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Project Narrative

The Great State of Idaho is honored to submit this application for the Rural Health Transformation Program (RHTP) to strengthen and sustain healthcare across rural Idaho.

Our rural communities are the backbone of our state and the nation. They feed America, fuel our economy, defend our nation, and keep alive the traditions and faith that make Idaho strong. Yet too many rural families face unacceptable barriers to timely, affordable, and high-quality care close to home. Idaho intends to change that—not by growing bureaucracy or creating permanent government programs, but by empowering rural hospitals, providers, clinics, community health centers, faith and family-centered solutions, and Idahoans themselves.

Led by the Idaho Department of Health and Welfare (IDHW), Idaho seeks a minimum of $200 million per year over five years to drive a bold plan rooted in the *Make America Health Again (MAHA)* emphasis on prevention, personal responsibility, local innovation and control, and community self-sufficiency. Idaho's plan will empower Idahoans and communities to take charge of their health by transforming today's fragmented healthcare infrastructure into a resilient, patient-centered system that delivers accessible, sustainable, and innovative care close to home. Through coordinated investments, strategic partnerships, and community-driven solutions, the State will innovate new learning opportunities at homegrown and regional education institutions; grow access to physicians, nurses and other healthcare providers and extenders; strengthen emergency and specialty services; modernize technology; support tele-pharmacy and telehealth; and keep care available in small towns and farming communities that define the Idaho identity. Idaho will treat this as the one-time federal investment it is. The Governor, through executive branch agencies, will ensure the initiatives remain aligned with the President's vision under the One Big Beautiful Bill and MAHA, and the Legislature will ensure continuity of local control by

participating in appropriation of awarded federal funds, which will ensure priorities remain aligned with Idaho local needs. Each initiative will include clear performance metrics, cost-efficiency targets, continuous tracking of progress and return on investment via third-party evaluation, and planned funding wind-down to ensure that every dollar contributes to tangible, lasting success without reliance on perpetual federal or state funding.

Idaho is committed to ensuring our rural families can access the care they need—locally, transparently, affordably, and without sacrificing freedom or growing government. By investing in prevention, workforce development and infrastructure, we will Make Rural America Healthy Again and ensure Idahoans remain healthy and independent in the communities they have called home for generations. Idaho's rural families, farmers, veterans, and seniors deserve local, community-rooted care, not permanent government expansion. This plan modernizes rural care through free-market innovation, transparency, and personal responsibility, not new entitlement systems.

Rural health needs and target population

Rural demographics: Idaho is a large western state ranking 14th in geographic size but only 38th in population among U.S. states, underscoring its unique rural character. In 2023, the U.S. Census Bureau estimated Idaho's population at 1,893,296 across 83,568.6 total square miles (~23 people per square land mile), much of which is vast, rugged, and difficult to access. This low population density makes Idaho one of the most rural states in the nation.[1] Using the Federal Office of Rural Health Policy (FORHP) definition of rural, 655,070 individuals, or 36% of the state's overall population, reside in rural census tracts. These rural areas comprise approximately 96% of Idaho's land area. Out of 44 counties, seven are considered urban (six are partial urban but include rural census tracts), 37 are classified as rural, and 16 as frontier (which are also

rural), meaning fewer than six people per square mile.[6] In addition, ~6% of Idaho's population lives in a frontier county.[7]

According to the 2024 American Community Survey, 10.6% of Idahoans live below the poverty level.[2] Poverty in nonmetropolitan Idaho counties (a rural area per FORHP) in 2023 was 12.2%.[4] Poverty and rural isolation contribute to limited access to healthcare services and worsen health outcomes.[7] In 2023, 31% of Idaho households were considered Asset Limited, Income Constrained, Employed (ALICE) – meaning these families are earning above the Federal Poverty Level, but are not able to afford essential expenses.[4] The 2023 unemployment rate in nonmetropolitan Idaho counties was 3.3%.[3]

In Idaho, 8.8% of adults aged 25 and older have not completed high school, while 26.3% hold a high school diploma or equivalent but never pursued further education. An additional 23.3% have some college experience without earning a degree, and 9.9% have earned an associate's degree. Roughly 21.8% hold a bachelor's degree, and 11.6% possess graduate or professional degrees. About 33% of Idaho adults and 22.1% of adults aged 25 and older in rural areas have attained a bachelor's degree or higher.[7]

In 2023, Idaho ranked 13th among U.S. states in the percentage of uninsured, with 9.2% lacking health insurance coverage compared to the national average of 8.2%.[8] The percentage of uninsured people ages 0-64 in nonmetropolitan Idaho counties was 12.4%.[10] Nearly 30% of Idaho mothers lacked health coverage prior to pregnancy.[12] These coverage gaps leave many rural residents without affordable healthcare options.

Health outcomes: Like many rural states, Idaho experiences disproportionately high rates of preventable illness and premature death. Consistent with national trends, Idaho's rural residents with chronic conditions have a higher mortality rate than those living in urban areas:

- **Heart Disease:** In 2023, 3.3% of Idaho adults had been diagnosed with heart disease.
- **Obesity:** In 2023, 31.0% of Idaho adults had been diagnosed with obesity.
- **Diabetes:** In 2023, 9.8% of Idaho adults had been diagnosed with diabetes.
- **Suicide:** In 2023, Idaho's suicide rate was 28.6 deaths per 100,000 people in rural counties and 38.7 per 100,000 people in remote counties, compared with 21.0 per 100,000 people in urban counties in the state. Overall, Idaho had the fourth highest suicide rate in the nation.[6]
- **Injury:** In 2021, Idaho recorded 16.5 deaths per 100,000 people from motor vehicle crashes (higher than 14.2 nationally) and 16.8 deaths per 100,000 from falls (higher than 13.5 nationally).
- **Maternal and child health:** Using the latest available national maternal and infant health data through the Health Resources and Services Administration, it is evident that while some areas of the state have relatively strong rates of prenatal care in the first trimester, other regions have room for improvement.[11] Idaho's geography can add challenges for pregnant women: 22.5% of rural women live more than 30 minutes from a birthing hospital, and 2.6% live more than 60 minutes away.[9]

Healthcare access: A critical driver of Idaho's health outcomes is its shortage of healthcare professionals. Idaho ranks 45th in primary care physician ratios.[5] Health Professional Shortage Area (HPSA) designations further illustrate the problem:

- **Primary Care:** 98.2% of Idaho's land area is designated as a Primary Care HPSA, impacting 57.8% of residents.
- **Dental Care:** 95.01% of the state's land area is classified as a Dental HPSA, impacting 65.8% of residents.

- **Mental Health:** Alarmingly, 100% of Idaho's land area and population fall within a Mental Health HPSA, signifying a complete statewide shortage of mental health professionals.[10]

Nursing shortages are similarly severe. Idaho has just 7.06 Registered Nurses (RNs) per 1,000 residents, compared to 10.6 nationally. Rural areas are hardest hit, with RNs choosing to migrate from these communities to larger ones, this is especially the case with younger nurses.[13] Geographic isolation compounds workforce shortages. Public transportation is limited as rural population density is typically below the level needed to support fixed route bus service.[14] Many rural residents must travel long distances across mountainous terrain to access healthcare. This burden often discourages patients from seeking timely treatment, particularly those with chronic conditions or co-occurring mental health needs. Local clinics frequently lack the resources, specialists, and equipment required to meet community needs, forcing patients to delay or forgo care altogether. Idaho's rural healthcare network has 36 hospital facilities and 274 non-hospital facilities, including 26 Critical Access Hospitals (CAHs), one Rural Emergency Hospital (REH), and 57 Rural Health Clinics (RHCs). The state has 53 Federally Qualified Health Centers (FQHCs) and two short-term prospective payment system hospitals (See Density of Health Care Facilities in Idaho in ID RHTP Other Supporting Documentation).[10]

Rural facility financial health: Rural healthcare facilities in Idaho face significant financial pressures affecting their ability to provide services. According to 2024 CAH Measurement and Performance Assessment System data from the Idaho Medicare Rural Hospital Flexibility Program, 15 Idaho CAHs maintain fewer than 100 days of cash on hand leaving them vulnerable to financial disruptions.

A 2025 assessment conducted by The Chartis Group as a contract deliverable for IDHW found that 46% of Idaho CAHs operate in the red, with an additional 4% classified as vulnerable and

one hospital identified as extremely vulnerable to closure. The report that Idaho CAHs collectively scored at the 23rd percentile in cost management, highlights a need for improved efficiency. These findings underscore the fragile financial position of hospitals that serve as the first and often only point of access to care in rural communities. In 2025, one of Idaho's CAHs converted to an REH to stay economically viable, decreasing rural access to inpatient care. RHCs, which are often located in smaller communities, also operate under considerable strain. Due to location, RHCs frequently serve low-volume patient populations, which limits their ability to spread fixed costs across patient encounters. Administrative burden, claim denials, and delays further reduce revenue predictability. Rising labor and supply costs add to these challenges, as RHCs must still cover staffing, facility maintenance, and regulatory compliance despite limited resources.

Idaho FQHCs deliver essential services through 192 clinics in 67 communities, nearly half of these being in rural areas. High staffing costs, administrative overhead, and payer mix challenges further strain budgets. Uncompensated care and bad debt are additional stressors across all rural health facilities. For example, the Idaho Hospital Association reported the total amount of uncompensated care for Critical Access Hospitals in 2024 was $68.7 million (personal communication, October 21, 2025). Free medical clinics (FMCs) and emergency medical services (EMS) help fill critical gaps but operate with often unstable funding. Rural EMS agencies are especially fragile; in rural Idaho, 69% of EMS providers are volunteers. This dependence reduces long-term financial stability and underscores the difficulty of sustaining essential services in geographically remote areas.

Overall, Idaho's rural health facilities operate on narrow margins, with many at risk of service line closures or reductions that threaten financial viability and community trust.

CAH utilization and patient volumes (reporting period of 10/1/2023 – 9/30/2024)

Hospital Name (M.C. = Medical Center)	Type	Total Beds	Total Admis-sions	Total Dis-charges	Total Newborn Deliveries	Total Emer-gency Visits
Bear Lake Memorial	CAH	21	252	256	48	2365
Benewah Community	CAH	19	123	113	0	3398
Bingham Memorial	CAH	35	1312	1327	0	10087
Bonner General	CAH	25	827	823	0	11489
Boundary Community	CAH	20	242	249	0	3774
Caribou Medical Center	CAH	23	217	218	24	2477
Cascade Medical Center	CAH	10	17	17	0	1455
Clearwater Valley Health	CAH	23	704	719	22	4019
Franklin County M.C.	CAH	18	579	578	89	3728
Gritman Medical Center	CAH	25	993	999	274	10889
Cassia Regional	CAH	25	1838	1870	508	10800
Lost Rivers M.C.	CAH	79	17	17	0	1551
Madison Memorial	Med/Surg	69	2468	2461	1159	10807
Minidoka Memorial	CAH	25	263	261	0	6034
North Canyon M.C.	CAH	18	292	299	1	5298
Oneida County	CAH	11	299	299	0	838
Power County District	CAH	10	47	43	0	2140
Shoshone M.C.	CAH	25	0	0	0	5420
St. Luke's Elmore	CAH	22	699	702	205	13015
St. Luke's Jerome	CAH	17	356	351	0	6417
St. Luke's McCall	CAH	15	622	620	133	6027
St. Luke's Wood River	CAH	25	818	814	158	9104
St. Mary's Health	CAH	25	393	403	49	8160
Steele Memorial M.C.	CAH	18	415	418	5	3593
Syringa District	CAH	16	290	290	38	3842
Teton Valley Health Care	CAH	13	243	243	0	3565
Walter Knox Memorial	CAH	16	91	0	0	4540
Weiser Valley District	CAH	20	267	267	59	3376

Target populations and geographic areas that will benefit from Idaho's RHTP: For this application, Idaho has adopted the FORHP definition of rural**.** The target population includes 655,070 residents residing in rural census tracts; all rural healthcare facilities, hospitals, and health centers; and the five federally recognized Native nations in Idaho (See Rural Health Transformation Program Grant Eligibility in ID RHTP Other Supporting Documentation). A

specific focus will be on women who are pregnant or recently gave birth, children and people younger than 20 years, older adults, and people who have disabilities or medically complex health conditions.

Idaho Rural Health Transformation Plan

Vision: *Catalyze rural health transformation through targeted, sustainable investments to build local capacity, promote self-reliance, and support the health and independence of Idahoans.* Idaho seeks to empower individuals and their communities to take responsibility for their health, emphasizing prevention over dependence, and fostering innovation through locally driven solutions. Public input identified three clear priorities guiding this plan: workforce, access, and chronic disease prevention—supported by five coordinated initiatives that build long-term system capacity. Each initiative is designed to achieve measurable impact, ensure fiscal accountability, and create enduring value long after federal funding concludes.

Goals and strategies for transforming rural health:

- **Improving access:** Enhance telehealth of all types, mobile and community-based services, and MAHA interventions; strengthen workforce and infrastructure. Aligns with all RHTP strategic goals and Idaho RHTP Initiatives.
- **Improving outcomes:** Deliver earlier, evidence-based care and targeted MAHA strategies focused on maternal and behavioral health risk reduction, and better chronic disease control. Aligns with RHTP strategic goal. “Make rural America healthy again,” and Idaho RHTP Initiatives 1, 2, and 4.
- **Technology innovation and use:** Modernize systems through telehealth expansion, interoperability, electronic health record (EHR) upgrades, cybersecurity, and artificial

intelligence (AI); pairing technology with provider training. Aligns with RHTP strategic goal "Tech innovation" and Idaho RHTP Initiatives 1, 2, and 5.

- **Partnerships:** Maintain strong collaboration through a Governor-appointed task force, the Idaho Legislature, and regional partners, informed by extensive statewide engagement of rural healthcare providers and individuals from rural communities. Idaho has offered to set-aside three and a half percent of the total award to support use of funds for the five federally recognized Native nations residing in Idaho. The three and a half percent is based on the American Indian (AI) population in Idaho over the total Idaho rural population using the most recent U.S. census data. Aligns with all RHTP strategic goals and all Idaho RHTP Initiatives, especially RHTP Initiative 5.
- **Workforce:** Recruit, train, and retain rural healthcare workforce through incentives and education partnerships. Create opportunities for allied healthcare professionals. Aligns with RHTP strategic goals, "Innovative care" and "Workforce development" and Idaho RHTP Initiatives 2, 3.
- **Data-driven solutions:** Use clear metrics, statewide data systems, rural health data dashboards, third-party evaluation, and continuous monitoring to drive accountability and improvement. Aligns with all RHTP strategic goals and Idaho RHTP Initiatives.
- **Financial solvency strategies:** Ensure sustainability of demonstrated successes by prioritizing investments that transition to self-sustained or funded local ownership, reimbursement, and/or operational efficiencies by Year 5. Aligns with all RHTP strategic goals and Idaho RHTP Initiatives.
- **Cause identification:** Address root causes of rural healthcare facility strain—low volume, workforce shortages, and reimbursement challenges—using modernized data, technology,

workforce strategies, and innovative care models. Additionally, address causes of premature mortality through evidence-based programs aimed at preventing disease and intervening to improve health outcomes through healthy behaviors and access to appropriate care. Aligns with RHTP strategic goals, "Tech innovation," "Innovative care," "Workforce development," "Sustainable access," and Idaho RHTP Initiatives 1, 2, 3, and 5.

Program key performance objectives: Idaho will track process, quality, and impact measures across all initiatives. Core targets include:

- **Initiative 1:** Increase telehealth and remote appointments by 50% by 2030, ensuring that rural Idahoans can receive high-quality care without leaving their communities.
- **Initiative 2:** Reduce emergency department (ED) visits for ambulatory-care-sensitive conditions by 20% from 30,779 per 100,000 ED visits in 2025 to less than 24,623 by 2030 demonstrating the value of early intervention and prevention.
- **Initiative 3:** Increase the ratio of physicians per 100,000 population from 193 in 2023 to at least 195 by 2030, ensuring sustainable local capacity.
- **Initiative 4:** Ensure at least 50% of participants in new or enhanced chronic disease prevention programs will meet clinical outcome goals by 2030.
- **Initiative 5:** Increase the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data point on "Getting needed care" from 83.3% to 90% by 2030, reflecting responsive, reliable rural healthcare delivery.

Additionally, Idaho will monitor two overarching measures that align with MAHA's call for accountability, transparency, and continuous improvement:

- **The Get Healthy Idaho Index:** A score representing conditions which support increased health and wellness of a community.[15] Overall score changes as well as advances in specific domains will be tracked to capture improvement through 2030.
- **Specialty-Care Access Index:** Assess and report on expanded access to specialty and preventative services in rural areas, documenting the return on this one-time federal investment. and track improvement in access to specialty care. These performance objectives and supplemental data efforts will ensure accountability, demonstrate impact, and drive continuous improvement in the accessibility, quality, and sustainability of care.

Legislative or regulatory action commitments and current state policies:

State Policy: B.2. Health and Lifestyle

- Idaho will actively communicate and work to encourage all public schools across the state, particularly in Idaho's rural communities, to reinstitute the Presidential Fitness Test. The Idaho Department of Education will develop materials to support and incentivize schools to do so by the end of CY 2027.

State Policy: B.3. SNAP Waivers

- Idaho was one of the first to ban candy and soda purchases with SNAP benefits.
- House Bill 109, passed in the 2025 Legislative Session, effective January 1, 2026.
- No future policy action is needed.

State Policy: B.4. Nutrition Continuing Medical Education

- Idaho requires Continuing Medical Education (CME) hours but does not mandate specific nutrition topics; physicians currently select their own CME subjects.
- Idaho will not be seeking legislative changes related to this state policy factor.

State Policy: C.3. Certificate of Need

- Idaho has no Certificate of Need requirements and received a zero score in the Cicero report.
- No future policy action is needed.

State Policy: D.2. Licensure Compact

- Idaho participates in multiple interstate licensure compacts, including compacts for physicians, nurses, EMS providers, and psychologists.
- Legislation is being drafted for a multi-state physician assistant compact to be considered for the 2026 state legislative session.

State Policy: D.3. Scope of Practice

- Idaho supports providers practicing at the top of their scope of practice; Idaho Code 56-2206 directs Medicaid to protect practice authority wherever allowed under state law.
- Current scope status:
    - **Physician Assistants:** advanced scope of practice
    - **Nurse Practitioners:** full scope of practice
    - **Pharmacists:** full scope of practice
    - **Dental Hygienists:** semi-restricted scope of practice
    - **EMS Personnel:** Idaho has expanded scope at all levels and allows these professionals to work in nontraditional settings (e.g. Emergency Departments)
- Legislation is being drafted to further expand scope of practice for physician assistants and dental hygienists to be considered for the 2026 state legislative session.

State Policy: E.3. Short-Term, Limited Duration Insurance (STLDI)

- Idaho allows STLDI plans as defined under federal regulation (45 CFR 144) and does not impose restrictions beyond federal guidance.
- This is addressed in administrative rule and Idaho Code 41-5214 and 41-5203(11).

- No future policy action is needed.

State Policy: F.1. Remote Care Services

- Idaho was an early adopter of telehealth and remote patient monitoring, supported through the Idaho Virtual Care Access Act. Idaho Medicaid reimburses telehealth at parity with in-person care and covers remote monitoring and video-based services.
- Idaho does not require in-state licensure for remote providers if they are licensed and in good standing elsewhere and agree to comply with Idaho regulations—this applies to both medical and behavioral health providers. Licensing and registration processes for interstate telehealth are established under Idaho Code 54-5714.
- No future policy action needed.

Other required information:

For factor A.2.: The most current list of Certified Community Behavioral Health Clinics (CCBHCs) entities within Idaho as of September 1, 2025

- Idaho started an effort with five FQHCs to transition to CCBHCs in 2022. All five serve rural communities or adjacent rural communities. Last year, Idaho paused this effort, including certification, to evaluate sustainability and Medicaid funding.

For factor A.7.: The number of hospitals that received a DSH payment as of State Plan Year 9/30/24

- For State Plan Year Ended 9/3/2024, a total of five hospitals received DSH payments.

<u>Proposed initiatives and use of funds</u>

All Idaho initiatives will be executed as *new* activities or be a *new* expansion of activities into rural communities serving a new population, not a duplication of existing programs.

1. Improving rural access to care through technology

Through investments in telehealth, interoperability, artificial intelligence, and cybersecurity, Idaho will strengthen the backbone of rural care--bridging distance, reducing duplication, and building durable infrastructure that allows communities to manage their own health more effectively in partnership with healthcare systems, treatment centers, and long-term care facilities. Proposed use of funds:

- **Facility technology assessments and shared infrastructure** to build sustainable, cost-effective technology capacity across rural facilities. Fund RHCs, CAHs, FQHCs, and other healthcare facilities to work with a consultant to complete technology assessments to determine the appropriate technological infrastructure strategies and tools to implement that will ultimately improve care delivery to rural citizens. Assessments inform other proposed uses of funds related to purchases of technology, equipment, and minor building renovations. *Expected impact:* Healthcare systems are equipped with the information they need to successfully integrate various types and methods of technology into their system. *Planned activities*:
    - Conduct assessments of rural healthcare facilities to identify technology gaps, needs, and readiness.
    - Develop shared technology infrastructure (e.g., regional data centers, shared telehealth hubs) to reduce duplication and costs.
    - Promote regional partnerships and cooperative agreements to share IT support, cybersecurity resources, and analytics tools.
- **Telehealth expansion** to increase access to both primary and specialty care through enhanced telehealth networks and infrastructure. Enhance access to care by funding

telehealth equipment, software, and training for the delivery of primary care services, specialty care, and behavioral health. *Expected impact*: Reduced transfers of care (particularly to hospitals for preventable admissions), improved continuity of care, and increased access to preventive and specialty services for rural residents. *Planned activities*:

- Develop regional telehealth networks connecting rural CAHs, RHCs, FQHCs, and urban referral centers for specialty services.
- Equip rural healthcare facilities with telehealth equipment and software to enable real-time specialty consultations, including purchase or upgrades of existing EHRs to improve or add telehealth capacity, allowing patients to receive advanced care locally without transfer.
- Support telepharmacy models in additional communities, including remote dispensing by pharmacy technicians.
- Prioritize service lines that address rural health gaps, including women's health and prenatal services; behavioral health; dental; radiology and diagnostic imaging support; dietetics and nutritional counseling; chronic disease management; gerontology; and pharmacy and medication management.
- Support training on telehealth, including appropriate billing procedures, for rural clinicians and staff to integrate virtual visits into routine workflows and care plans.

- **Digital health** to empower Idahoans to actively prevent and manage chronic disease through consumer-facing apps and online platforms ultimately increasing access and ability to track health information such as vital signs and symptoms leveraging existing broadband and satellite connectivity. Invest in AI tools, consumer-facing apps, and online platforms to enhance healthcare delivery in rural communities. Provide training and technical assistance

to facilities and providers to utilize these digital health tools effectively and contain cost. Implement AI tools to help hospitals and other health systems increase revenue by managing front-end, mid-cycle, and back-end revenue cycle management. *Expected impact*: Improved chronic disease self-management, higher patient engagement, reduced hospital readmissions, and increased appropriate follow up care. *Planned activities*:

  - Procure mobile apps and online portals that integrate with EHR systems to support self-monitoring, appointment scheduling, medication adherence, and coaching.
  - Create digital education campaigns tailored for rural populations most inclined to leverage consumer facing applications, focusing on behavioral health and chronic disease prevention and management.
  - Partner with community organizations and provider entities to promote adoption of digital health tools among rural residents with limited digital literacy.

- **Cybersecurity modernization and AI tools** to protect Idaho's healthcare infrastructure and enhance data-driven decision-making. Invest in updated cybersecurity systems for rural hospitals, clinics, and facilities to help protect confidential patient data, maintain care delivery, and avoid unnecessary IT support costs. *Expected impact*: Strengthened cybersecurity, reduced risk of data breaches, and improved analytical capacity for patient care. *Planned activities*:
  - Modernize cybersecurity systems in rural healthcare facilities, ensuring compliance with federal data protection standards (e.g., HIPAA, HITECH).
  - Deploy AI-driven monitoring tools to identify and mitigate cyber threats in real time.
  - Introduce AI-enabled clinical tools that assist with diagnostic support, patient risk stratification, and predictive analytics for disease trend identification.

- Create training resources for IT and healthcare personnel on data privacy, cyber hygiene, and secure telehealth practices.

- **Emergency communication systems implementation and enrollment** to ensure timely care in rural emergencies and strengthen statewide communication capacity between Idaho's public health and healthcare systems. *Expected Results:* Emergency communication solutions in place to notify healthcare providers of public health threats and updated 911 service infrastructure to improve public emergency communications, especially in rural areas where none exist today. Idaho understands that broadband infrastructure cannot be covered through this grant. *Planned activities:*
  - Replace the antiquated Idaho Health Alert Network (HAN) for provider facing communications with a modern system and enroll all rural health providers and healthcare organizations. Rapid notification of healthcare providers and other partners of emerging health threats is critical to create awareness of these issues, especially in rural areas where providers are less likely to be part of large healthcare systems.
  - Upgrade emergency communication systems to Next Generation 911 standards, to improve location accuracy, multimedia communication, and dispatch speed in rural areas.
- **Health management and data analytics tools** to enable data-driven approaches to improve health outcomes. *Expected impact*: Measurable improvements in rural health outcomes and targeted interventions. *Planned activities*:
  - Implement health management software at rural clinics, hospitals and other facilities to support risk stratification, care coordination, and outcome tracking across rural populations. This will be critical for rural provider success in any contracting with payers, further promoting improved revenue generation, sustainability, and cost containment.

- Use data analytics to identify high-need communities, track chronic disease trends, and evaluate success of health interventions.
- Leverage data to inform future policy and resourcing.

- **EHR software and upgrades** to ensure interoperability and efficiency across Idaho's rural healthcare facilities. *Expected impact*: Enhanced care coordination, reduced administrative burden, and improved population health data accuracy. *Planned activities*:
  - Provide funding for EHR implementation or upgrades in rural healthcare facilities.
  - Provide funding to providers and EHR vendors to grow interoperability via the updated CMS Interoperability Framework. Support system setup, technical assistance, and workforce training to optimize EHR adoption and data quality.
  - As a condition of receiving funds tied to EHR software and updates, require healthcare facilities to participate in a state facilitated work group to formally adopt and implement the CMS Interoperability Framework.

Main strategic goal: Tech innovation

Uses of funds: A, C, F, G, H

Technical score factors: B.1, C.1, F.1, F.2, F.3

Key stakeholders: post-secondary programs and institutions, career technical and professional education programs, professional associations, rural healthcare providers such as RHCs, CAHs, pharmacies, EMS, FQHCs, the five federally recognized Native nations in Idaho, Idaho Office of Emergency Management, Bureau of EMS.

Outcomes:

- Increase the number of facilities utilizing telehealth by 50% by December 2030.

- Increase the percentage of physicians located in each of Idaho's rural counties that are connected to the new Health Alert Network (HAN) to at least 80% by December 2030.
- Increase the number of facilities implementing new EHR software or updating existing EHR software that is not yet HITECH certified to at least 10 facilities by December 2030.
- Increase the number of appointments completed using telehealth or remote delivery modality by 50% by December 2030.

Impacted counties: 16003, 16005, 16007, 16009, 16011, 16013, 16015, 16017, 16019, 16012, 16023, 16025, 16027, 16029, 16031, 16033, 16035, 16037, 16039, 16041, 16043, 16045, 16047, 16049, 16051, 16053, 16055, 16057, 16059, 16061, 16063, 16065, 16067, 16069, 16071, 16073, 16075, 16077, 16079, 16081, 16083, 16085, 16087

Estimated required funding: $209,000,000 for five years

2. Ensuring accessible quality care through innovative models

This initiative addresses challenges to timely, affordable and high-quality healthcare services in geographically isolated areas with workforce shortages and financial barriers through implementation of care models that extend the reach of healthcare beyond traditional facilities. By investing in access to innovative diagnostics, leveraging new technologies, expanding workforce by enhancing the role of health extenders (e.g., community health workers, community health EMS [CHEMS], pharmacy allied professionals, and other non-physician healthcare professionals), strengthening EMS systems, and supporting home-based and community-based care solutions, this initiative will ensure that rural Idahoans can receive care at and close to home. Proposed use of funds:

- **Diagnostic and care access innovations** to increase access to care through technology-enabled points of service. *Expected impact*: Increased early detection of disease, improved

medication adherence, and reduced travel barriers for rural residents preventing and managing chronic conditions. *Planned activities*:

  - Deploy diagnostic kiosks, care stations, and telehealth pods in easy to access locations in rural communities, such as libraries, schools, faith-based entities and houses of worship, pharmacies, grocery stores, and other community centers, to provide accessible entry points for preventive screenings, lab testing, and virtual consultations.
  - Install pharmacy kiosks and prescription lockers in accessible community spaces and enhance mail-order pharmacy services to ensure reliable medication access.
  - Implement remote patient monitoring programs, to include purchase of necessary devices, for individuals with chronic conditions and following hospital discharge, allowing continuous observation of vital signs and other health measures, and early intervention to prevent hospitalizations.
  - Integrate data from kiosks and remote patient monitoring systems with local clinics and hospitals to support coordinated care and proactive patient engagement.

- **Health extenders** to strengthen access to timely healthcare in rural communities. Idaho also anticipates aligning with priority efforts to implement Medicaid work requirements over the next year. Through rural job creation such as extender positions, rural residents can be employed full time in well-paying positions and transition off public benefits. *Expected impact*: Reduced emergency department utilization, improved chronic disease prevention and management, and strengthened local capacity for health promotion and prevention. *Planned activities*: Recruit, train, and deploy health extenders to provide outreach, patient navigation, and health education in underserved rural areas.

- Create designated rural locations where health extenders' in-person contact hours or apprenticeships are offered.
- Develop Community Health Emergency Medical Services (CHEMS) programs in rural communities to enable trained EMS professionals to perform preventive visits, follow-up checks, and wellness assessments in the home setting.
- Develop cross-training and train-the-trainer programs to coordinate health extender personnel and ensure long-term sustainability of workforce pathway of extenders and continuing education.
- Integrate health extenders into telehealth and follow up care processes for referral tracking, data sharing, and outcome reporting.

- **EMS expansion and workforce stabilization** to support reliable, timely emergency medical response across all Idaho counties. *Expected impact*: reduced emergency response times, improved continuity of emergency care, and greater system reliability for rural residents.

  Planned activities:

  - Provide targeted funding and technical assistance to support EMS agencies to establish CHEMS programs, prioritizing those with less than one paid full-time equivalent EMS provider. EMS agencies selected will commit to establishing an ongoing CHEMS position, creating a sustainability plan to continue the position through alternate funding sources after year five, to ensure the staff give five years of service in the rural area, to participating in needs assessment and evaluation to demonstrate gaps and cost-savings, and to participate in a RHTP CHEMS workgroup with hospitals, non-Medicaid payers, clinics, state agencies, and evaluators, to ensure sustainability after the grant period.

- Invest in the development of EMS recruitment, retention, and leadership programs with curriculum that can be used ongoing to build sustainable staffing models.
- Support EMS integration with healthcare partners, enabling shared response planning and data, and care coordination with rural healthcare clinics and facilities.

- **Understand opportunities to leverage health extenders and optimize service delivery** to align rural health extender programs, emergency medical, and healthcare services with local needs and rural health trends. *Expected impact:* Optimized EMS coverage, health extender capacity, reduced redundancy, and more efficient use of limited rural healthcare resources.

  Planned activities:

  - Complete rural community needs assessment specifically examining the gaps in care that can be filled by health extenders and opportunities for cost savings. During year five of funding, complete evaluation of efforts completed to close identified gaps and determine opportunities for further health extender program, optimize service delivery, and leverage extenders to contain healthcare costs.
  - Develop technical assistance resources for rural provider entities, including EMS agencies, specific to the assessment findings to improve patient care and utilize staff in the most efficient way. Support these entities to use data-driven approaches to integrate health extender models to right-size emergency response, preventive care, chronic disease care, and follow-up on patients after hospital admission at home.
  - Develop shared resource agreements between counties to pool personnel, training, and equipment as needed following the assessment.

- Increase the number of available allied and health extender certificate programs available through high schools and community colleges in Idaho with focus on pharmacy, maternal and child health, emergency services, and behavioral health.

Main strategic goal: Innovative care

Uses of funds: A, B, D, E, F, G, I, J, K

Technical score factors: B.1, C.1, C.2, D.3, F.1

Key stakeholders: EMS agencies, Idaho Bureau of EMS, rural providers including CAHs, RHCs, FQHCs, pharmacies, the five federally recognized Native nations in Idaho, Idaho Commission on Aging, post-secondary programs and institutions, career technical and professional education programs, community employers and programs (including faith-based entities and houses of worship).

Outcomes:

- Increase the number of CHEMS positions supporting Idaho's rural counties from 26 in October 2025 to at least 62 by December 2030.
- Increase the percentage of Idaho's rural counties that have at least one county-level full-time equivalent paid EMS position from 28% in October 2025 to at least 97% by December 2030.
- Decrease the rate of emergency department visits for ambulatory care sensitive conditions from 30,779.2/100,000 ED visits in 2025 to less than 24,623.3/100,000 by December 2030.
- Decrease the percentage of emergency responses to repeat users (those who received emergency services [excluding CHEMS visits] more than once in a year) from 32% in 2013-2016 to less than 10% by December 2030.

Impacted counties: 16003, 16005, 16007, 16009, 16011, 16013, 16015, 16017, 16019, 16012, 16023, 16025, 16027, 16029, 16031, 16033, 16035, 16037, 16039, 16041, 16043, 16045, 16047,

16049, 16051, 16053, 16055, 16057, 16059, 16061, 16063, 16065, 16067, 16069, 16071, 16073, 16075, 16077, 16079, 16081, 16083, 16085, 16087

Estimated required funding: $125,000,000 for five years

3. Sustaining rural workforce with training, recruitment, and retention

To transform rural health sustainably, this plan focuses on a comprehensive rural workforce strategy that leverages financial incentives, training pathways, infrastructure and community support to build and sustain a skilled rural health workforce addressing the need for high demand, specialty providers and allied healthcare providers in the far reaches of the state. This initiative prioritizes positions that must be physically present in rural counties to meet care needs. Participants will commit to a minimum of five years of service in rural communities, ensuring continuity of care and strengthening local health systems. Proposed use of funds:

- **Ladder payments based on priority positions and rural presence** to address challenges in staffing by offering escalating incentives. A tiered system (ladder payments) based on workforce priorities and geographic need will be implemented. Health professionals filling essential roles in rural counties may receive incentives aligned with community need and service during challenging shifts (e.g., weekends, nights). *Expected impact:* Health professionals receiving incentives will commit to working in rural settings where recruitment has historically been difficult, directly supporting Idaho's most critical workforce gaps. Those who receive incentive payments will commit to serving in a rural Idaho community for no less than 5-years. Repayment will be required if the 5-year minimum obligation is not fulfilled. *Planned activities*:
    - **Recruitment incentives**: Signing bonuses and relocation stipends will be made available to attract new hires, particularly for hard-to-fill positions and shift gaps. Recruitment will

actively focus on rural-based candidates and professionals with ties to Idaho communities who are most likely to continue to live in the rural area beyond the 5-year commitment. Other candidates who demonstrate a desire to serve a minimum 5-year period will also be considered.

- **Retention bonuses:** To foster long-term retention, health professionals meeting multi-year service commitments in rural counties may receive retention bonuses at key milestones (e.g., at two and four years). These bonuses reward loyalty and reduce turnover, preserving institutional knowledge and patient trust.
- **Healthcare education scholarships:** Students accepted into a healthcare education program, with an emphasis on post-graduate programs, will be eligible to receive scholarship funding. Requirements of the scholarship funding includes a minimum of 5-years clinical service in a rural community and completion of their program in a designated, appropriate, amount of time.

- **Healthcare career exploration and advancement programs** to attract Idahoans to pursue healthcare careers by exposing them to opportunities within the healthcare field, to further train those already in healthcare careers, including "learn in place" and "grow your own" strategies available to those residing in rural communities. These programs will offer online or in-person experiences or events in rural communities. Additionally, support development of new healthcare education programs in areas of the state where these are not currently established, and for needed specialties. *Expected impact:* More individuals who choose to live and work in Idaho's rural communities going into, or advancing in, healthcare careers.

  Planned activities:

- In coordination with post-secondary programs and institutions, develop healthcare profession training and education programs using a “learn in place” or “grow your own” approach. These could also be made available within high schools to create a career pathway for students.
- Develop or enhance available training, education, and degree programs for healthcare professions in coordination with educational institutions. This could include new undergraduate medical education pathways explicitly serving rural populations, degree or certificate programs, and space renovations to support learning and training.
- Provide incentives for staffing or healthcare professionals serving as mentors and instructors for new or enhanced healthcare profession programs with a minimum 5-year obligation.

- **Work-based learning:** Support creation of new healthcare career apprenticeship and preceptorship programs including providing supervision incentives. *Expected impact:* Increase in available programs and the number of available preceptors, supervisors, and mentors with a minimum 5-year obligation. *Planned activities*:
  - Develop partnerships with post-secondary programs and institutions and provider entities to create new preceptorship programs with priority for nursing, dental, mental and behavioral health, pharmacy, and allied health students in rural communities
  - Provide incentives to supervisors who mentor students in rural settings, strengthening training capacity and encouraging trainees to remain locally.
- **Graduate medical education programs** with a priority on obstetrics and gynecology, mental and behavioral health, and geriatrics. These specialties are in high need and will help close provider specialty gaps in rural communities. These programs will emphasize placing

clinicians on rotations in rural communities where there is a significant need for these specialties. *Planned activities*:

- **Fellowships:** Establish specialized fellowship opportunities in rural hospitals and clinics, with an emphasis on behavioral health, obstetrics and gynecology, and geriatrics. Fellows will gain immersive rural experience with structured mentorship and financial support.
- **Residency programs:** Enhance existing rural residency programs and create new tracks where needed, including but not limited to obstetrics and gynecology, behavioral health, and geriatrics. Where appropriate, this may support GME programs with short-term housing rental costs to support increased rotational opportunities and expose more residents to practice in rural settings. Residency in rural areas increases the likelihood clinicians will establish practices there after training. This could also be paired with proposed ladder payments to recruit for longer-term provider employment.

Main strategic goal: Workforce development

Uses of funds: E, G, H

Technical score factors: C.1, D.1

Key stakeholders: Junior high and high schools, pathway programs, post-secondary programs and institutions, career technical and professional education programs, professional associations, the five federally recognized Native nations in Idaho, hospitals, other healthcare and non-healthcare facilities, community-based organizations.

Outcomes:

- Increase the number of individuals completing a “learn in place” or “grow your own” program to at least 200 by December 2030.

- Increase the number of individuals completing a new fellowship program to at least 20 by December 2030.
- Increase the number of individuals completing a new residency program to at least 10 by December 2030.
- Increase the number of physicians per 100,000 individuals living in Idaho from 193 in 2023 to at least 195 by December 2030.

Impacted counties: 16003, 16005, 16007, 16009, 16011, 16013, 16015, 16017, 16019, 16012, 16023, 16025, 16027, 16029, 16031, 16033, 16035, 16037, 16039, 16041, 16043, 16045, 16047, 16049, 16051, 16053, 16055, 16057, 16059, 16061, 16063, 16065, 16067, 16069, 16071, 16073, 16075, 16077, 16079, 16081, 16083, 16085, 16087

Estimated required funding: $172,500,000 for five years

4. Implement population specific, evidence-based projects to Make America Healthy Again

This initiative will advance Idaho's rural health systems by implementing population-specific, evidence-based prevention and treatment programs that address chronic disease, behavioral health, and maternal and child health; and build local capacity for implementation and ongoing sustainability. To ensure long-term impact, all interventions will be based on proven models and supported by training, monitoring, and evaluation systems. Proposed use of funds:

- **Chronic disease prevention and treatment** to reduce incidence and improve management of chronic diseases through proven prevention, screening, and education programs accessible to rural populations. Plan to implement evidence-based programs that prevent, manage, and reduce the burden of chronic disease across rural Idaho. Partner with rural entities beyond traditional healthcare facilities such as faith-based organizations or local community organizations, to support prevention activities. *Expected outcomes:* Increased local capacity

for screening, early intervention, and patient self-management through community-based delivery models and partnerships. *Planned activities:*

- **National Diabetes Prevention Program (DPP):** Bring National DPP to additional communities to provide proven interventions that prevent or delay type 2 diabetes and reduce long-term healthcare costs.
- **Diabetes self-management education and support (DSMES):** Implement DSMES programs to help patients prevent complications and improve self-care and health.
- **Alzheimer's and related dementias:** Support development of dementia awareness materials and screening capabilities within rural provider entities. Leverage technology to support screening and improve early detection and proactive care planning for older adults and families who reside in rural areas.
- **Cancer, heart disease, and other chronic disease prevention programs:** Implement scalable, technology-based programs to promote sustainable habits to prevent chronic disease, which could include nutrition, activity, and other evidence-based programs.

- **Behavioral health prevention and treatment** to expand access to behavioral health services through integration into primary care, school-based programs, and mobile or telehealth-enabled crisis response. Funds will promote early intervention, coordinated treatment, and resilience-building. *Expected impact:* Improved continuum of care addressing prevention, crisis response, and treatment tailored to rural realities. *Planned activities*:
  - **Pediatric psychiatry access line (PPAL):** Support initial start-up costs to implement a PPAL. Idaho lacks a centralized resource for pediatric providers to consult with child psychiatrists on child behavioral health conditions. Given the state's shortage of child psychiatrists, pediatricians often are tasked with managing behavioral health conditions.

A PPAL will bridge that gap, empowering primary care physicians to identify and manage youth mental health conditions earlier and reduce unnecessary hospitalizations.

- **Mobile crisis response and MAT linkage:** Enhance mobile crisis response teams service to include post crisis linkage. This ensures individuals in crisis are connected to ongoing care. Advance medication assisted treatment (MAT), developing options that may include mobile medication services to reach underserved areas and reduce overdose.
- **Space for parent-selected behavioral health professionals** to support access to services through integration into school-based settings while mitigating disruption during the academic day. Rural families often must travel for mental health treatment, resulting in substantial disruption to a child's school day or absence of care. By providing or creating space at existing schools, parent-selected mental health professionals can come to the student, improving early learning and access to parent-selected care while reducing crisis episodes and class disruption. All activities will follow the Idaho Parental Rights Act, Idaho Code 32-1010.
- **Behavioral health prevention and education programming:** Partner with rural healthcare facilities, community organizations, including faith-based entities and houses of worship, to implement evidence-based mental health and substance use prevention and education programming. Programming will focus on self-sustaining models and integration within existing prevention and treatment services. Idaho's high suicide and substance use rates, which are particularly prevalent in rural counties, underscore the need for stronger prevention efforts.

- **Maternal and child health efforts** to strengthen maternal and perinatal care through implementation of evidence-based programs that improve maternal safety, enhance prenatal

and postpartum services, and coordinate community-based supports for mothers and infants. Many Idaho rural and frontier counties lack obstetric providers and birthing facilities. These shortages contribute to delayed prenatal care and preventable complications. *Expected outcomes:* Strengthen Idaho's capacity to deliver timely, high-quality prenatal, delivery, and postpartum care. *Planned activities:*

- **Complete statewide maternal and neonatal care assessment** to collect data and establish baseline understanding of the resources available across the state. Leverage assessment to prioritize funding and supports to close gaps in care.
- **Maternal and child health programs** to reduce differences in maternal outcomes in rural areas. Address leading causes of maternal mortality and morbidity. Support rural provider entity obstetric readiness for both birthing and non-birthing facilities and launch quality improvement initiative with an Obstetric Emergency Readiness Resource Kit to meet the CMS Obstetrical Services' Conditions of Participation.
- **Idaho Perinatal Quality Collaborative (IPQC) initiatives** to enhance IPQC participation into rural hospitals and clinics. The IPQC plays a vital role in improving outcomes for mothers and infants through data-driven quality improvement projects. Smaller and rural hospitals often lack the capacity to participate fully in statewide initiatives. Enhancing IPQC participation will ensure all rural hospitals benefit from evidence-based best practices to reduce severe maternal morbidity, prevent preterm births, and improve newborn outcomes. Program expansion will be limited to rural areas with new hospitals, new activities, and new milestones.

Main strategic goal: Make rural America healthy again

Uses of funds: A, C, D, E, F, G, H, I, K

Technical score factors: B.1, B.2, B.4, C.1, D.3, E.2, F.1, F.3

Key stakeholders: RHCs, CAHs, FQHCs, behavioral health clinics and providers, school systems, the five federally recognized Native nations in Idaho, primary care clinics, community-based organizations, including faith-based organizations and houses of worship.

Outcomes:

- Increase the percentage of individuals newly enrolled in a new or enhanced evidence-based chronic disease prevention or treatment program who reach program specific retention or completion milestones to at least 50% by December 2030.
- Increase the percentage of individuals enrolled in a new or enhanced evidence-based chronic disease prevention or treatment program who reach program specific clinical outcome measures (e.g., weight or blood pressure reduction) to at least 50% by December 2030.
- Increase the number of rural hospitals completing one or more new perinatal collaborative initiatives from zero to eight by December 2030.
- Decrease the number of deaths from suicide, drug overdose, and alcoholism by 25% from 1,216 in 2023 to 912 or fewer by December 2030.
- Decrease the number of monthly emergency department visits for suicidality, drug overdose, and alcoholism from 625 in September 2025 to 400 by December 2030.

Impacted counties: 16003, 16005, 16007, 16009, 16011, 16013, 16015, 16017, 16019, 16012, 16023, 16025, 16027, 16029, 16031, 16033, 16035, 16037, 16039, 16041, 16043, 16045, 16047, 16049, 16051, 16053, 16055, 16057, 16059, 16061, 16063, 16065, 16067, 16069, 16071, 16073, 16075, 16077, 16079, 16081, 16083, 16085, 16087

Estimated required funding: $75,000,000 for five years

5. Investing in rural health infrastructure and partnerships

This initiative aims to address sustainable access to rural healthcare through investments in rural health infrastructure and partnerships including Tribal rural health transformation support.

Proposed use of funds:

- **Healthcare facility renovations** tied to other Idaho RHTP initiatives. Initiatives 1, 3, 4 and 5 could require facility and equipment upgrades to support innovative care delivery, such as spaces and technology appropriate for telehealth services and evidence-based programs to MAHA. Funds could be used to support healthcare facility renovations that will allow for implementation of innovative care and accommodate specialized equipment. All funded projects would require financial viability/instability assessment and needs modeling.

  Expected impact: Modernization of healthcare facilities will allow for implementation of innovative care initiatives. *Planned activities:*

  - Once statewide assessment of technology gaps, needs, and readiness in rural healthcare facilities is complete in Initiative 1, identify and support space upgrades that will accommodate technology infrastructure.
  - Support renovations of areas within existing healthcare facilities to accommodate training and supervision of health extenders.
  - Support renovations of areas within existing healthcare facilities to facilitate deployment of evidence-based programs for chronic disease prevention and treatment, behavioral health (including programs serving individuals with co-occurring intellectual and developmental disabilities), dental services, and maternal and child health.
- **Pharmacy solutions** to enhance healthcare access in rural communities**.** Pharmacies play a key role in enhancing healthcare access in rural communities, often with extended hours,

where there may be no other healthcare providers. Clinical pharmacists can also play a critical role within healthcare clinics, such as medication reconciliation, review for dosing and safety, testing for common illnesses and conditions, prescribing for certain medications, and provision of medication for opioid use disorders (all allowed per Idaho law). Pharmacists can assist patients with obtaining medications for lower cost to the patient through medication-assistance programs. *Expected impact:* Enhancing role of pharmacies and pharmacists in rural areas will increase healthcare access in rural areas *Planned activities:*

  - Upgrade pharmacy facilities to create space for the practice of clinical pharmacy services within Idaho's allowable scope of practice for pharmacists.
  - Renovate areas within outpatient clinics to provide space for clinical pharmacists to provide consultation--either in person or via remote services.
  - Purchase pharmacy lockers in centralized community spaces from which patients can obtain medication refills without needing to be seen by a pharmacist or pharmacy technician or mail orders can be securely delivered.

- **Clinical equipment purchases** to help rural healthcare facilities offer more efficient, modernized services and generate ongoing revenue. Examples of equipment purchases that could be supported include remote monitoring equipment, pharmaceutical equipment for compounding pharmaceuticals, automated medication dispensing systems, lab equipment, cardiac catheterization lab equipment, dental chairs and dental equipment, imaging equipment such as mammography units, DEXA scanners, MRIs, CT scanners, and other imaging modalities. *Expected impact*: Decreased travel time for rural residents able to receive higher level services closer to home. Revenue generation for rural provider entities. *Planned activities*:

- Establish a process for soliciting requests for clinic equipment purchases and prioritize those that provide for modernized or enhanced services within rural areas. Leverage healthcare assessments outlined in other initiatives to prioritize and target areas for clinic equipment purchases.

- **Vehicles for patient transport and rural mobile health units** to bring services to rural areas with limited healthcare access. Lack of transportation can be a major barrier to healthcare access in rural areas. Enhance existing successful mobile unit models in Idaho, using retrofitted vehicles to deliver full primary, preventive, and basic urgent care services to rural communities, including point-of-care testing, and on-board EHR capabilities. Other services, such as mammography, can be offered via mobile units. In addition, certain services, such as obstetrics and certain specialty care (e.g., dialysis) require in-person service delivery. *Expected impact:* Addressing transportation barriers in rural communities will improve healthcare access. *Planned activities:*
  - Support rural clinics, hospitals, or other facilities to purchase and retrofit vehicles to enhance services to rural areas with limited healthcare access and for patient transport, including ambulances for emergency transportation.
  - Purchase mobile mammography units so mammograms can be offered in rural communities where mammography is not available.
  - Create partnerships with volunteer driver programs; shared emergency vehicle partnerships within regions; and ride coordination for ongoing transportation availability.
- **Bring all healthcare facilities into compliance with current federal, state, and local safety code** to ensure patients and providers are safe**.** Many Idaho rural provider entities, such as critical access hospitals, were built decades ago and need physical structure upgrades

to ensure patient and provider safety. *Expected impact*: Reduced risk of critical safety incidents. *Planned activities:*

  - Provide funds for Idaho rural healthcare facilities to support physical structure upgrades to bring them into compliance with current local, state, and federal safety codes.

- **Tribal rural health transformation support** to strengthen partnership and improve health outcomes for the five federally recognized Native nations residing in Idaho. A set-aside of three and a half percent of the total award has been proposed to support tribal RHTP goals and approved use of funds in alignment with the Idaho RHTP plan. *Expected impact:* Support for targeted investments for tribal healthcare facilities and efforts to transform the availability of services serving Native nations members residing in Idaho. *Planned activities:*
  - IDHW will request the five federally recognized tribes in Idaho to submit a coordinated proposal for use of the three and a half percent set-aside over the five-year period. The proposal will be required to align with this submitted application and Idaho's proposed use of funds and will be due by February 28, 2026.

Main strategic goal: Sustainable access

Uses of funds: A, E, G, I, J, K

Technical score factors: B.1., C.1, D.1., F.1 (if renovations tied to remote care services)

Key stakeholders: Healthcare systems and clinics, RHCs, CAHs, FQHCs, the five federally recognized Native nations in Idaho, and pharmacies

Outcomes:

- Each of the five federally recognized tribes in Idaho will implement an approved RHTP plan that aligns with Idaho's RHTP plan by December 2030.

- Increase the number of preventive screenings (e.g. mammograms) completed through new mobile service delivery units to 2,000 per year by December 2030.
- Increase the number of pharmacy sites using new pharmacy lockers/kiosks to one in each of seven rural counties by December 2030.
- Increase the 'Getting needed care' composite score on the federally required Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H, Adult Version (Medicaid) from 83.3% in 2024 to at least 90% by December 2030.

Impacted counties: 16003, 16005, 16007, 16009, 16011, 16013, 16015, 16017, 16019, 16012, 16023, 16025, 16027, 16029, 16031, 16033, 16035, 16037, 16039, 16041, 16043, 16045, 16047, 16049, 16051, 16053, 16055, 16057, 16059, 16061, 16063, 16065, 16067, 16069, 16071, 16073, 16075, 16077, 16079, 16081, 16083, 16085, 16087

Estimated required funding: $387,000,000 for five years

Implementation plan and timeline

Governance and project management structure: IDHW will serve as the lead state agency for the RHTP and will coordinate closely with Legislative leadership (including the Joint Finance and Appropriations Committee and germane committees for Health & Welfare), partner state agencies, private business, community organizations including faith-based organizations and houses of worship, Native nations, local stakeholders, and federal collaborators throughout the duration of the grant. Frequent communication, cross-agency alignment, and a clearly defined decision-making process will be essential to successful implementation, given the scope of changes that will occur in rural communities and across Idaho's healthcare system. IDHW will coordinate with a Governor's RHTP Task Force, which will serve as the primary advisory and stakeholder alignment body throughout the duration of the funding period. The task force will

meet quarterly throughout the grant period to review program milestones, provide feedback on key decisions, and help troubleshoot implementation challenges. Task force membership may include applicable state agencies, Legislative partners, Native nations, rural healthcare providers (rural healthcare facilities, EMS, behavioral health providers, etc.) and other key rural stakeholders.

To ensure strong internal coordination among engaged state agencies and branches of state government, IDHW will establish a structured governance and transparent communication model that includes:

- **Monthly interagency coordination meetings,** within IDHW and applicable agency divisions (e.g. Medicaid and Behavioral Health), and any supporting state agencies, boards, and councils.
- **Quarterly contractor coordination meetings**, beginning in Q3 2026, once vendor partners are procured.
- **Quarterly legislative report updates**, beginning in Q2 of 2026 (or earlier as directed) to be provided to the Idaho Legislature on overall progress, key milestones, expenditures, and compliance updates.
- **Annual public reporting on impacts, outcomes, and rural access measures** to be shared on the IDHW website and discussed at semi-annual stakeholder briefings.
- **Semi-annual public stakeholder briefings** to share progress, gather input, and maintain rural community trust and participation.
- **A formal decision-making framework** that defines roles, responsibilities, escalation pathways, and approval authority for all major implementation decisions and issue resolution.

Progress will be tracked quarterly, with milestone-based deliverables and continuous stakeholder engagement to ensure transparency, accountability, and sustained system transformation. Final program evaluation and close-out reporting will be completed in 2031.

IDHW will dedicate 15.0 full time employees to this program, the majority of which will be hired specifically for this project and on a temporary basis only through the funding period (See Office of Idaho Rural Health Transformation organizational chart in ID RHTP Other Supporting Documentation). Project management support and technical assistance vendors will be contracted in Q2-Q3 of 2026. IDHW will also seek contracted support for evaluation, data collection, outcome measurement, and financial reporting.

When initiating agreements tied to RHTP funds, IDHW will follow all Idaho procurement and contracting laws and federal requirements outlined in the Notice of Funding Opportunity (NoFO). Awards and subawards will also require that contractors comply with Idaho laws aligned with the Administration, including No Public Funds for Abortion Act, Idaho Code title 18, chapter 87; Idaho Code 67-7903 outlining lawful presence requirements; and anti-boycott or anti-ESG standards laws related to Israel, firearms, fossil fuel-based energy, timber, minerals, hydroelectric power, nuclear energy, and agriculture (Idaho Code 67-2346, 67-2347A); and others related to higher education (Idaho Code 67-5909D). Contractors must also verify they are not owned or operated by the government of China (Idaho Code 67-2359). Subaward solicitations will include program criteria as specifically called out in the NoFO and Idaho specific criteria in alignment with current Executive and Legislative branch actions and priorities. Criteria will include items such as full pricing transparency to patients, rural access guarantees, long-term fiscal discipline and sustainability beyond the 5-year funding period, ensuring funds do not duplicate or supplant existing programs or current funding streams, target

population alignment, feasibility within funding period, and direct impact on the health of Idahoans residing in rural communities. IDHW will partner with other state entities for subject matter expertise to support successful subaward solicitations such as the State Board of Education, Idaho Office of Information Technology Services, and the Idaho Workforce Development Council. All terms and conditions of the federal award will flow down to subawards, and contractors as specified in 2 CFR 200.101(b)(1).

Initiative timelines

Initiative 1: Improving rural access to care through technology

Stage	Key Activities	Milestones & Deliverables
2026 Stage 0-1	• Execute contracts and formalize partnerships • Conduct statewide technology readiness and facility assessments • Begin development of shared infrastructure strategy and interoperability based on CMS Interoperability Framework • Initiate cybersecurity baseline assessments	Q1–Q2: Contracts executed; statewide assessments launched Q3: Facility technology assessments completed; cybersecurity gap analysis initiated Q4: Shared infrastructure and interoperability roadmap and cybersecurity baseline finalized
2027 Stage 1	• Launch telehealth infrastructure enhancements (equipment, software) • Begin digital health and mobile app procurement • Implement cybersecurity upgrades • Begin Idaho Health Alert Network (HAN) system modernization • Initiate training programs for providers and IT staff	Q1–Q2: Telehealth equipment installed in first rural sites; digital tools released Q3: Cybersecurity upgrades implemented in pilot locations; first HAN modernization tasks completed Q4: Initial provider and IT workforce training completed
2028 Stage 2	• Establish regional telehealth networks and implement telepharmacy models • Begin health management software rollout • Deploy AI tools for revenue and care optimization • Launch emergency communication system upgrades (NG911)	Q2: Majority of rural sites live with telehealth/telepharmacy Q3: Population health and AI tools deployed in pilot facilities Q4: NG911 emergency communication upgrades launched

2029 Stage 3	• Evaluate early outcomes of telehealth and digital health tools • Enhance EHR upgrades and interoperability efforts • Scale health management data analytics • Continue cybersecurity monitoring and training	Q2: Midpoint evaluation report Q3: Multi-facility interoperability Q4: Achieved regional analytics dashboards deployed
2030 Stage 4	• Continue implementation of all tech solutions and data tools • Conduct usability assessments and adapt tools for local needs • Develop sustainability and maintenance models for infrastructure	Q3: 90% of targeted rural facilities using updated systems Q4: Maintenance and sustainability plans drafted
2031 Stage 5	• Conduct final program evaluation and reporting • Assess outcomes in care access, efficiency, cost, and quality • Disseminate findings and ensure sustainable post-grant transitions	Q2: Outcome data compiled and shared with stakeholders Q3: Technology systems transitioned to long-term management Q4: Final evaluation and impact report submitted

Initiative 2: Ensuring accessible quality care through innovative models

Stage	Key Activities	Milestones & Deliverables
2026 Stage 0-1	• Execute contracts and engage partners • Begin community needs assessments • Plan deployment of diagnostic kiosks, telehealth pods, and pharmacy access points • Development of curriculum for health extender certification programs	Q1–Q2: Contracts and needs assessments initiated Q3: Site selection for kiosks/pharmacy access points Q4: Community needs and healthcare assessment completed
2027 Stage 1	• Begin installation of diagnostic and telehealth infrastructure in community locations • EMS workgroup convened • Remote patient monitoring and pharmacy access solutions initiated • Hiring and training initial cohort of health extenders in rural communities	Q1: EMS support grants disbursed to high-need counties Q2: Diagnostic kiosks and telehealth pods live in pilot areas Q2-Q3: First cohort of health extenders working in the field
2028 Stage 2	• Enhance remote patient monitoring and pharmacy access solutions • Continue health extender recruitment and integration with healthcare partners • Begin building shared infrastructure (e.g., credentialing, prior authorization systems)	Q2: Remote monitoring systems integrated with local clinics Q3: Pharmacy lockers and mail-order services enhanced. EMS systems linked with local hospitals or data exchange platforms. Q4: Draft shared infrastructure models completed

2029 Stage 3	• Continue training and deploying health extenders in rural areas • Continue evaluation of diagnostic and community care models	Q2: Stakeholder feedback sessions held Q4: Midpoint evaluation of community-based access models completed
2030 Stage 4	• Enhance cross-training of health extenders • Support sustained integration of health extenders and remote care systems • Finalize EMS coverage maps and health extender optimization strategies	Q2: Expanded health extender roles and training completed Q4: County-level shared resource agreements finalized
2031 Stage 5	• Conduct final evaluation of initiative outcomes • Complete reporting on health access improvements, workforce impacts, and care quality • Transition successful models to long-term funding and oversight structures	Q4: Final reports submitted. Sustainability plans adopted for EMS, health extender, and diagnostic models

Initiative 3: Sustaining rural workforce with training, recruitment, and retention

Stage	Key Activities	Milestones & Deliverables
2026 Stage 0-1	• Finalize contracts and partnerships • Develop program infrastructure, requirements, and outreach plans • Pilot healthcare career exploration and recruitment efforts • Begin Graduate Medical Education (GME) planning and program development.	Q1: Contracts signed Q2: Program guidelines and payment structure finalized Q4: Initial pilot programs launched in selected rural communities Q4: Sites selected for GME expansion
2027 Stage 1	• Launch preceptorships and apprenticeships • Enhance outreach and student engagement efforts • Continued GME program development, instructor hiring, etc. • Implement retention bonuses, recruitment incentives, and scholarships • Launch rural residency expansions and nursing education cohorts • Initiate “grow your own” programs	Q2: First cohort recruited and deployed Q3: Career exploration programs active statewide. Preceptorships active in rural sites. Fellowship and residency active
2028 Stage 2	• Fellowship and residency programs launch in rural settings • Enhanced mentorship, training, and career pathway support • Intensify recruitment incentives, retention bonuses, and scholarships	Q1: First cohort in Year 1 of service Q2: GME programs begin training clinicians in rural areas Q4: Mentorship and supervisor incentives disbursed

2029 Stage 3	• Midpoint program evaluation • Adjust program design as needed • Enhance partnerships and training pathways • Continue incentive distributions • Enhance training and career advancement • Strengthen "grow your own" programs • Evaluate recruitment and retention impacts	Q2: Interim evaluation completed and adjusted program guidelines issued Q3: Workforce pathway strengthened Q4: 2-year retention bonuses disbursed to early cohort
2030 Stage 4	• Continue implementation and refinement • Plan for sustainability and post-grant transition • Ongoing incentive and training delivery	Q2: Long-term sustainability strategy drafted Q4: 4-year retention bonuses disbursed and annual reporting to stakeholders
2031 Stage 5	• Final reporting and program closeout • Evaluate outcomes and impact • Disseminate findings and support transition to permanent programs	Q1: Final cohort recruited Q3: Results shared with state leaders and partners Q4: Final evaluation and impact report completed

Initiative 4: Implementing population specific, evidenced-based projects to MAHA

Stage	Key Activities	Milestones & Deliverables
2026 Stage 0-1	• Contract award and kickoff • Establish partnerships • Finalize program protocols • Develop data systems • Launch initial programs (NDPP, Pediatric Psychiatry Access Line) • Start training and certification programs	Q1: Contracts executed Q2: Initial programs launch Q4: Training programs initiated
2027 Stage 1	• Scale chronic disease and mental health programs • Collect baseline data	Q2: Program enrollment increased Q4: First data reports
2028 Stage 2	• Conduct mid-project evaluation • Adjust program strategies • Deepen community engagement • Enhance prevention programs	Q2: Midpoint evaluation report Q3: Program modifications implemented Q4: Enhanced service coverage
2029 Stage 3	• Develop sustainability plans • Enhance data-driven decision making	Q2: Sustainability plan drafted Q4: Improved health indicators
2030 Stage 4	• Complete program delivery • Conduct long-term outcome evaluation • Prepare final reports • Transition ownership to local/state entities	Q2: Final evaluation completed Q4: Reports submitted
2031 Stage 5	• Complete administrative closeout • Public dissemination of outcomes • Document lessons learned	Q2: Closeout documentation Q3: Public briefing Q4: Knowledge dissemination completed

Initiative 5: Investing in rural health infrastructure and partnerships initiative

Stage	Key Activities	Milestones & Deliverables
2026 Stage 0	• Execute contracts and engage healthcare facility and partner stakeholders • Begin facility and infrastructure needs assessments • Develop application and prioritization process for renovations, equipment, and vehicle requests • Work with five federally recognized Native nations in Idaho to submit a coordinated proposal for use of the three and a half percent set-aside over the five-year period.	Q1: Contracts signed, and grant governance structure established. Native nations proposals reviewed and accepted. Q2: Facility needs assessment framework finalized Q3: Application process for infrastructure upgrades launched
2027 Stage 1	• Begin disbursing funds for renovations • Launch pharmacy facility upgrades and clinical pharmacy integration projects • Initiate purchase of clinical equipment and safety code compliance grants • Develop GME and health extender training space renovation plans • Deploy mobile health units and patient transport vehicles	Q1: First round of facility renovations Q1: Mobile health services launched in underserved areas Q2: Transport vehicles deployed Q2: Pharmacy upgrade and locker installations started, and equipment purchase requests reviewed and approved Q4: Mini grants for safety code compliance disbursed
2028 Stage 2	• Implement and evaluate upgraded training and telehealth spaces • Continue supporting pharmacy access and chronic disease program space renovations	Q3: Renovated telehealth/training areas in use Q4: Pharmacy renovations and medication access programs enhanced
2029 Stage 3	• Monitor implementation progress and gather facility-level impact data • Provide technical assistance for sustained maintenance of infrastructure and equipment • Continue partnership development	Q2: Midpoint program review and progress report completed Q3: Technical assistance plans delivered to grantees.
2030 Stage 4	• Optimize infrastructure and equipment utilization across facilities • Identify lessons learned and best practices • Support long-term planning for sustainability and facility maintenance post-grant	Q1: Infrastructure and clinical asset utilization review completed Q3: Long-term maintenance and sustainability models developed Q4: Final round of mini grants issued
2031 Stage 5	• Conduct final evaluation of infrastructure investments and partnerships • Complete reporting on access, service expansion, and safety improvements	Q1: Final impact and outcomes report submitted Q2: Summary of service expansion and access improvements completed Q4: Recommendations shared with state policymakers and stakeholders

	• Disseminate outcomes and recommendations for future rural health infrastructure planning	

Stakeholder engagement

Rural stakeholder input in planning Idaho's RHTP: Under the leadership of the Governor's Office, IDHW is committed to transforming rural healthcare through sustainable, collaborative, and data-driven partnerships. To inform Idaho's RHTP plan, IDHW conducted a statewide public and stakeholder input survey from September 5–30, 2025, prior to CMS's release of the NoFO. The survey gathered input on rural healthcare challenges, funding priorities across the nine NoFO areas, hospital financial risk, regional care gaps, and strategies for sustaining rural providers. Respondents also offered general feedback on how Idaho should prioritize RHTP investments. The survey was broadly distributed through IDHW's internal and external partner networks, website, social media, and statewide media channels. IDHW received over 500 responses and 200 proposed concepts. Respondents included healthcare associations, nonprofits, RHCs, CAHs, FQHCs, primary care and behavioral health providers, dental providers, rural hospitals, independent clinics, educational institutions, Native nations, local governments, and members of the public. All 44 Idaho counties were represented. IDHW also held two formal Tribal Consultations with tribal leaders and held several meetings with tribal health leaders. Consultation and meetings aimed to provide an opportunity for IDHW to share information on the RHTP grant and the use of funds with tribal leaders, share public survey results, gather input on tribal member healthcare concerns, challenges, and their specific needs to transform care for tribal members specific to each individual tribe. As noted in the above section, Idaho has proposed a three and a half percent set-aside to support targeted efforts supporting the federally recognized Native nations in Idaho.

Survey findings informed the development of Idaho's five RHTP initiatives, related activities, infrastructure needs, and partnerships. Prior to submission, IDHW shared these initiatives with legislative leadership to ensure alignment with state priorities. Governor Little reinforced this collaboration by issuing an Executive Order in October 2025 establishing an RHTP Task Force, including representatives from the Legislature, State Board of Education, Workforce Development Council, Military Division, Tribal governments, and IDHW, to review and refine proposed fund uses. The pre-submission Task Force met several times in late October 2025 to finalize recommendations.

Idaho RHTP stakeholder engagement framework: Sustained stakeholder engagement is central to Idaho's RHTP. Through both statewide and regional approaches, IDHW will ensure ongoing input from rural communities, fostering long-term collaboration and system sustainability.

The Governor's RHTP Task Force will guide Idaho's five initiatives, strengthen regional partnerships, and maintain alignment with local needs. Task Force members will include legislators from rural districts, the Idaho Behavioral Health Council, Tribal representatives, and key IDHW staff (e.g., State Medicaid Director, Office of Rural Health, Tribal Liaison).

Building on Idaho's strong foundation of regional collaboration, RHTP will formalize three Regional Rural Health Transformation Networks (RHTNs) by leveraging existing structures:

- **The Hospital Cooperative (THC)**: The mission of THC is to strengthen regional healthcare by providing support and increasing value to members through shared resources, knowledge and information. With guidance from an executive board of 17 hospital leaders, in southern and eastern Idaho, the staff members of THC plan and organize programs and activities that enable member hospitals to accomplish more together than would be possible alone and will play a vital role in driving economies of scale and supporting financial sustainability.

- **Northwest Hospital Alliance (NHA)**: NHA is a collaborative network of CAHs, established in 1991, including eight in northern Idaho such as Clearwater Valley Health, St. Mary's Health, and Syringa Hospital and Clinics. NHA strengthens the capacity of Idaho's rural hospitals to provide high-quality, cost-effective care to their communities. The Idaho RHTP will collaborate with NHA-participating facilities to enhance quality improvement tools and telehealth infrastructure.
- **CAH integrated networks:** Informal CAH networks across Idaho engage in peer learning, shared staffing, and emergency preparedness.
- **Idaho Healthcare Coalitions:** These healthcare coalitions comprise representatives from healthcare (e.g., hospitals, health systems, healthcare facilities), EMS, patient transport services, and public health. Additional acute care members may include medical supply chain organizations, pharmacies, blood banks, clinical labs, federal healthcare organizations, outpatient care centers, and long-term care facilities.

These regional and strategic partnerships have demonstrated success in fostering rural collaboration, operational efficiency, shared service delivery, and community preparedness. They represent both a county level and boots on the ground perspective on an ongoing basis. The newly formed RHTNs, will have quarterly meetings and will be formalized with community-based governance and accountability and promote regional strategic partnerships and collaboration opportunities to drive measurable improvements and sustainability within all five of Idaho’s RHTP initiatives. These regional and strategic partnerships will be central to Idaho’s RHTP strategy to optimize cost savings through joint purchasing, share clinical and operational best practices, coordinate regional workforce development, invest in IT infrastructure and data analytics, and align on quality metrics and shared outcomes.

Key activities of Regional Rural Health Transformation Networks:

- **Information sharing and data use agreements:** Establish interoperability and population health data sharing to enable coordinated, outcomes-focused care.
- **Joint training and workforce support:** Help facilitate and scale rural workforce development strategies, including preceptorships, cross-training, and support for community health workers and rural fellowship and residency programs.
- **Group purchasing and financial optimization:** Enhance cooperative purchasing power to improve financial resilience of rural providers.
- **Referral coordination:** Implement closed-loop referral systems connecting primary, specialty, behavioral health, and social services.
- **Telehealth expansion:** Broaden virtual care options for chronic care management, behavioral health, and specialty services, especially in remote areas.
- **Integrated care planning:** Foster adoption of team-based care and flexible care models that shift services to lower-cost, high-value settings.

These coordinated efforts will promote best practices for sustainable access, innovative care delivery, and ensure rural providers are equipped to meet evolving community health needs.

Governance structure and community reflection: The three regional RHTNs will report to the Governor's RHTP Task Force, which will provide statewide oversight, fund allocation guidance, and ensure program accountability. This governance structure ensures decisions reflect the voices of rural communities and elevate both provider and patient perspectives in the transformation process. To maintain transparency, coordination, and accountability, Idaho will include the following with its formal stakeholder engagement process:

- **Quarterly forums** for ongoing public input and responsiveness.

- **Specialized workgroups** focused on technology, workforce, tribal collaboration, and behavioral health.
- **Regional patient advisory panels** to guide community-centered care models.

This engagement structure fosters co-ownership of the transformation process, helps align local innovations with state-level goals, and promotes community voice in all program phases.

Leveraging IT and data infrastructure: A critical enabler of Idaho's RHTP is the expansion and coordination of practical, scalable, and secure data-sharing infrastructure to support care coordination, chronic disease management, and population health improvement. Rather than building entirely new systems, Idaho will leverage the infrastructure, expertise, and collaborative frameworks already in place across hospital cooperatives, CAH networks, and regional partners. To ensure feasibility and local ownership, the responsibility for implementing and maintaining IT and data solutions will rest primarily with Idaho's integrated networks—including the THC, CAH networks, and RHTNs. These networks are best positioned to tailor digital solutions to their regional workflows, provider capabilities, and patient needs.

Ongoing coordination and collaboration: To appropriately support and coordinate statewide efforts as part of this funding opportunity, IDHW will create a time-limited, project-specific team to report through the agency Director's Office. Individuals hired will be limited-service staff, brought on specifically for the five years. This team will oversee the entirety of the RHTP, associated agreements, contract oversight, reporting, communications, and coordinate with internal agency divisions and other state agency partners as needed. The agency is also proposing to hire limited-service staff positions for additional contract, procurement, and financial audit and reporting support.

Idaho will build upon its existing strengths—hospital cooperatives, integrated CAH networks, academic partnerships, and grassroots engagement—to create a modern rural health system that is sustainable, community-driven, and outcome-oriented. By aligning statewide priorities with regional solutions, and by investing in infrastructure, technology, and workforce, Idaho will successfully lead rural health transformation and ensure that every Idahoan—no matter where they live—can access high-quality, affordable, and coordinated care (See Letters of Support in ID RHTP Other Supporting Documentation).

Metrics and evaluation plan

Idaho plans to evaluate the impact of selected initiatives through a combination of in-house evaluation and formal third-party evaluation implemented in cooperation with contracted evaluators. Idaho will also cooperate with any CMS-led evaluation or monitoring, providing requested data and findings in the formats and timelines agreed upon. The tables below outline the metrics planned to evaluate each initiative.

Initiative 1: Improving rural access to care through technology

1A: Telehealth capabilities	
Description	Number of facilities utilizing telehealth.
Baseline	Unknown
Target	Increase by 50% over baseline by December 2030
Data Collection	A telehealth utilization assessment will be designed and implemented at least bi-annually throughout the funding period. Anticipated scope of participation would include critical access hospitals, rural health clinics, federally qualified health centers and other healthcare providers in Idaho's rural counties.
Data Analysis	Run Chart Analysis
Responsibility	Contractor
1B: Health Alert Network (HAN) provider participation	
Description	Number of physicians connected to the new HAN located in each of Idaho's rural counties divided by total number of physicians located in each of those rural counties.
Baseline	0
Target	Increase to 80% by December 2030

Data Collection	IDHW will manage the Health Alert Network and keep a running contact list. Data will be pulled and analyzed quarterly. Data on total number of doctors will be obtained from the Idaho Board of Medicine.
Data Analysis	Run Chart Analysis
Responsibility	IDHW program staff
1C: Electronic Health Record (EHR) upgrades	
Description	Number of facilities implementing new EHR software, or updating existing EHR software that is not yet HITECH certified
Baseline	0
Target	Increase 10 facilities by December 2030
Data Collection	Funded partners will report quarterly using a standardized subgrant monitoring report template on progress and challenges with EHR upgrades.
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
1D: Use of telehealth or remote delivery modalities	
Description	Number of appointments completed using telehealth or remote delivery modality
Baseline	Unknown
Target	Increase by 50% over baseline by December 2030
Data Collection	A telehealth utilization assessment will be designed and implemented at least bi-annually throughout the funding period. Anticipated scope of participation would include critical access hospitals, rural health clinics, federally qualified health centers and other healthcare providers in Idaho's rural counties.
Data Analysis	Run Chart Analysis
Responsibility	Contractor

Initiative 2: Ensuring accessible, quality care through innovative models

2A: Integration of Community Health Emergency Medical Services (CHEMS)	
Description	Number of CHEMS positions supporting Idaho's rural counties
Baseline	26 as of October 2025
Target	Increase to at least 62 (assumes maintenance of existing capacity with added target of at least one additional CHEMS position supporting the 36 rural counties that do not currently have CHEMS implemented).
Data Collection	Funded partners will report quarterly on progress and challenges with establishment of new CHEMS positions by using a standardized subgrant monitoring report template.
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
2B: EMS personnel capacity	
Description	Percentage of Idaho's rural counties with at least one county-level full-time equivalent paid EMS personnel
Baseline	28% (13 of 43 rural counties and counties with rural census tracts)

Target	Increase to at least 97% (42 of 43 rural counties and counties with rural census tracts)
Data Collection	Funded partners will report quarterly on progress and challenges with establishment of new paid EMS positions and their locations by using a standardized subgrant monitoring report template.
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
2C: Potentially Preventable Emergency Department Visits	
Description	Rate of emergency department (ED) visits for ambulatory care sensitive conditions (nine types of conditions that should typically be addressed outside of an ED) out of total number of ED visits in Idaho's rural counties
Baseline	30,779.2 per 100,000 ED visits (median rate from past 24 months as of October 2025)
Target	Decrease by 20% to less than 24,623.3 per 100,000 by December 2030
Data Collection	Data from CDC's BioSense platform will be queried and analyzed monthly
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
2D: Repeat EMS emergency responses	
Description	Percentage of EMS emergency responses to repeat users (those who received emergency services [excluding CHEMS visits] more than once in a year)
Baseline	32% (2013–2016 estimate)
Target	Decrease to 10% or less per year by December 2030
Data Collection	Data from Idaho's EMS service providers will be collated and analyzed at least biannually.
Data Analysis	Run Chart Analysis
Responsibility	Contractor

Initiative 3: Sustaining rural workforce with training, recruitment, and retention

3A: Completion of "learn in place" or "grow your own" programs	
Description	Number of individuals completing a "learn in place" or "grow your own" program
Baseline	0
Target	Increase to 200 by December 2030
Data Collection	Funded partners will report quarterly on progress and challenges helping individuals complete "learn in place" or "grow your own" programs by using a standardized subgrant monitoring report template.
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
3B: Completion of fellowship programs	
Description	Number of individuals completing a new fellowship program
Baseline	0
Target	Increase to 20 by December 2030

Data Collection	Funded partners will report quarterly on progress and challenges helping individuals complete new fellowship programs by using a standardized subgrant monitoring report template.
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
3C: Completion of residency programs	
Description	Number of individuals completing a new residency program
Baseline	0
Target	Increase to 10 by December 2030
Data Collection	Funded partners will report quarterly on progress and challenges helping individuals complete new residency programs by using a standardized subgrant monitoring report template.
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
3D: Ratio of physicians per 100,000 population	
Description	Number of physicians per 100,000 Idaho residents.
Baseline	193 in 2023
Target	Increase to at least 195 by December 2030
Data Collection	The U.S. Physician Workforce Data Dashboard hosted by the Association of American Medical Colleges (AAMC) publishes this statistic annually. Data can be stratified by specialty type
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff

Initiative 4: Implementing population specific, evidence-based projects to Make America Healthy Again

4A: Retention or completion of evidence-based prevention or treatment programs	
Description	Percentage of newly enrolled individuals in new or enhanced evidence-based prevention or treatment programs who reach program specific retention or completion milestone
Baseline	0
Target	Increase to at least 50% by December 2030
Data Collection	Funded partners will report quarterly using a standardized subgrant monitoring report template on progress and challenges retaining individuals in identified programs
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
4B: Clinical Outcome Measure(s) for Chronic Disease Prevention Programs	
Description	Percentage of individuals enrolled in new or enhanced evidence-based prevention or treatment programs who reach program specific clinical outcome measure (e.g., A1c, weight reduction, hypertension control)
Baseline	0
Target	Increase to at least 50% by December 2030

Data Collection	Funded partners will report quarterly on progress and challenges reaching desired clinical outcomes for identified programs by using a standardized subgrant monitoring report template
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
4C: Implementation of Perinatal Collaborative Initiatives	
Description	Number of rural hospitals completing one or more new perinatal collaborative initiatives
Baseline	0
Target	Increase to eight hospitals by December 2030.
Data Collection	Funded partners will report quarterly using a standardized subgrant monitoring report template on progress and challenges reaching desired clinical outcomes for identified programs
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
4D: Mental and Behavioral Health Initiatives Mortality Rate	
Description	Number of deaths from suicidality, drug overdose, and alcoholism
Baseline	1,216 in 2023
Target	Decrease by 25% to 912 or fewer by December 2030.
Data Collection	Data from IDHW Vital Records will be queried and analyzed annually with variables looked at individually and in aggregate.
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
4E: Mental and Behavioral Health Initiatives Morbidity Rate	
Description	Number of ED visits from suicidality, drug overdose, and alcoholism
Baseline	625 monthly visits (from September 2025)
Target	Decrease to 400 or fewer by December 2030.
Data Collection	Data from CDC's BioSense platform will be queried and analyzed monthly (in aggregate and by each individual visit type)
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff

Initiative 5: Investing in rural health infrastructure and partnerships

5A: Partnership with Tribes in Idaho	
Description	Each of the five federally recognized tribes in Idaho will implement an approved RHTP plan that aligns with Idaho's RHTP plan
Baseline	0
Target	Increase to five by December 2030
Data Collection	Tribes will report quarterly on progress and challenges in implementing approved RHTP activities by using a standardized subgrant monitoring report template.
Data Analysis	Trend Analysis and Qualitative Synthesis
Responsibility	IDHW Program Staff

5B: Mobile Service Delivery	
Description	Number of screenings completed through new mobile service units
Baseline	0
Target	Increase to 2,000 screenings per year by December 2030
Data Collection	Funded partners will report quarterly on progress and challenges in operationalizing new mobile service units by using a standardized subgrant monitoring report template
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
5C: Pharmacy Lockers/Kiosks	
Description	Number of pharmacy sites using new pharmacy lockers/kiosks
Baseline	0
Target	Increase to one in each of seven rural counties by December 2030
Data Collection	Funded partners will report quarterly on progress and challenges in operationalizing pharmacy lockers/kiosks by using a standardized subgrant monitoring report template
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff
5D: Patient Experience	
Description	The annual Medicaid CAHPS Health Plan Survey 5.1H, Adult Version (Medicaid) includes a composite value for "Getting needed care" that combines responses from two questions regarding how easily respondents got various aspects of needed care
Baseline	83.3% in 2024
Target	90% by December 2030
Data Collection	The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is implemented annually and provides patient experience data for a representative sample of Idahoans in several categories. These data will be reviewed annually.
Data Analysis	Run Chart Analysis
Responsibility	IDHW Program Staff

Sustainability plan

Sustainability is at the heart of Idaho's vision to Make Rural Idaho Health Again – a future where communities are empowered, resilient and equipped to maintain high-quality healthcare without long-term dependence on federal or state support. This plan was deliberately designed as a one-time investment that creates enduring capacity, not continuing obligation. Sustainability is defined not only by the continuation of services but by the creation of systems that are

accountable, efficient, and locally-owned. Each RHTP initiative includes explicit deliverables tied to long-term viability, financial self-reliance, and measurable outcomes. Contracts and subgrants will include sustainability milestones, with required performance and fiscal reporting. Projects that fund personnel or operating costs will follow a graduated scale-down model, reducing dependency each year, so that by Year 5, local partners, health systems and community organizations are positioned to sustain operations independently through new reimbursement streams, local partnerships, and demonstrated efficiency gains.

Key sustainability strategies include:

- **Shared Infrastructure and Economies of Scale:** Investments in telehealth, data systems, and cybersecurity are structured to serve multiple facilities and communities, minimizing overhead and maximizing long-term utility.
- **Revenue and Reimbursement Transition:** IDHW will work with Medicaid, private insurers, and rural providers to establish sustainable payment mechanisms and improved billing supports – ensuring continuity after federal funding concludes.
- **Accountability and Transparency:** Each funded entity will report quarterly on cost savings, outcomes, and operational transitions using standardized run-chart analysis and third-party validation, where appropriate, to ensure credible tracking of results.
- **Local Ownership and Workforce Stability:** Workforce programs and facility upgrades are structured to create self-reinforcing local capacity – training, retraining, and supporting providers who will remain part of rural Idaho's long-term health ecosystem.
- **Policy and Data Alignment:** IDHW will coordinate annual legislative and administrative reviews to align regulatory frameworks with sustainability goals, ensuring state policy supports data- driven accountability and fiscal prudence.

1. **Improving rural access to care through technology**

- **Technology infrastructure, telehealth and digital health tools:** Build shared technology infrastructure and ongoing costs among rural provider entities to leverage economy of scale and reduce duplication and costs. Rural provider entities offering a greater array of available services via telehealth digital health tool utilization, will increase revenue generation through already reimbursable services across payers. Evaluate additional opportunities for near-future innovative, sustainable telehealth reimbursement models.
- **Cybersecurity and AI tools:** Use AI-driven monitoring to strengthen data security through early threat detection and guide efficient spending. Require policy reviews to ensure accountability for any cybersecurity or AI-generated actions. Support revenue generation via AI tools to support future provider funded updates to cybersecurity platforms.
- **Emergency communication systems:** Fund one-time implementation of emergency communication network, then maintain through existing local and state funding streams.
- **Health management, data analytics tools, and electronic health record software and upgrades:** Identify opportunities for shared infrastructure costs among healthcare facilities and improve interoperability between systems. Leverage data analytics tools to support value-based contracts, risk stratification, and revenue maximization for rural provider entities to support any ongoing costs and future updates.

2. **Ensuring accessible quality care through innovative models**

- **Community-based access models:** Transition community-placed telehealth pods, diagnostic kiosks, pharmacy kiosks and other health extenders to local ownership and maintenance by Year 5 through reimbursement revenue and regional cost-sharing agreements. Complete

third-party evaluation to (including post-discharge and readmission data) to determine return on investment and opportunities for further optimization.

- **EMS integration and expansion; workforce stabilization; community needs assessment; and service optimization:** Sustain EMS stabilization and training programs through local levy partnerships, hospital networks, and cross-training of existing staff to reduce duplication and long-term costs. Opportunities to bill payers will be explored and leveraged as appropriate.

3. **Sustaining rural workforce with training, recruitment, and retention**

- **Ladder payments for priority positions and rural presence:** Provide time-limited support tied to workforce placement in high-need areas with service requirements that exceed support sunset. Sustain beyond grant period through new billing and revenue capacity.
- **Healthcare career and work-based learning:** Use funds for start-up development only; transfer ongoing operation to local healthcare partners supported by foundations or employers, and post-secondary education institutions utilizing program prioritization to limit or eliminate need for ongoing state support.
- **Graduate medical education programs:** Build GME capacity that self-sustains through resident billing and long-term provider retention.

4. **Implementing population specific, evidenced-based projects to MAHA**

- **Prevention and treatment programs:** Launch chronic disease, behavioral health and maternal-child health initiatives with initial start-up costs such as training curriculum and train-the-trainer models; sustain through insurance reimbursement and integration into provider operations.

5. **Investing in rural health infrastructure and partnerships initiative**

- **Facility and equipment upgrades:** Fund one-time capital improvements – facility and personnel space remodels, vehicles, mobile units, and pharmacy solutions – and equipment purchases paired with local plans for upkeep and replacement.
- **Regional partnerships:** Strengthen networks such as the Northwest Hospital Alliance and The Hospital Cooperative to share services and leverage economies of scale for long-term sustainability.

Partnership sustainability

The RHTP, established though the One Big Beautiful Bill and HR1, has served as a significant catalyst in advancing collaboration among Idaho's rural health partners and stakeholders. While strong partnerships previously existed, RHTP will further enhance coordination, alignment, and collective positive impact across the state. The development of RHTNs will further bridge and strengthen partnerships, fostering greater commitment and sustainability among rural communities. These strengthened connections, combined with the foundation established through the Governor's RHTP Task Force, will ensure ongoing collaboration and long-term sustainability—ultimately improving access to and the delivery of quality healthcare for citizens throughout rural Idaho.

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