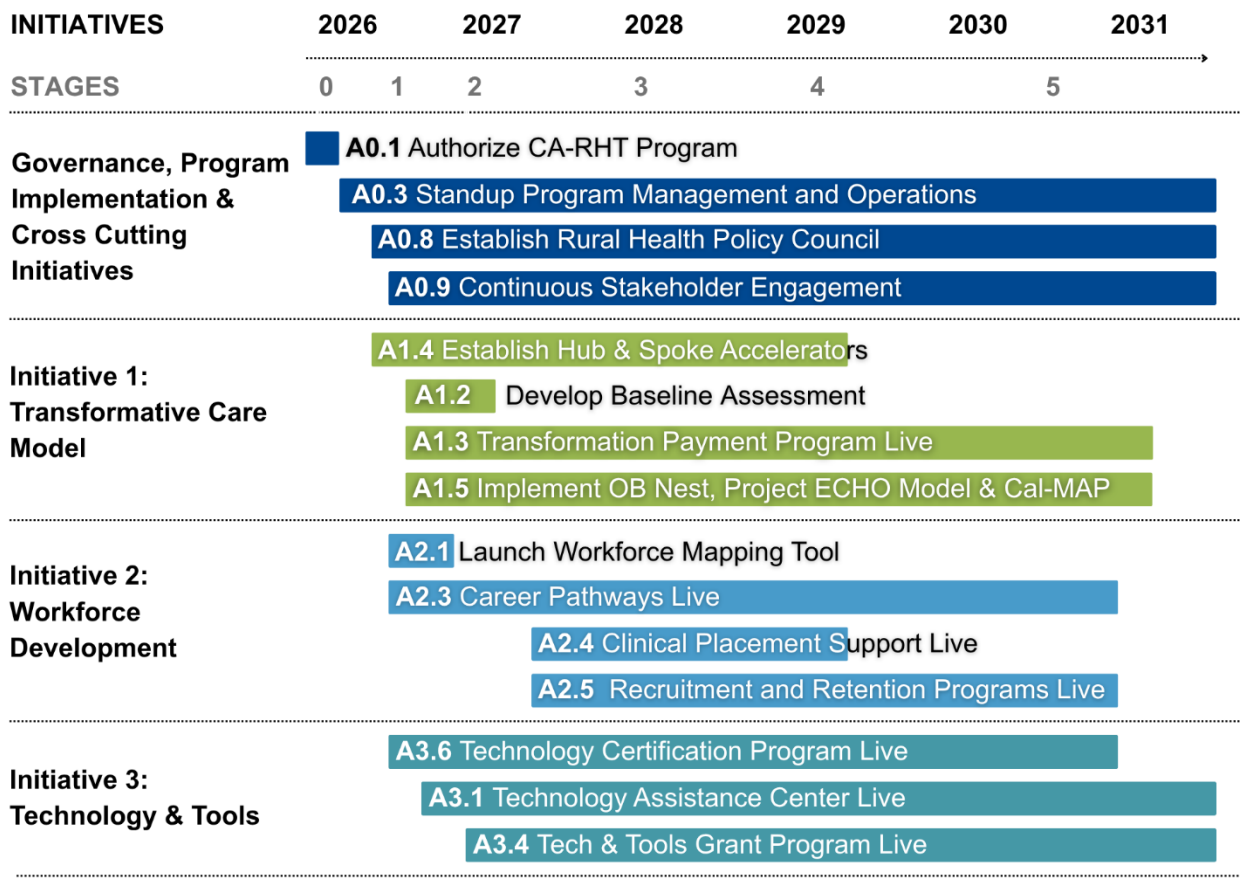
Figure 5 CA-RHT Program Organizational Chart

The CA-RHT implementation plan is grounded in robust statewide data and designed to deliver early, measurable improvements in access and quality across rural and frontier regions. Guided by rural and frontier needs, the program will strategically sequence deployment to Accelerator TCM partners that demonstrate both readiness and opportunity for rural health impact. Each initiative includes defined milestones, cross-sector partnerships, and performance metrics aligned to CMS staging requirements. Quarterly monitoring, continuous quality improvement, and integration with Medicaid managed care systems will track progress and sustain over time. The phased approach balances rapid impact with long-term system change, positioning California to demonstrate a scalable, policy-aligned model for rural health transformation that meets the technical, operational, and fiscal expectations of CMS.

Application is currently under review with CMS.
The final activities and budget may change pending CMS award decisions.

The following snapshot highlights major launch points and milestones for core initiative action steps, including stakeholder engagement, the transformation payment program, regional hub-and-spoke networks and accelerator sites, career pathways, clinical placement and retention programs, and technology supports. It is intended to illustrate timing and relationships and is not a comprehensive schedule; full task-level detail is in the workplan.

Table 2 - Snapshot Timeline of Key Launch Points and Milestones



Stakeholder Engagement

The California Rural Health Transformation (CA-RHT) program plan reflects a broad and deliberate stakeholder engagement process that meets statutory requirements under Public Law 119-21, §71401(h)(2)(A) and builds durable partnerships across rural

communities. The state's approach emphasizes inclusive representation, alignment with federal guidance and continuous consultation.

Stakeholder Engagement Approach and Participants

The CA-RHT program was developed through a comprehensive, multi-modal stakeholder engagement process that prioritized inclusion, transparency, and continuous dialogue. Over 1,396 stakeholders participated statewide through listening sessions, surveys, and key informant interviews, representing a cross-section of rural health partners. Participants included rural hospitals and Critical Access Hospitals, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Tribal health programs, behavioral health providers, local governments, community-based organizations, academic and training institutions, managed care plans, and provider associations. The stakeholder survey, distributed to more than 8,000 contacts and completed by 368 respondents, captured statewide perspectives on priorities such as workforce retention, digital infrastructure, payment reform, and maternal health. In addition, six listening sessions were conducted between October 1-6, 2025, with topic-specific discussions on workforce development, technology innovation, sustainable access, and community health workers. A total of 23 targeted interviews further deepened insights into regional challenges and opportunities.

Integration of Stakeholder Feedback

Feedback collected through these engagement efforts directly shaped the design and prioritization of CA-RHT program initiatives. Survey results highlighted top priorities, including workforce retention and relocation, telehealth and digital infrastructure, and

regional care coordination, which now anchor the program's core initiatives. Listening sessions surfaced actionable recommendations such as expanding regional hub-and-spoke networks, embedding community health workers, and implementing virtual primary, maternity, and specialty care. Stakeholder input also emphasized financial sustainability, guiding the inclusion of value-based payment models and targeted investments in high-need geographies. HCAI held an initial Tribal consultation on the RHTP and plan to conduct formal consultation that will begin at the start of 2026 and continue through the implementation of the project. HCAI will continue to integrate feedback throughout program implementation via quarterly regional councils, annual RHPC meetings, and public dashboards that track outcomes and transparency. This continuous engagement loop ensures that rural voices remain central to decision-making, advancing a responsive and community-informed transformation strategy.

Statutorily Required Stakeholders

California has identified and engaged the following entities as core partners in the Rural Health Transformation Program:

Governor-designated lead agency: HCAI will serve as the lead agency, providing overall governance, program oversight, and implementation.

State Medicaid agency: DHCS will be engaged in, evidence-based population health approaches, service integration efforts, and assessment of payment model approaches.

State public health agency: CDPH will contribute through its maternal, child, and adolescent health branch, and population health priorities.

State Office of Rural Health: HCAI's State Office of Rural Health (SORH) will function as a key convener of counties, providers and other stakeholders to solicit input, ensuring that rural perspectives are incorporated into planning and implementation.

Tribal Affairs and IHS/Tribal providers: The Office of Tribal Affairs and Indian Health Service (IHS) area offices will provide essential consultation and coordination with California's federally recognized Tribes.

Additional Priority Stakeholders

To strengthen statewide collaboration and promote locally driven innovation, California has broadened its coalition to include:

Rural hospitals and CAHs, including those in financial distress. FQHCs and RHCs will serve as key access points for primary and preventive care. Community behavioral health providers, including Certified Community Behavioral Health Clinics (CCBHCs) and opioid treatment programs, will integrate behavioral health into rural service delivery. Academic and training institutions, such as California Academy of Family Physicians, will support family medicine residency and fellowship programs, with emphasis on family medicine obstetrics fellowships, to expand the rural perinatal workforce as well as expanding educational capacity to train midwives and allied health professionals. Community based organizations (CBOs) will address maternal health disparities, support perinatal community health workers (CHWs). Provider groups and associations such as the California Hospital Association, California Medical Association, California Primary Care Association, America's Physician Groups, and relevant specialty societies will inform policy and practice alignment. Universities and training consortia

will advance workforce development and technical assistance through initiatives such as Project ECHO, Cal-MAP, and other rural health pathway programs. Existing regional coalitions and collaboratives will work in parallel with these efforts, aligning their local initiatives and stakeholder networks to integrate seamlessly into the statewide engagement framework.

Engagement Strategy and Structure

California will use a layered engagement framework to maintain accountability, transparency, and two-way communication:

The RHPC will serve as a statewide advisory body chaired by HCAI and composed of sibling departments and representatives from hospitals, clinics, CBOs, and Tribal partners. Meeting quarterly, the Council will review program progress, ensure policy alignment, and guide financing reform efforts. The RHPC will act as a convener and facilitator, fostering collaboration among state and local partners, promoting open dialogue, and addressing barriers to successful implementation.

Regional Hub-and-spoke Workgroups: Modeled on perinatal regional councils, these groups will convene local hubs, spokes, alternate birth centers, rural residents and CHWs to coordinate transfers, drills, and service integration.

Workforce and Training Partnerships: Hospitals receiving CA-RHT program support, if applicable, must serve as training sites for residents, fellows, nurses, midwives, allied health professionals, and CHWs. Hospitals must also allow full medical staff privileges for family medicine physicians who seek admission, general management, and obstetric credentials.

Engagement Cadence and Milestones

Monthly: CMS and state coordination calls will take place with participation of key stakeholders when needed.

Quarterly: Statewide RHPC meetings will convene a wide range of stakeholders that are integral to sustainable transformation efforts in rural and frontier communities across California. This will include state-level partners and representation from regional hub-and-spoke CA-RHT program accelerator and pilot sites.

Annually: Statewide RHPC meetings aligned with the non-competing continuation (NCC) reporting cycle will be held.

Tribal Consultation

California will honor government-to-government consultation obligations and establish standing Tribal workgroups aligned with Indian Health Service and Tribal provider needs. The State initiated a formal Tribal Consultation process to engage Tribal leaders and receive feedback about the CA-RHT program during the proposal development process, including engaging Tribal clinics to learn from their rural and frontier experience and which components of the CA-RHT program would be most impactful for their communities. This consultation will continue after initial planning, and the State will partner in implementation of the core goals of the Transformative Care Model (TCM).

Metrics and Evaluation Plan

California's RHT program will use a structured performance and evaluation framework with specific and measurable metrics aligned with initiative objectives that meets the

statutory requirements of Public Law 119-21, §71401(h)(2)(A) and aligns with CMS reporting expectations. Initiative-specific metrics will track measures from BY1 through BY5 to inform both the ongoing operation of the program and a structured evaluation, including access to primary, maternity, and specialty care; chronic disease management; workforce capacity; telehealth utilization; and health information exchange and technology capability among providers and with consumers. The Metrics and Evaluation Plan is further supplemented by the milestones detailed in the attached workplan, aligning with CMS expectations for staged, continuous improvement across initiatives throughout the program.

Metrics will directly inform the program evaluation and each initiative's impact on access, quality, and sustainability of rural health systems. Metrics will inform a comprehensive evaluation of the RHT program that will continue through the program period and culminate in a final report shared with CMS, as further detailed in the workplan.

The following section specifies the metrics used for evaluation within and across the Transformative Care Model, Workforce Development, and Technology and Tools Initiatives. Metric baselines are provided where available or will be collected at the facility or regional level as noted in BY1. The 5-Year Targets have been developed based on national and state quality targets, including Healthy People 2030 where applicable.

Table 3 - Overview of Initiative Outcome Metrics

Measures were aligned with HEDIS whenever applicable.[lvi]

Outcome Measures by Initiative	Total
Transformative Care Model	6
Facility- or regional-level metrics designed to assess impact at a county or community level of granularity: • % of persons 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during reporting period • % of persons 18–75 years of age with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9.0% • % of persons 45–75 years of age who had appropriate screening for colorectal cancer • % of deliveries that received a prenatal care visit in the first trimester • Vaginal births per 100 women with previous Cesarean deliveries (Vaginal Birth after Cesarean (VBAC) Rate, Uncomplicated) • Number of virtual visits or e-Consult completed for patients with chronic conditions (e.g., diabetes, hypertension), maternity and other specialty needs (Cardiology, GI, Dermatology, Neurology, Urology, Oncology, Gynecology)	
Workforce Development	5
Statewide rural metrics: • Number of licensed health workers with a primary practice location in rural areas (including but not limited to LVNs, RNs, NPs, PAs, licensed allied professionals and other advanced practitioners) • Number of certified health workers in rural areas as determined by list of certified allied health professionals developed in statewide planning tool • Number of individuals who participated in education and training programs supported by RHTP Facility- or regional-level metrics designed to assess impact at a county or community level of granularity: • Time to hire for primary and maternity care providers and allied health professionals • Number of virtual visits or e-Consult completed for patients with chronic conditions (e.g., diabetes, hypertension), maternity and other specialty needs (Cardiology, GI, Dermatology, Neurology, Urology, Oncology, Gynecology)	
Technology and Tools	6
Statewide rural metrics: • Number of rural hospitals reporting a connection to a national network or Qualified Health Information Organization (QHIO) • Primary care providers reporting data exchange capabilities, including electronically receiving event notifications Facility- or regional-level metrics designed to assess impact at a county or community level of granularity: • Number of grantees that have completed a standardized security risk assessments in the last 3 years • Number of grantees whose data is managed by a technology with sustained cybersecurity certification • Number of unique visits of patient portal to access records during reporting period • Number of virtual visits or e-Consult completed for patients with chronic conditions (e.g., diabetes, hypertension), maternity and other specialty needs (Cardiology, GI, Dermatology, Neurology, Urology, Oncology, Gynecology)	

Application is currently under review with CMS.
The final activities and budget may change pending CMS award decisions.

Table 4 - Transformative Care Model Outcome Metrics and KPIs

Outcome Measure	Baseline	5-Year Target (BY5)	Data Source	Reporting Frequency
% of persons 18–85 years of age who h diagnosis of hypertion (HTN) and whose blod pressure (BP) was adequately controll (<140/90 mm Hg) ding reporting period	Baseline numbers to be collected in BY1 from participating TCM providers	0.8 percentage-point increase in % of persons 18-85 years of age who had a diagnosis of HTN and whose BP was adequately controlled compared to baseline	To be reported by grantees in collaboration with health plans	Annually
% of persons 18–75 years of age with diabetes (type 1 or tpe 2) whose most rece glycemic status (hemoglobin A1c [H1c] or glucose managem indicator [GMI]) was >9.0%	Baseline numbers to be collected in BY1 from participating TCM providers	2.1 percentage-point decrease in % of persons 18–75 years of age with diabetes whose most recent glycemic status was >9.0% compared to baseline	To be reported by grantees in collaboration with health plans	Annually
% of persons 45–75 years of age who h appropriate screenior colorectal cancer	Baseline numbers to be collected in BY1 from participating TCM providers	2.8 percentage-point increase in % of persons 45-75 years of age who had appropriate screening for colorectal cancer compared to baseline	To be reported by grantees in collaboration with health plans	Annually
% of deliveries that received a prenatalare visit in the first trimeter	CA FORHP Rural: 69.19% Baseline numbers to be collected in BY1 from participating TCM providers	1.2 percentage- point increase in % of deliveries that received a prenatal care visit in the first trimester compared to baseline	Healthcare Payments Database (HPD)	Annually
Vaginal births per 10 women with previo Cesarean deliveries (Vaginal Birth after Cesarean (VBAC) Re, Uncomplicated)	State FORHP Rural: 6.18% Baseline numbers to be collected in BY1 from participating TCM providers	1.9 percentage-point increase in vaginal births per 100 women with previous Cesarean deliveries compared to baseline	HCAI Patient Discharge Data	Annually

Table 5 - Workforce Development Initiative Outcome Metrics and KPIs

Outcome Measure	Baseline (i available)	5-Year Target (BY5)	Data Source	Reporting Frequency

Number of licensed health workers with a primary practice location in rural areas (including but not limited to LVNs, RNs, NPs, PAs, licensed allied professionals and other advanced practitioners)	Primary Care: 3637 (total count) Maternal Health: 985 (total count)	Increase the number of licensed primary care and maternal health workers in rural areas by 2%	Baseline: HCAI License/Survey Data Annual Updates: To be reported by facilities in participating regions	Bi-annually for license/survey data Annually for self-report from facilities
Number of certified health workers in rural areas as determined by list of certified allied health professionals developed in statewide planning tool	Baseline numbers to be collected in BY1 among participating rural facilities	Increase the number of certified health workers in rural areas by 2.5%, to be set based on baseline data	To be reported by facilities in participating regions	Annually
Number of individuals who participated in education and training programs supported by RHTP	Baseline numbers to be collected in BY1 among grantees	Increase the number of participants who participated in educational and training programs by 5%	To be reported by grantees	Annually
Time to hire for primary and maternity care providers and allied health professionals	Baseline numbers to be collected in BY1 among grantees	Reduce average time to hire for primary and maternity care providers and allied health professionals by 5 % compared to baseline	To be reported by grantees	Annually

Table 6 - Technology & Tools Initiative Outcome Metrics and KPIs

Outcome Measure	Baseline	5-Year Target (BY5)	Data Source	Reporting Frequency
Number of rural hospitals reporting a connection to a national network or QHIO	Baseline numbers to be collected in BY1	Increase the number of rural hospitals reporting a connection to a national network or QHIO by 5%	Data Exchange Framework (DxF) Participant Directory	Annually

Primary care providers reporting data exchange capabilities, including electronically receiving event notifications	59% of primary care providers in California report they are “Often” or “Sometimes” automatically notified of their patients’ admit, discharge, or transfer status	Increase the percentage of primary care providers in California reporting they are “Often” or “Sometimes” automatically notified of their patients’ admit, discharge, or transfer status by 3 percentage-point increase	American Board of Family Medicine Continuous Certification Questionnaire	Annually
Number of grantees that have completed a standardized security risk assessments in the last 3 years	Baseline numbers to be collected in BY2 among rural facilities awarded grants	80% of grantees have had a standardized security risk assessment in the last 3 years	To be reported by grantees	Annually
Number of grantees whose data is managed by a technology with sustained cybersecurity certification	Baseline numbers to be collected in BY2 among rural facilities awarded grants	80% of grantees whose data is managed by a technology with sustained cybersecurity certification	To be reported by grantees	Annually
Number of unique visits of patient portal to access records during reporting period	Baseline numbers to be collected in BY2 among rural facilities awarded grants	Increase number of unique visits of patient portal to access records by 6% compared to baseline	To be reported by grantees	Annually

Table 7 - Cross-Initiative Outcome Metric

Outcome Measure	Baseline (if available)	5-Year Target (BY5)	Data Source	Reporting Frequency
Number of virtual visits or e-Consult completed for patients with chronic conditions (e.g., diabetes, hypertension), maternity and other specialty needs (Cardiology, GI, Dermatology, Neurology, Urology, Oncology, Gynecology)	Baseline numbers to be collected in BY1 among participating TCM providers and grantees	Increase number of virtual or e-Consult visits for patients by 10%, to be set based on baseline data	Healthcare Payments Database (HPD)	Annually

The number of telehealth visits and e-Consults for patients with chronic conditions, maternity needs, and specialty care will increase through integrated implementation of

the three proposed initiatives. Telehealth and e-Consults serve as core strategies for specialty care access within the Transformative Care Model initiative. The Workforce Development and Technology and Tools initiatives are designed to strengthen and sustain this model by ensuring expansion of workforce capacity through telehealth upskilling programs, provider retention and relocation and building and strengthening the digital “nervous system” to enable telehealth infrastructure.

Table 8 - Available Data Sources

Data Source	Description	Who Collects	Data Source Update Frequency
Healthcare Payments Date (HPD)	The Health Care Payments Database (HPD) is California’s All Payer Claims Database. The HPD is a research database comprised of healthcare administrative data: claims and encounters generated by transactions among payers and providers on behalf of insured individuals.	HCAI	Annually
HCAI License Survey Data	HCAI License Survey Data collects information from licensed health care professionals at the time of electronic licensure registration and renewal. HCAI collaborates with the Department of Consumer Affairs and various licensing boards to collect this data.	HCAI	Bi-Annually
HCAI Patient Discharge Dat	The HCAI Patient Discharge Dataset consists of a record for each inpatient discharge from a California-licensed hospital. Licensed hospitals include general acute care, acute psychiatric, chemical dependency recovery, and psychiatric health facilities	HCAI	Annually
DxF Participa Directory	The DxF Participant Directory is a listing of health and social service organizations’ choices of Intermediaries and/or technologies to Exchange Health and Social Services Information (HSSI) under California’s Health and Human Services (CalHHS) DxF.	HCAI	Weekly
American Boar Family Medicne Continuous Certification Questionnair (CCQ)	The American Board of Family Medicine administers the CCQ as a required component of their continued certification process. Family physicians take this web-based survey on a rolling basis every year based on their initial year of certification.	American Board of Family Medicine	Annually

Statewide Workforce Mapping and Planning Tool	The Statewide Workforce Mapping and Planning Tool will be developed by HCAI during the first year of RHTP implementation to map existing rural and frontier workforce supply, identify demand trends, and pinpoint county-level capacity gaps across licensed professionals and allied health roles.	HCAI	Annually
RHTP Grantee Surveys	HCAI will administer regular RHTP surveys to collect self-reported information from grantees to track relevant outcome measures.	HCAI	Annually

Data Collection and Analysis Capabilities

HCAI currently administers several large-scale datasets and existing reporting mechanisms. HCAI will coordinate with other agencies, including DHCS and CDPH, to regularly update data from the sources specified above to evaluate the progress of RHT program implementation and success.

Evaluation Timeline

HCAI will undertake a comprehensive evaluation of the RHT program informed by the metrics outlined above, in cooperation with any CMS evaluation and monitoring. The program will establish baseline measures, launch dashboards, and begin collection of participant provided-data in BY1. The program will proceed with ongoing evaluation to inform program activities and conclude with a final evaluation to be submitted to CMS, as further detailed in the workplan.

Sustainability Plan

The CA-RHT program is designed to achieve lasting improvements in rural access, health outcomes, workforce development, and financial stability beyond the five-year cooperative agreement. Sustainability is embedded throughout the CA-RHT program's

tiered design, with defined sustainability goals in each initiative and an ongoing stakeholder and advisory process to strengthen, scale, and sustain program outcomes over time. The sustainability strategy is in alignment with Public Law 119-21, §71401(h)(2)(A), which directs states to develop approaches for maintaining the solvency of rural hospitals and continuing care delivery models after federal support concludes.

CA-RHT uses a program design that centers sustainability through its tiered structure consisting of three interlocking initiatives that support transformation of rural health care. By combining the program's statewide rural efforts with the targeted accelerator partnerships in areas of greatest need through the Transformative Care Model Initiative, the proposal maximizes federal RHT funds to catalyze change in the near-term while creating the infrastructure and capacity for lasting transformation. The Workforce Development and Tech and Tools Initiatives lay the foundation for capacity building across rural areas which in turn enables coordinated transformation in targeted regions via the Transformative Care Model Initiative. In addition to program-wide sustainability design, each of the three initiatives independently focus on the sustainability of their activities and outcomes beyond the program period.

The Transformative Care Model (TCM) Initiative will establish rural hub-and-spoke systems with a shared, evidence-based framework for capabilities and transfers. TCM will promote access to care and long-term financial stability for rural hospitals by reducing rural hospital bypass, preserving and enhancing accessibility to appropriate levels of care, improving workforce retention, and stabilizing revenue streams. As measured by increases in service utilization and improved health outcomes, this

initiative aims to promote long-term rural health care stability and foster an integrated and sustainable care delivery system that is financially solvent.

The Workforce Development Initiative will build and sustain a capable, community-based health workforce in rural areas through programs that strengthen data, training, and education. The initiative will enhance regional networks to expand capacity of training and education programs along with scalable “Train-the-Trainer” programs to upskill and cross-train medical and allied staff. A statewide workforce mapping and planning tool will provide crucial insight into current workforce supply, trends, and gaps during and beyond the program period. Pipeline and locally-based recruitment approaches efforts will build a foundation for workforce development infrastructure in rural and frontier areas that will sustain into the future.

The Technology and Tools Initiative will assist rural providers in modernizing technology and health information exchange. Regional collaboration and shared services, including group purchasing, will not only increase access to innovative technologies but unlock cost savings. The initiative will build on the success of telehealth adoption and e-Consults in California through strategic investments in technological infrastructure to build provider capacity to participate in such programs. In recent years, California has expanded telehealth and e-Consult coverage and reimbursement to ensure providers implementing e-Consult can effectively sustain the benefits of increased access to care and cost-savings beyond the program period. In addition, a statewide Technical Assistance Center will assist grantees in implementation, promote shared learnings and diffusion of best practices, and ensure participants are maximizing efficiencies and savings with new technology in the near and long-term.

The California Rural Health Transformation program, through its interconnected initiatives, ongoing stakeholder engagement, and two-way partnership communication processes, will analyze the most effective components of the program and seek opportunities to magnify those successes. As the lead state agency, HCAI will closely coordinate with other state departments, the legislature, and Governor's office, as well as providers, purchasers, and other key stakeholders to ensure findings from the Rural Health Transformation initiatives inform future health policy in the state. Additionally, the RHPC will continue to convene key stakeholders to advise on opportunities to continue the most effective efforts of the transformation program. This collaborative approach will ensure successes from the program are scaled regionally or statewide based on available evidence.

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