Project Narrative - Alabama

The Alabama Rural Health Transformation Program (ARHTP) is a catalyst to ignite transformational change to Alabama's healthcare delivery system. Specifically, ARHTP targets improvements to healthcare access, healthcare quality, and health outcomes for the over 1.6 million Alabama citizens who live in one of the state's 58 rural counties.[i] The funding and investments promised by Congress and the Trump Administration are significant and needed, but even more importantly, ARHTP represents a comprehensive strategy of state policy reforms, innovative startup healthcare initiatives, expansions of proven methods, and a general retooling of healthcare services delivery in Alabama.

With guiding principles of transformation, sustainability, and accountability, ARHTP will improve health outcomes in Alabama and achieve key focuses of the Rural Health Transformation Program (RHTP): promoting innovation, fostering strategic partnerships, enhancing infrastructure development, and bolstering workforce investment. The initiatives within ARHTP will also accomplish each of the RHTP's strategic goals to make rural America healthy again, develop more sustainable access to care, achieve meaningful workforce development, spark innovative care, and deploy needed tech innovation.

Each year, rural Alabama's deteriorating healthcare system contributes to worsening health and economic stability. Rural healthcare facilities are closing and losing important specialty services due to declining populations, diminishing health literacy and nutrition awareness, increasing costs, and the inability to recruit and retain qualified physicians and other healthcare professionals. Alabama's private insurance reimbursement rates are among the lowest in the nation; many Alabamians are uninsured or underinsured; and access barriers, including residential proximity to

healthcare facilities and emergency transportation shortages, all compound the unsustainable financial condition of rural Alabama healthcare facilities.

Health metrics in Alabama trail national benchmarks: chronic diseases, including diabetes, hypertension, and heart disease, and cancer prevail at higher rates than in most states; infant and maternal mortality are higher than national averages; and behavioral health crises, including substance use disorders, intensify amid provider shortages. Without transformative change, these and other health indicators will continue to decline.

Despite the current trajectory of Alabama's rural healthcare ecosystem, higher quality care and improved health outcomes are within reach for Alabama's 1.6 million rural citizens.[ii] The ARHTP will stabilize essential services, strengthen provider networks, expand healthcare access through innovative telehealth/teleconsulting and reimagined workforce pipelines that bring services and training directly to rural communities, and redesign rural health delivery systems around modern community needs. It will target key populations, including rural low-income families, elderly citizens, pregnant women and their children, chronic disease patients, deserving veterans, and individuals in medically underserved areas. Coupled with targeted investments and intentional policy reforms, Alabama—and specifically, rural Alabama—will achieve a sustainable system of healthcare delivery and a healthier population.

Famed American author and poet Maya Angelou stated, "If you don't know where you've come from, you don't know where you're going." This introduction and the following data help describe the current status of rural healthcare in Alabama. The ARHTP tells the success story of where it is going.

Table I – Acronyms and Shorthand	
Acronym/Shorthand	**Definition**
AANP	American Association of Nurse Practitioners
ACHN	Alabama Coordinated Health Network
ADECA	Alabama Department of Economic and Community Affairs
ADPH	Alabama Department of Public Health
ALOHR	Alabama One Health Record ®: Alabama's health information exchange system
ARHTP	Alabama Rural Health Transformation Program
ASHS	Alabama School of Healthcare Sciences
BME	Alabama Board of Medical Examiners
BREMSS	Birmingham Regional Emergency Medical Services System
CAH	Critical Access Hospital
CCBHC	Certified Community Behavioral Health Clinic
CHPL	Certified Health Information Technology (IT) Product List
CLIA	Clinical Laboratory Improvement Amendments
CME	Continuing Medical Education
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
COACHES	Community Healthcare Education Simulation (at Children's Hospital of Alabama)
CT	Computed Tomography
DHR	Alabama Department of Human Resources
DSH	Disproportionate Share Hospital (in context: Medicaid DSH payments)
D-SNP	Dual Eligible Special Needs Plan
ED	Emergency Department
EMR/EHR	Electronic Medical Record/Electronic Health Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
FIPS	Federal Information Processing Standards code
FM-OB	Family Medicine-Obstetrics
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
HIE	Health Information Exchange
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IMLC	Interstate Medical Licensure Compact
L&D	Labor and Delivery
LPN	Licensed Practical Nurse
LEA	Local Education Agency
Med/Surg	Medical-Surgical Nursing
NLC	Nurse Licensure Compact

NOFO	Notice of Funding Opportunity (in reference to RHTP)
OB-GYN	Obstetrician-Gynecologist
OMB	Office of Management and Budget
PA	Physician Assistant
PACE	Program of All-Inclusive Care for the Elderly
PSYPACT	Psychology Interjurisdictional Compact
REH	Rural Emergency Hospital
RFP	Request for Proposal
RN	Registered Nurse
RPM	Remote Patient Monitoring
SNAP	Supplemental Nutrition Assistance Program
SPL	State of Principal License (for IMLC)
STEMI	ST-Elevation Myocardial Infarction
STLDI	Short-Term, Limited-Duration Insurance
T-MSIS	Transformed Medicaid Statistical Information System
TMaH	Transforming Maternal Health grant
UAB	University of Alabama at Birmingham
USA Health	University of South Alabama Health
USDA	United States Department of Agriculture
OBA	Outcome-Based Assessment
FIR Division	Federal Initiatives and Recreation Division (of ADECA)
IME	Indirect Medical Education (IME adjustments referenced for sustainability)

I. Rural Health Needs and Target Population

Approximately 32 percent of Alabama's population, over 1.6 million citizens, live in rural counties. These communities experience persistent disparities in income, health outcomes, and healthcare access compared with their urban counterparts.[iii] Rural residents have higher rates of chronic diseases, higher uninsured/underinsured rates, and lower healthcare accessibility, especially for maternity, emergency, and specialty care services.

Criteria for Identifying Rural Areas

Alabama Medicaid and the Alabama Department of Public Health (ADPH), in October 2025 calculated Alabama's rural population and rural counties using census tracts defined as rural by the Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy. HRSA classifies 58 of 67 counties as rural, fully or partially, representing approximately 1.6 million citizens.[iv] Per the requirements of the Notice of Funding Opportunity (NOFO), this application identifies rural areas according to the HRSA definition. The data included in this application was developed by various sources, including ADPH, each which may have relied on different definitions of rural at different points in time.[v] As a result, not all statistics are based on the 58 counties and 1.6 million residents identified above.

Data Overview

Rural demographics:

- *Rural Counties:* 58 of 67 counties in 2025 were considered rural or partially rural.[vi]
- *Population:* 1,613,122 people or 32 percent of Alabamians live in rural areas.[vii]
- *Population density:* Approximately 99.2 people per square mile statewide, with significantly lower density in rural tracts.[viii]
- *Income:* Per-capita income in Alabama in 2023 was $54,112; third lowest in the United States. Alabama is a poor state relative to others, and rural areas in Alabama are poorer than urban areas. Per-capita income in 2023 was $45,725 in rural Alabama and $56,594 in urban Alabama.[ix]

- *Poverty rate:* The percentage of people living in poverty in Alabama in 2023 was 15.6 percent, eighth highest among the United States. The U.S. rate was 12.5 percent. Within Alabama, 19.1 percent of people lived in poverty in rural Alabama compared to 14.8 percent in urban Alabama.[x]

- *Education:* The percentage of Alabamians with a bachelor's degree or higher in 2019-2023 was 28.9 percent, eighth lowest among the United States. Within Alabama, the percentage of people with a bachelor's degree or higher in 2019-2023 was 16.9 percent in rural Alabama and 30.9 percent in urban Alabama.[xi]

- *Unemployment:* The unemployment rate in 2023 was 2.8 percent in rural Alabama and 2.4 percent in urban Alabama.[xii] Notably, Alabama's Labor Force Participation rate during the same period was 55.0 percent in rural Alabama and 60.4 percent in urban Alabama.[xiii]

Health outcomes:

- *Infant mortality:* The rate for the entire state in 2023 was 7.64 deaths per 1,000 live births, third highest for the United States. The national rate: 5.61 deaths per 1,000 live births[xiv] and 10.4 percent of all live births are diagnosed as having a low birth weight.[xv]

- *Life expectancy:* The life expectancy at birth for the entire state in 2021 was 72.0 years, third lowest among the United States. The national life expectancy during the same year was 76.4 years. ADPH reported state and county life expectancies for 2023 and reported a state life expectancy of 75.0 years, perhaps reflecting recovery from the pandemic. Some urban and rural counties exceeded the state life expectancy, but six rural counties had life expectancies less than 70.0 years.[xvi]

- *Chronic conditions:* In Alabama in 2023, 14.6 percent of adults had three or more chronic conditions, ranking 46th among the states. The national value was 10.7 percent.[xvii] Other statistics for chronic conditions include:
    - *Cancer:* In 2023,155.6 Alabamians died of cancer per 100,000 people, the tenth highest rate in the United States.[xviii]
    - *Diabetes:* 13.9 percent of adults have a diabetes diagnosis; the mortality rate is 30.4 in rural areas, which is nearly 50 percent higher than in urban areas.[xix]
    - *Heart disease:* In 2023, 227.3 Alabamians died of heart disease per 100,000 people, the third highest rate for the United States. The median was 160.8.[xx]
    - *High blood pressure:* In 2023, 13.5 Alabamians died of high blood pressure per 100,000 people, the seventh highest rate for the United States. The median was 9.2.[xxi]
    - *Obesity:* 39.2 percent of adults are obese, which is the fifth highest rate nationwide, with rural prevalence above state averages.[xxii]

Healthcare access:

- *Rural hospitals:* There are 52 hospitals in 41 of Alabama's rural counties.[xxiii]
- *L&D units:* Twelve of Alabama's rural counties have L&D units.[xxiv]
- *Maternal distance to care:* The percentage of women in Alabama living more than 30 minutes from a birthing hospital, according to a 2022 report, was 89.9 percent in rural areas and 26 percent in urban areas.[xxv]

- *Emergency medical response:* The statewide average response time by emergency medical services from call to arrival to the scene in 2024 was less than seven minutes: five minutes or less in urban counties and 11 to 15 minutes in rural counties, and in some rural counties 30 minutes.[xxvi]

- *Workforce shortage - Primary-care providers:* There were 241.0 primary-care providers in Alabama per 100,000 people in 2024, ranking 45th among the states. The national value was 283.4 primary-care providers per 100,000 people.[xxvii]

- *Workforce shortage - Mental health providers:* Alabama had 152.2 mental health providers per 100,000 people in 2024, ranking last among the states. The national value was 344.9 providers per 100,000 people.[xxviii]

- *Workforce shortage - Dentists:* There were 3.2 dentists per 10,000 residents in rural areas and 5.5 dentists per 10,000 residents in urban areas of Alabama in 2024. Compared to other states, Alabama in 2024 had 43.3 dental-care providers, including dentists and advanced practice dental therapists, per 100,000 residents, ranking 49th. The U.S. value was 65.8 dental-care providers per 100,000 residents.[xxix]

- *Hospital beds:* Rural hospitals in 2024 had 21.4 general hospital beds per 10,000 residents compared to 34.6 beds per 10,000 residents in urban counties.[xxx]

- *Cost barriers:* 13.5 percent of residents avoided healthcare due to cost, compared to the national average of 10.6 percent. The rural uninsured rate is approximately 16.4 percent, versus 14.1 percent in urban areas.[xxxi]

- *Preventable Hospitalization:* Alabama reports a preventable hospitalization rate of 3,387 per 100,000 Medicare beneficiaries age 18 or older, compared to the national average of 2,665, ranking 49th in the country.[xxxii]

- *Transportation:* Limited public transportation options exacerbate access barriers.

Rural facility financial health:

- *Rural hospitals at risk of closure:* As of August 2025**,** 60 percent of Alabama's rural hospitals were at risk of closing, the seventh highest percentage among the 50 states, 48 percent were at "immediate risk" (second highest), and in 2024, 65 percent had a negative margin (loss) on patient services. (sixth highest).[xxxiii]

- *Rural hospital closures:* Rural hospitals closed in Butler County in 2019, Pickens County in 2020, Clarke County in 2024, and Lawrence County this year. The Lawrence County facility became an outpatient center. No urban hospitals have closed since 2019, but Jackson Hospital in Montgomery declared Chapter 11 bankruptcy earlier this year.[xxxiv]

- *Rural hospital L&D unit closures:* Three hospitals in rural southwest Alabama have closed their L&D units in 2023 or 2024, in Monroe County (2023), Marengo County (2024) and Clarke County (2024). Many L&D units lose money. Closing them is a way to cut costs.[xxxv]

- *Rural hospital conversions to emergency hospitals:* Rural hospitals in Bullock, Chambers, and Wilcox counties have become Rural Emergency Hospitals (REHs), shuttering in- patient beds to focus on outpatient services, keeping emergency

departments open, and getting monthly checks from the federal government in return.[xxxvi]

Target Populations and Geographic Areas

Alabama's participation in the RHTP will target and prioritize all hospitals and persons in the state's 58 rural and partially rural counties where health disparities, provider shortages, and economic hardship are most severe.

Table II - Rural Facility and Population Score Factors		
Scoring Factor	**Scoring Factor Description**	**Alabama Demographic**
A.1	Absolute size of rural population in a state	1,613,122
A.2	Proportion of Rural Health Facilities in the State	51% (acute care hospitals: general acute, CAH, REH); 42% (including specialty hospitals); 60% (incl. FQHC, Rural Health Clinics); 58% (incl. CMHC, CCBHC)
A.3	Uncompensated care in a state	$799M FY2020, $779M FY2021
A.4	% of State population located in rural areas	32%
A.5	Metrics that define a State as being frontier	109,492 population in Frontier level 2, 2.30% population level percentage
A.6	Area of a State in total square miles	52,419
A.7	% of hospitals in a State that receive Medicaid DSH payments	99% of general acute care, Critical Access hospitals and children's hospitals are eligible for Medicaid DSH (84 of 85)

II. Rural Health Transformation Plan: Goals and Strategies

Vision, goals, and strategies of ARHTP: To deliver high quality healthcare services while adhering to the key principles of transformation, sustainability, and accountability. Transformation will be achieved through targeted investments, introduction of new technologies and methods, and state policy changes. Sustainability will be maintained by deploying efficient, effective, and broad reaching initiatives. Accountability will be ensured by establishing evaluation performance

measures and outcome metrics. The end result will be a sustainable and accountable transformation of Alabama's healthcare delivery system that will make rural America healthy again, ensure sustainable access, develop a qualified workforce, promote innovative care, and foster tech innovation. Table III and the following Cause Identification section address the RHTP required elements.

Table III – Goals and Strategies		
Element	**Initiatives**	**Strategic Goal Alignment**
Improving Access	• Establish a statewide telehealth network and remote monitoring capacity linking rural providers to specialty hubs; maintain emergency access and expand maternal health services through digital regionalization and telerobotic ultrasound. • Develop regional specialty networks for oncology screening and follow-up via mobile and regional services. • Expand behavioral health access by converting CMHCs to CCBHCs and integrating behavioral and physical health in networked rural clinics. • Implement Emergency Medical Services (EMS) diversion/routing and Treat-in-Place tele-consults to optimize urgent and low-acuity access close to home.	**Make Rural America Healthy Again**: Preventive, prenatal, behavioral, and chronic disease services closer to patients. **Sustainable Access**: Coordinated regional networks and EMS reforms stabilize local access points. **Innovative Care**: Flexible telehealth, EMS tele-consults, and mobile models. **Tech Innovation**: Remote monitoring, digital obstetric tools, telehealth endpoints.
Improving Outcomes	• Deploy evidence-based, outcomes-driven interventions for chronic disease management via remote monitoring and care coordination enabled by regional IT hubs. • Reduce maternal morbidity and mortality through digital obstetric regionalization and timely specialty consults. • Increase cancer screening rates through mobile screening, regional referral pathways, and outreach. • Increase chronic disease prevention. • Improve behavioral health outcomes by adopting the CCBHC model and embedding integrated care in rural practices.	**Make Rural America Healthy Again:** Measurable disease prevention. **Innovative Care:** Coordinated, outcomes-based models and flexible care arrangements. **Tech Innovation:** Use of data dashboards to guide quality improvement.

Technology Use	• Stand up regional collaborative IT and cybersecurity hubs to support Electronic Health Record (EHR) integration, interoperability, compliance, and shared security operations. • Provide for the interconnectivity of these hubs to allow for the secure free-flowing exchange of health information. • Within the regional collaborative IT space, utilize data and technology to provide healthcare to rural patients within their home district. • Deploy telehealth endpoints, integrate rural providers, and launch mobile units for digital care delivery. • Implement evaluation of suitability and sustainability for emerging technologies and plan for long-term shared-service funding models.	**Tech Innovation:** Scaled telehealth, secure data sharing, and emerging technology adoption. **Sustainable Access:** Shared services lower unit costs and improve resilience and creates sustainable infrastructure. **Innovative Care:** Technology-enabled team-based and remote care models providing real-time access to healthcare data.
Partnerships	• Create and strengthen local and regional networks among rural hospitals, clinics, FQHCs, EMS, behavioral health providers, and academic partners for information sharing, joint training, group purchasing, and coordinated service lines. • Govern networks to reflect community representation and needs, leveraging regional hubs.	**Sustainable Access:** Economies of scale and shared operations. **Innovative Care:** Network-based coordination and care integration. **Tech Innovation:** Shared data and cybersecurity infrastructure.
Workforce	• Build rural training pipelines, expand Graduate Medical Education (GME) opportunities, and grow EMS, nursing, certified nurse midwifery, and physician capacity; extend specialty reach via telehealth support. • Expand specialty-based simulation training statewide to accelerate competency and retention. • Sustain pipelines through partnerships with the Alabama School of Healthcare Sciences and community colleges.	**Workforce Development:** Recruitment, retention, and top-of-license practice. **Make Rural America Healthy Again:** Increased access to primary, prenatal, and behavioral care. **Innovative Care:** Team-based practice supported by telehealth and simulation.
Data-Driven Solutions	• Harness data and technology to furnish high-quality health care services as close to a rural patient's home as possible.	**Make Rural America Healthy Again:** Increased access to care closer to home
Financial Solvency Strategies	• Use connected EHRs and data dashboards to track quality, utilization, and outcomes; drive continuous improvement and reduce avoidable transfers. • Implement payment and delivery reforms that support regionalization, telehealth billing, treat-in-place reimbursement, and shared-service cost recovery, transitioning to self-funded models by FY2030. • Service offerings via mobile and network models; diversify revenue streams through group purchasing and shared cybersecurity services.	**Sustainable Access:** Financial resilience and right-sized care models. **Innovative Care:** Value-aligned payment and lower-cost settings. **Tech Innovation:** Data to manage quality and costs across networks.

Cause Identification

Four of Alabama's rural hospitals have closed since 2019, three have closed their L&D units since late 2023, and three have reduced in-patient services to become REHs in the last few years, as noted in the rural facility financial health section.

More than half of Alabama's rural hospitals are operating at a loss, with many reporting negative margins due to low patient volumes, high fixed costs, and the growing burden of uncompensated care. Low insurance reimbursements and a large percentage of uninsured people in Alabama are some of the reasons cited by the Alabama Hospital Association.[xxxvii]

In August 2025, the Center for Healthcare Quality & Payment Reform (CHQPR) reported that 60 percent of Alabama's rural hospitals were at risk of closing, the seventh highest percentage among the 50 states. According to CHQPR, 48 percent of Alabama's rural hospitals were at "immediate risk" (second highest percentage in the U.S.), and that in 2024, 65 percent had a negative margin (loss) on patient services.

Each year, Alabama hospitals provide more than $650 million in uncompensated care.[xxxviii] In 2023, 10.2 percent of people under age 65 in Alabama had no health insurance coverage, higher than 9.5 percent for the entire country.[xxxix] Further, Alabama ranks among the bottom 10 states for commercial insurance reimbursement for in-patient hospital care, further eroding financial stability.[xl] These pressures are magnified by the state's high poverty rate.[xli] Alabama also has high rates of chronic diseases such as diabetes and cancer, which often lead to hospitalizations. Further, many patients, especially in rural counties, have Medicaid, which tends to pay less than commercial insurance.[xlii] In 2024, over 1 million Alabamians were eligible for Medicaid.[xliii]

The consequences of this decline reach far beyond hospital walls. When rural hospitals close or scale back services, residents lose access to emergency care, obstetrics, and other critical health services, leading to worse health outcomes and higher mortality rates. The closures also devastate local economies, as hospitals are often the largest employers and economic anchors in their communities. Alabama's rural healthcare safety net is, therefore, in jeopardy—not only threatening public health but also undermining rural economic vitality.

Program Key Performance Objectives and Sustainability

By FY2030, Alabama will achieve measurable outcomes and performance to improve healthcare delivery and will transition from ARHTP-supported implementation to self-sustainability. Sustainability will be achieved in several ways. Some initiatives simply require startup funding and will be sustainable after implementation. Others will be sustained through targeted state policy changes that enhance financial viability. Still other ARHTP initiatives offer a new, innovative method to deliver care that may require some level of public or private funding beyond the life of the program. In these instances, the initiatives will be designed to incentivize adoption of new approaches and enable more efficient practices that offer higher quality healthcare services to a broader population—it is truly an effort to drive transformation that would not be initiated otherwise.

Strategic Goals Alignment

See Table III – Goals and Strategies (pages 11-12).

Legislative or Regulatory Action

Table IV – Technical Scoring Factors		
Scoring Factor	**Scoring Factor Description**	
B.2	Presidential Fitness Test	Alabama law requires all schools to carry out a system of physical education that conforms to the program or course outlined by the Alabama Department of Education. Ala. Code § 16-40-1. Additionally, Ala. Admin. Code r. 290-3-1-.02(8)(c)1.(ii), at minimum, requires all schools that allow substitution of physical education for physical activity-based subjects, such as athletics, to administer the Alabama Physical Fitness Assessment to all students in grades 2-12. The governor's office has begun discussions with the Alabama Superintendent of Education to include the Presidential Fitness Test as part of the physical education course for Alabama students once full guidance is available.
B.3	SNAP Waivers	HB 31 was introduced for the 2026 legislative session and would require Alabama to request a waiver from the USDA Food and Nutrition Service to authorize the Alabama Department of Human Resources (DHR) to exclude soda, energy drinks, candy, and prepared desserts from the definition of eligible foods for the SNAP program.
B.4	Nutrition Continuing Medical Education	Currently, the State does not require a nutrition component to existing Continuing Medical Education (CME) Requirements. However, the governor's office has begun discussions with the Alabama Board of Medical Examiners (BME) to consider including a nutrition component to CME requirements for physicians moving forward.
C.3	Certificate of Need	Currently, according to the Cicero Institute report "Policymaking Playbook for Certificate of Need Repeal: Ranking", Alabama holds a score of 80 using the metrics applied in the report.
D.2	Licensure Compacts	Currently, Alabama is a member state for the Interstate Medical Licensure Compact (IMLC) and serves as a State of principal license (SPL). Alabama is a participant in the Nurse Licensure Compact (NLC) and is considered a NLC state. Alabama is a participant in the EMS Compact. Alabama is a member state in the Psychology Interjurisdictional Compact (PSYPACT). Currently, Alabama is not a member of the Physician Assistants (PA) compact.
D.3	Scope of Practice	Currently, according to the PA State Practice Environment published by the American Academy of Physician Associates (AAPA) and the American Association of Nurse Practitioners (AANP) State Practice Environment, Alabama is listed as "Reduced". According to the Cicero Institute, Alabama is reporting as having "Barriers to Innovation in Place: 0-3 points" for overall full practice authority, "Laws are Innovation Ready: Full authority" for pharmacists full practice authority for drug administration, "Improvements Needed: CLIA-Waived Authority" for pharmacist full practice authority for laboratory testing, and "Barriers to Innovation in Place: Restricted Authority" for pharmacist full practice authority for independent prescribing. According to the Oral Health Workforce Research Center, Alabama Dental Hygienists are shown to have a "restricted" scope of practice.
E.1	Medicaid provider payment incentives	Alabama currently has value-based provider payment incentives for the Alabama Coordinated Health Network (ACHN) program.

E.2	Individuals dually eligible for Medicare and Medicaid	There are currently 11 Dual Eligible Special Needs Plans (D-SNP) in Alabama; currently 106,000 recipients on average are enrolled in a Medicare Advantage Plan as dual-eligibles. Currently, Alabama does have one Program of All-Inclusive Care for the Elderly (PACE) in the Mobile/Baldwin County area with 200 participants.
E.3	Short-term, limited-duration insurance	STLDI plans are not currently restricted in Alabama beyond any federal guidance issued on August 7, 2025.
F.1	Remote care services	Alabama Medicaid currently covers remote patient monitoring (RPM) services through the Alabama Department of Public Health and the University of Alabama-Birmingham.
F.2	Data infrastructure	Alabama consistently meets the Transformed Medicaid Statistical Information System (T-MSIS) targets for all three categories of Outcome-Based Assessments (OBA) and Data Quality Issues and has remained in the "blue" status on the national map. Medicaid does not anticipate any challenges in maintaining this performance moving forward, placing an emphasis on promptly reviewing and researching new items as they arise. In support of this effort, monthly meetings are held within the Agency to review issues, exchange updates and track progress. In addition, Alabama actively participates in the Mathematica-hosted monthly meetings to discuss T-MSIS topics, receive updates on Data Quality Issues and collaborate on potential solutions.

1. *Commitment and Scope:* The State will pursue legislative and/or regulatory actions to support telehealth parity and cross-facility credentialing; EMS Treat-in-Place reimbursement; CCBHC certification and funding alignment; data sharing and participation requirements for regional hubs; and healthcare services payment updates to sustain rural facility solvency and network models, consistent with RHTP technical factors. Other states policies that align with the RHTP or otherwise advance health outcomes and healthcare service viability will likely be developed.

2. *ARHTP Advisory Group via Executive Order:* By executive order, the Governor will establish an advisory group of key legislators and stakeholders to develop and advance legislation, regulation, and other state policy changes aligned with ARHTP strategies and timelines.

    a. Charge: Recommend sustainable statutory and regulatory reforms for telehealth reimbursement, licensure and credentialing portability, EMS treat-in-place

payment, CCBHC expansion, data exchange participation and cybersecurity standards, workforce development initiatives, healthcare payment policies that stabilize rural providers and promote regionalization. and other policies as identified. The group will align policies with outcomes, access, quality, and cost goals for rural communities.

b. Timeline: The executive order will be issued by the Governor by early 2026.

Milestones will ensure ARHTP policy fulfillments by December 31, 2027, to retain technical score credit; and by December 31, 2028, for factors B.2 and B.4.

The state policy changes to be achieved by executive, legislative, or regulatory action will increase health literacy and promote healthy lifestyles, improve access to healthcare services, foster adoption of needed technology innovations, promote data-sharing and credentialing policies to enable timely specialty input and coordinated care, develop a robust health professional workforce, and achieve fiscally sound payment and shared-service models to lower the cost of healthcare delivery.

III. Proposed Initiatives and Use of Funds

Summary

- The **Collaborative Electronic Health Record (EHR), IT, and Cybersecurity Initiative** will help modernize healthcare IT infrastructure by establishing regional "hubs" for IT and cybersecurity support and will assist with electronic health record (EHR) integration for rural hospitals and clinics. This regionalized model will reduce costs, improve interoperability, and enhance system reliability statewide while allowing independent providers to maintain their independence.

- The **Rural Health Initiative** will expand access to specialty and emergent care through a network of telehealth hubs linking EMS, first responders, hospitals, and other healthcare facilities to regional referral centers. It aims to bring advanced services such as tele-stroke, tele-behavioral health, and remote patient monitoring directly into rural communities, improving health outcomes and reducing unnecessary transfers.

- The **Maternal and Fetal Health Initiative** uses digital tools to connect rural facilities with maternal-fetal medicine specialists, provides access to telerobotic ultrasound, addresses shortages of obstetric services, and reduces high-risk maternal and infant morbidity in underserved communities. The initiative will also include expansion of an existing pilot program to provide emergency L&D carts to rural hospitals, thereby offering lifesaving care and stabilization for mothers and newborns until they can be relocated to an appropriate hospital setting.[xliv]

- To ensure long-term viability for rural providers, the **Rural Workforce Initiative** invests in coordinated training and recruitment pipelines for all healthcare professionals, including but not limited to, physicians, nurses, EMS professionals, certified nurse midwives, dentists, dental hygienists, and dental assistants, and leverages remote learning and clinical partnerships to grow the local healthcare workforce. It further provides incentives for providers to practice in rural areas and expands Graduate Medical Education programs.

- Complementary initiatives, including the **Cancer Digital Regionalization Initiative**, the **Simulation Training Initiative**, the **Statewide EMS Trauma and Stroke Initiative**, and the **EMS Treat-In-Place Initiative** will advance preventative care,

strengthen provider readiness and interconnectivity, and enhance emergency response capacity. The **Mental Health Initiative**, **Community Medicine Initiative**, and **Rural Health Practice Initiative** will expand behavioral health access, preventative wellness care, integrated primary care delivery, and dental care through both mobile-units and community-based clinics.

Together, these initiatives will create a sustainable, transformative, data-driven, regionally-coordinated healthcare system by offering rural providers needed assets and tools to improve the quality of care they deliver in a sustainable, public-facing way. The reimagined system will improve rural access to care, enhance clinical capacity, and ensure that Alabama's rural residents receive the highest-quality healthcare possible as close to home as possible.

In implementing ARHTP initiatives and activities, ADECA will conduct duplication assessments in compliance with its duplication policy (attached to the Duplication Assessment) to ensure that RHTP funds are not used to duplicate state, local, or federally funded programs and activities.

Initiatives

1. **Collaborative EHR, IT, and Cybersecurity Initiative**

Description: The **Collaborative EHR, IT, and Cybersecurity Initiative** will assist rural healthcare facilities in working with regional referral centers to upgrade, support, and expand IT infrastructure and cybersecurity operations, integrate EHR systems, connect to HIE, improve and increase collaboration and communication between regional partners, and create cost savings through the creation of a “shared services” model with regionalized services, including cybersecurity monitoring and response.

With very thin, and sometimes negative, operating margins, many rural providers do not have funds necessary to update critical operations infrastructure, including IT systems. Older systems are more costly to operate and maintain due to staffing requirements, cybersecurity inadequacies, and lack of interoperability. A lack of unified or integrated EHR systems can reduce the quality of patient care, prevent necessary information exchange, and potentially increase the risk of hospital readmissions as providers do not have access to patient medical history and other patient health information at the time of treatment.

This initiative will allow regional hospitals and rural healthcare facilities to contract with regional referral centers as "hubs," which serve as IT and cybersecurity resource centers. These hubs will establish IT provider-based centers to provide services, including cybersecurity upgrades, monitoring, and response; infrastructure and regulatory compliance assessments; incident response and recovery support; reduction in overall hospital expenditures through shared services and group purchasing; ensure foundational IT operations are in place to support clinical care and regulatory compliance; and provide technical support and guidance in replacing outdated and insecure equipment used in direct patient care. The hubs will also provide guidance and technical support in the adoption and/or upgrading of EHR platforms to a unified regional provider. Interoperability between EHR systems that serve multiple regions can be expeditiously, efficiently and economically achieved by connecting them to the Alabama One Health Record (ALOHR) Health Information Exchange (HIE), operated by the Alabama Medicaid Agency. To enhance sustainability, priority consideration will be given to ALOHR proposals and preferred vendors on the Certified Health Information Technology (IT) Product List (CHPL).

Should Alabama be awarded additional RHTP funding, this initiative could be scaled up to include increased adoption of shared services by more rural healthcare facilities and further modernize outdated healthcare technologies.

Proposed uses of funds:

- Establishment of regional IT provider-based hubs to assist/advise rural providers in upgrading IT and cybersecurity platforms; provide monitoring and response to incidents; provide infrastructure and regulatory compliance; assessments; provide incident response and recovery support; provide infrastructure and advise on EHR upgrades/conversions.
- Procurement and deployment of updated IT and cybersecurity platforms.
- Procurement and deployment of new/upgraded/updated EHR platforms.

Table V-A1. Collaborative EHR, IT, and Cybersecurity Initiative Summary		
Category	**Information**	
Main strategic goals	Sustainable access; Tech innovation	
Uses of funds	D, F, K	
Technical score factors	C.1, F.2, F.3	
Impacted counties	005, 007, 009, 011, 013, 017, 019, 021, 023, 025, 027, 029, 031, 035, 037, 039, 041, 043, 045, 047, 049, 053, 057, 059, 063, 065, 067, 071, 075, 085, 087, 091, 093, 095, 099, 105, 107, 109, 111, 119, 121, 123, 127, 129, 131	
Estimated required funding	$125M for 5 years	
Key stakeholders	• Hospitals • Critical Access Hospitals • Rural Emergency Hospitals • IHS/Tribal Facilities • Rural Health Clinics	• Federally Qualified Health Centers • Certified Community Behavioral Health Clinics • Community Mental Health Centers

Table V-A2. Collaborative EHR, IT, and Cybersecurity Initiative Outcomes and Metrics		
	Outcome (Program Metrics)	**Impact Level**
1	Number of regional hubs established and serving as IT provider-based hubs to local providers	Total statewide
2	Number of rural providers connected to regional hubs via IT and security operations	Number per county Total statewide

3	Number of rural providers connected to regional hubs via EHR	Number per county Total statewide
4	Number of EHR upgraded to connect with ALOHR HIE	Number per county Total statewide
	Outcome (Technology Use Metrics)	**Impact Level**
5	Cost savings	By provider Total statewide
6	Interoperability of rural providers and health care networks over the ALOHR HIE	By healthcare network Total Statewide
7	Upgraded systems uptime percentage	By provider
8	Number of cybersecurity alerts triaged/worked by IT-provider based hubs	Total statewide

2. Rural Health Initiative

Description:

The primary purpose of the **Rural Health Initiative** is to efficiently provide the most appropriate level of care to patients in rural areas as close to home as possible. This will be accomplished through adoption of telehealth/tele-consult services and minor infrastructure upgrades to provide technology-based access to mental health, chronic disease management, and primary care services to address health disparities across rural Alabama. Using Auburn University's Rural Health Initiative as a model, Alabama has already demonstrated the State's ability to implement this type of initiative to bring a successful—and sustainable—healthcare services to rural Alabama citizens.

This initiative is designed to deploy telehealth/tele-consult services to EMS, FQHCs, Rural Health Clinics, rural hospitals, critical access hospitals, REHs, regional referral centers, and other healthcare facilities. Access to these services will increase the availability of services provided and allow patients to receive appropriate care closer to home. It will reduce EMS transport and wait times, lessen patient waiting times, and improve healthcare facility patient volumes. Resources offered through this initiative will deploy proven telehealth programs to rural areas across the state, speed adoption of new telehealth service lines, and foster technological methods of chronic disease

prevention and management. Access to care will also be improved for maternal and fetal health, cardiac care, mental health and substance use disorder treatment, and other conditions.

The initiative will also integrate inpatient virtual care capabilities, including tele-stroke, tele-behavioral health, tele-ICU, and virtual nursing; ambulatory access via virtual visits and e-consult services; remote patient monitoring for chronic care management; and specialized programs, including dialysis services and infectious disease stewardship. Equipment upgrades and minor building renovations or alterations will be allowed to prepare providers to offer services contemplated by this initiative and to ensure long-term costs are commensurate with patient volume. Additionally, this initiative will support the creation or expansion of non-emergency transport services from homes or from nursing homes.

The final component of this initiative will support a pilot program to create a Rural Health Network, preferably an academic medical center-supported partnership with rural healthcare facilities to create a shared-services model. The shared-services model should consolidate billing, linen, shredding, medical waste, laboratory, management, and other services to create operational efficiency and cost savings for smaller rural healthcare facilities. This integrated rural health network will allow participants to coordinate resources, achieve economies of scale, improve financial viability, and enhance sustainability through reduced overhead costs and improved operational efficiencies. A goal of the program is to create a shared governance strategy that benefits all network members, allows all participants to have a voice in decision-making, and ensure smaller rural providers benefit from the cooperation and coordination offered by the larger providers in the network.

Should Alabama be awarded additional RHTP funding, this initiative could be scaled up to more extensively support the establishment of regional hubs, help modernize more rural healthcare facilities, and duplicate the Rural Health Network pilot program if demand exists.

Proposed uses of funds:

- Creation of regional hubs to serve as primary support centers to local rural providers by providing telehealth and tele-consult services for specialties not currently offered at rural locations.
- Funding healthcare facilities to integrate with a regional hub to receive and offer
- telehealth/tele-consult services to patients.
- Funding for local hospitals to serve as secondary support center for primary care services to local clinics if required and for local clinics to integrate with local hospitals to receive the services.
- Funding equipment upgrades and minor building renovations or alterations to prepare rural healthcare facilities to provide the care contemplated by this section and ensure that long term costs are commensurate with patient volume.
- Creation or expansion of non-emergency transportation systems/entities.
- Creation of "Rural Health Network" pilot program utilizing a shared services model for services, including combined billing, linen, shredding, medical waste, laboratory, management etc. Priority consideration will be given to applicants partnering with an academic medical center that also seeks to be approved for

funding to upgrade IT, EHR, and Cybersecurity abilities through the appropriate initiative.

Table VI-B1. Rural Health Initiative Summary		
Category	**Information**	
Main strategic goals	Make rural America healthy again; Workforce development; Sustainable access; Innovative care; Tech innovation	
Uses of funds	A, C, D, E, F, G, H, I, K (non-exhaustive)	
Technical score factors	B.1, C.1, D.1, F.1, F.2, F.3 (non-exhaustive)	
Impacted counties	005, 007, 009, 011, 013, 017, 019, 021, 023, 025, 027, 029, 031, 035, 037, 039, 041, 043, 045, 047, 049, 053, 057, 059, 063, 065, 067, 071, 075, 085, 087, 091, 093, 095, 099, 105, 107, 109, 111, 119, 121, 123, 127, 129, 131 (non-exhaustive)	
Estimated required funding	$275M for 5 years	
Key stakeholders	• Hospitals • Critical Access Hospitals • Rural Emergency Hospitals • IHS/Tribal Facilities • Rural Health Clinics	• Federally Qualified Health Centers • Certified Community Behavioral Health Clinics • Community Mental Health Centers

Table VI-B2. Rural Telehealth Initiative Outcomes and Metrics		
	Outcome (Program Metrics)	**Impact Level**
1	Number of regional hubs created	Total statewide
2	Number of endpoints deployed	Number per county Total statewide
3	Number of telehealth consultations provided	Number per county Total statewide
4	Number of transfers avoided	Number per county Total statewide
7	Number of non-emergency transportation services created or expanded	Total statewide
8	Number of rural providers joining Rural Health Network pilot	Total statewide
9	Number of shared services created in Rural Health Network	Total statewide

3. Maternal and Fetal Health Initiative – Obstetric Digital Regionalization Initiative

Description: The **Maternal and Fetal Health Initiative – Obstetric Digital Regionalization Initiative** addresses the maternal and fetal health crisis impacting rural Alabama due to the closure of multiple L & D units at rural facilities. Many rural facilities have closed their L&D units due to the overhead costs of maintaining 24/7 coverage with low patient volumes. Further, the loss of rural L&D services has led to a decrease in the provision of primary maternal and fetal health care

in rural counties as OB-GYNs seek to practice in locations closer to hospitals with active, fully staffed L&D units.

While maternal and fetal health services limitations impact prenatal and postnatal care for all women, the impact is most acute for women with "high-risk" pregnancies. This initiative addresses the lack of access to care by connecting smaller rural providers and healthcare facilities without immediate access to high-quality maternal and fetal health services to regional care hubs that can provide those services via digital maternity care platforms and by using telerobotic ultrasound devices to ensure that patients receive appropriate care close to home.

Another component of this initiative is expansion of a current pilot project to provide emergency L&D carts to healthcare facilities that do not have L&D units. Emergency L&D carts provide lifesaving care and stabilization for mothers and newborn babies until they reach an appropriate hospital setting. This is a low-cost approach to provide lifesaving services and improve mortality rates.

This initiative also allows for regional care hubs to connect with a central coordinating provider and access specialty services not offered at the regional hub level. A central provider can then offer services to regional care hubs and to smaller healthcare facilities collaborating with the regional hubs.

Equipment upgrades and minor building renovations or alterations would also be allowed under this initiative. This will ensure healthcare facilities have the infrastructure and equipment necessary to provide appropriate services.

Should Alabama be awarded additional RHTP funding, this initiative could be scaled up to ensure more rural healthcare facilities are equipped to offer tele-maternal healthcare services.

Proposed uses of funds:

- Establish regional referral hubs focused on maternal and fetal health.
- Provide funding for healthcare facilities, including but not limited to, rural hospitals, critical access hospitals, REHs, rural health clinics, FQHCs, to connect with regional referral hubs.
- Acquire and install telerobotic ultrasound devices at regional hubs and, through the regional hubs, to smaller rural hubs throughout the state to allow for optimization of maternal and fetal health services delivery.
- Deploy emergency L&D carts to rural healthcare facilities without L&D units.

Table VII-C1. Maternal and Fetal Health Initiative Summary		
Category	**Information**	
Main strategic goals	Make rural America healthy again; Sustainable access; Innovative care; tech innovation	
Uses of funds	A, C, D, F, G, I, K (non-exhaustive)	
Technical score factors	B.1, B.2, C.1, F.1, F.2, F.3 (non-exhaustive)	
Impacted counties	005, 007, 009, 011, 013, 017, 019, 021, 023, 025, 027, 029, 031, 035, 037, 039, 041, 043, 045, 047, 049, 053, 057, 059, 063, 065, 067, 071, 075, 085, 087, 091, 093, 095, 099, 105, 107, 109, 111, 119, 121, 123, 127, 129, 131 (non-exhaustive)	
Estimated required funding	$24M for 5 years	
Key stakeholders	• Hospitals • Critical Access Hospitals • Rural Emergency Hospitals • IHS/Tribal Facilities • Rural Health Clinics	• Federally Qualified Health Centers • Non-profit healthcare organizations

Table VII-C2. Maternal and Fetal Health Initiative Outcomes and Metrics		
	Outcome (Program Metrics)	**Impact Level**
1	Number of regional hubs created	Total statewide
2	Number of local providers connected with regional providers to receive services	Number per county Total statewide
3	Number of telehealth consultations provided	Number per county Total statewide
4	Number of transfers avoided	Number per county Total statewide
5	Number of telerobotic ultrasound procedures performed	Number per county Total statewide
6	Number of emergency labor and delivery deployed and used	Number per county Total statewide

4. Rural Workforce Initiative

Description: The purpose of the **Rural Workforce Initiative** is to increase the number and quality of healthcare providers in rural Alabama, including physicians in needed specialties, nurses (both LPN and RN), EMS professionals (both EMTs and paramedics), certified nurse midwives, dental hygienists, and technical staff. The state's top 25 occupations in highest demand include RNs and LPNs, medical and health services managers, and Nurse Practitioners.[xlvxlv] As of May 2025, 61 of Alabama's 67 counties are fully designated as primary care professional shortage areas, with all but one being mental health professional shortage areas. Moreover, all of these areas are partial or full medically underserved areas.[xlvi] Maternity care target areas are also in 61 counties. These are high-need, primary care Health Professional Shortage Areas (HPSAs) that meet specific criteria based on the ratio of women to maternity care providers, low-income women, distance/travel time to care, fertility rates, social vulnerability, and maternal health indicators (pre-pregnancy diabetes, hypertension, obesity, and early access to prenatal care). Health professional shortages have a detrimental impact on the provision of care in rural areas and can contribute to a reduction in healthy lifestyles among residents.

Should Alabama be awarded additional RHTP funding, this initiative could be scaled up to help establish or expand additional GME programs in rural areas and to incentivize more healthcare professionals to train and work in rural Alabama.

Proposed uses of funds:

- Provide funding to the Alabama School of Healthcare Sciences (ASHS) for curriculum development and training equipment procurement. Established in 2025 and accepting students in 2026, the ASHS is free, state- supported residential specialty high school in

rural Demopolis, Alabama, which will offer a first-of-its-kind, hands-on curriculum designed to inspire and educate young Alabamians for in-demand, high-impact roles in healthcare with a focus on critical needs in rural areas.

- Provide funding to develop and implement remote training opportunities for emergency medical technicians (EMTs) and paramedics. Online and virtual technologies will be prioritized to reach rural students ("Bring the class to the student").

- Develop a centrally-managed healthcare workforce pipeline partnership program between K-12 education, community colleges, institutions of higher education, the Alabama Department of Workforce, and rurally-located healthcare providers to develop and expand accelerated healthcare professional training programs designed to shorten completion times and integrate in-facility experience toward credentialing requirements. In-facility training includes on-site virtual learning, potentially using staff as trainers, and on-the-job credentialling.

- Establish new or expand existing Graduate Medical Education (GME) programs in rural areas.

- Provide funding to create new or expand existing training programs for Certified Nurse Midwives.

- Provide incentives for healthcare practitioners, dentists, and dental hygienists to relocate to rural areas.

- Provide free or reduced-cost education and training for people who commit to five years of practice in rural Alabama.

Table VIII-E1. Rural Workforce Initiative Summary		
Category	**Information**	
Main strategic goals	Make rural America healthy again; Workforce development	
Uses of funds	A, D, E, G, K	
Technical score factors	B.1, B.2, C.1, C.2, F.1	
Impacted counties	005, 007, 009, 011, 013, 017, 019, 021, 023, 025, 027, 029, 031, 035, 037, 039, 041, 043, 045, 047, 049, 053, 057, 059, 063, 065, 067, 071, 075, 085, 087, 091, 093, 095, 099, 105, 107, 109, 111, 119, 121, 123, 127, 129, 131	
Estimated required funding	$309.75M for 5 years	
Key stakeholders	• Hospitals • Critical Access Hospitals • Rural Emergency Hospitals • IHS/Tribal Facilities • Rural Health Clinics • Skilled Nursing Facilities	• Federally Qualified Health Centers • Non-profit healthcare organizations • Community partners

Table VIII-E2. Rural Workforce Initiative Outcomes and Metrics		
	Outcome (Program Metrics)	**Impact Level**
1	Number of new students accepted to rural remote training programs	Number per county Total statewide
2	Number of programs established at existing rural providers to offer remote training for EMS	Total statewide
3	Number of programs established at existing rural providers to offer remote training for LPN/RN	Total statewide
4	Number of programs established to provide specialized GME in rural areas	Total statewide
5	Number of GME program graduates practicing in rural counties post-education	Number per county Total statewide
6	Number of students entering certified nurse midwife training programs created or expanded through this initiative	Total statewide

5. Cancer Digital Regionalization Initiative - Prevention, Screening and Treatment

Description: One cause of rural health disparities is inadequate access to preventative care, detection, and treatment for cancer. In 2023, ADPH established OPERATION WIPE OUT[xlvii] as an evidence-based plan to eliminate cervical cancer. Alabama continues to be the first and only state in the U.S. with such a plan in place. The **Cancer Digital Regionalization Initiative** will replicate the successful model established by OPERATION WIPE OUT to target other cancers for prevention and early detection through cross-sector partnerships and improved access to screening services in rural areas. Once replicated, three core principles will be critical: 1) the initiative is not led by one centralized organization; 2) it is based on strategic partnerships, with each partner plays

important roles; and 3) local partners take the lead in their own communities. Moreover, this model serves as an innovative approach to screening that offers greater efficiencies, more effectiveness, and broader reach than traditional brick-and-mortar clinics.

Proposed uses of funds:

- Expand capabilities of a proven, effective cancer detection system.
- Establish regional referral hubs to provide cancer detection services to local rural healthcare facilities and help facilitate connection with these hubs.
- Provide funding for mobile screening units to be offered in conjunction and consultation with local providers to allow for screening to be offered locally without accidental duplication of services with established local primary care physicians, clinics, and hospitals that already have established screening protocols and services.
- Use community partnerships to establish community activation teams to provide social mobilization and education.

Table IX-D1. Cancer Prevention, Screening, and Treatment Initiative Summary		
Category	**Information**	
Main strategic goals	Make rural America healthy again	
Uses of funds	A, D, G, I, K (non-exhaustive)	
Technical score factors	B.1, B.2, C.1, F.1 (non-exhaustive)	
Impacted counties	005, 007, 009, 011, 013, 017, 019, 021, 023, 025, 027, 029, 031, 035, 037, 039, 041, 043, 045, 047, 049, 053, 057, 059, 063, 065, 067, 071, 075, 085, 087, 091, 093, 095, 099, 105, 107, 109, 111, 119, 121, 123, 127, 129, 131 (non-exhaustive)	
Estimated required funding	$25M for 5 years	
Key stakeholders	• Hospitals • Critical Access Hospitals • Rural Emergency Hospitals • IHS/Tribal Facilities • Rural Health Clinics	• Federally Qualified Health Centers • Non-profit healthcare organizations • Community partners

Table IX-D2. Cancer Prevention, Screening, and Treatment Initiative Outcomes and Metrics		
	Outcome (Program Metrics)	**Impact Level**
1	Number of regional hubs created	Total statewide

2	Number of local providers connected with regional providers to receive services	Number per county Total statewide
3	Number of mobile screening opportunities offered	Number per county Total statewide
4	Number of patients screened using mobile services	Number per county Total statewide

6. Simulation Training Initiative

Description: The **Simulation Training Initiative** will improve the quality of care in rural healthcare facilities by providing training in specific services that are needed but not typically offered.

This initiative will allow rural healthcare providers to enhance their workforce and improve their level of patient care through broader access to training. It will reduce patient travel and wait times, increase providers' patient volumes and revenues, reduce overcrowding at tertiary care providers, and ensure patients receive the appropriate level of care at a location as close to home as possible.

For example, the Children's Hospital of Alabama (Children's) currently offers COACHES (Children's of Alabama Community Healthcare Education Simulation), a healthcare education simulation program administered by a multidisciplinary team of pediatric critical care trained physicians and nurses that conduct simulation training interventions in rural and community hospitals with a goal of improving pediatric patient outcomes. Another effective simulation training program is offered by Faulkner University. With proper training, local providers are better equipped to keep patients within their community, when appropriate. This reduces healthcare system expenditures and patient transportation needs, while increasing local provider volumes and reimbursements and decreasing overcrowding and wait times at larger referral centers.

A goal of this initiative is to increase the amount of simulation training offered each year and to create and implement additional programs in other specialties. Priority consideration will be given to applicants that already operate in the state and can prove the effectiveness of their training.

Proposed uses of funds:

- Expand or replicate simulation-based training programs to increase the amount of simulation training offered each year.
- Create new or expand other existing simulation-based training programs.

Table X-F1. Simulation Training Initiative Summary		
Category	**Information**	
Main strategic goals	Make rural America healthy again; Sustainable access; Workforce development	
Uses of funds	A, B, D, E, G, J, K (non-exhaustive)	
Technical score factors	B.1, C.1, C.2, D.1 (non-exhaustive)	
Impacted counties	005, 007, 009, 011, 013, 017, 019, 021, 023, 025, 027, 029, 031, 035, 037, 039, 041, 043, 045, 047, 049, 053, 057, 059, 063, 065, 067, 071, 075, 085, 087, 091, 093, 095, 099, 105, 107, 109, 111, 119, 121, 123, 127, 129, 131 (non-exhaustive)	
Estimated required funding	$15.5M for 5 years	
Key stakeholders	• Hospitals • Critical Access Hospitals • Rural Emergency Hospitals • Rural Health Clinics	• Federally Qualified Health Centers • IHS/Tribal Facilities • Non-profit healthcare organizations

Table X-F2. Simulation Training Initiative Outcomes and Metrics		
	Outcome	**Impact Level**
1	Number of simulation programs established or expanded to deliver specialty-specific training	Total statewide
2	Number of simulation training sessions conducted	Number per county Total statewide
3	Number of patient transfers to regional referral centers from specialties with established simulation training	Number per county Total statewide
4	Number of patients treated locally by providers in specialties with established simulation training	Number per county Total statewide

7. Statewide EMS Trauma and Stroke Initiative

Description: The Alabama Trauma Communications Center directs ambulances statewide that carry trauma and stroke patients to the most appropriate available hospital emergency departments for treating the conditions. The Center is an operational arm of the Birmingham Regional EMS System (BREMSS), one of six regional EMS agencies in Alabama, and the only EMS agency with a statewide reach. The Center operates in Birmingham but directs ambulances statewide to roughly

100 urban and rural hospitals across Alabama and in four neighboring states. The Center is developing plans to expand its statewide hospital-referral system to also include routing patients experiencing a ST-elevation myocardial infarction (STEMI) heart attack.

Under the **Statewide EMS Trauma and Stroke Initiative**, stateside hospital-referral services could be expanded to include additional patient conditions for which ambulances could be routed to the most appropriate available hospital, potentially to include psychiatric distress, L&D, respiratory distress, and many other conditions. The Trauma Communications Center is partially funded by the Alabama Education Trust Fund through the ADPH, and additional funding through this initiative would allow for a lifesaving expansion of its efforts.

Proposed use of funds:

- Expand EMS diversion system availability statewide to all EMS and hospitals. Priority consideration will be given to applicants that already operate systems servicing multiple EMS partners and hospitals throughout the state, instead of merely at a regional level.

Table XI-G1. Statewide EMS Trauma and Stroke Initiative Summary		
Category	**Information**	
Main strategic goals	Make rural America healthy again; Sustainable access; Innovative care; Tech innovation	
Uses of funds	F, G, H, I, K (non-exhaustive)	
Technical score factors	B.1, B.2, C.1, C.2, F.1, F.2 (non-exhaustive)	
Impacted counties	001, 003, 005, 007, 009, 011, 013, 015, 017, 019, 021, 023, 025, 027, 029, 031, 033, 035, 037, 039, 041, 043, 045, 047, 049, 051, 053, 055, 057, 059, 061, 063, 065, 067, 069, 071, 073, 075, 077, 079, 081, 083, 085, 087, 089, 091, 093, 095, 097, 099, 101, 103, 105, 107, 109, 111, 113, 115, 117, 119, 121, 123, 125, 127, 129, 131, 133	
Estimated required funding	$20M for 5 years	
Key stakeholders	• EMS • Rural hospitals • Critical Access Hospitals • Rural emergency hospitals	• Federally Qualified Health Centers • Rural Health Clinics • Community Partners • Regional referral centers

Table XI-G2. Statewide EMS Trauma and Stroke Initiative Outcomes and Metrics		
	Outcome	**Impact Level**
1	Number of hospitals participating in diversion systems	Number per county Total statewide
2	Number of EMS/ambulance services participating in diversion systems	Number per county Total statewide
3	Number of new service lines included in diversion systems	Total statewide
4	Number of calls appropriately diverted to suitable locations through use of diversion systems	Number per county Total statewide

8. EMS Treat-in-place Initiative

Description: Many EMS units are often unavailable to take local calls because they are transporting low-acuity patients that do not require full emergency department (ED) level of care or inpatient admission. These situations reduce overall ambulance availability for true emergencies in local communities and are exacerbated in rural communities with lower overall ambulance availability. Unnecessary transport also increases the amount of time EMS is required to wait at EDs before discharging patients to hospitals, increasing the total EMS turnaround time and reducing coverage for other patients. Implementing an **EMS Treat-in-place Initiative** model would allow EMS providers to treat patients on-site and be reimbursed for their services, saving transportation costs, reducing ED overcrowding, and decreasing the resource burden on hospitals. It also creates a needed revenue source for EMS providers and keeps ambulances in the community, thereby reducing response times and improving overall care for residents, especially in rural areas.

Proposed uses of funds:

- Establish a pilot program to institute "treat-in-place" for EMS providers.
- Fund protocol development, telehealth consulting equipment, software, cellular connectivity, training, and other implementation needs as identified.

Table XII-H1. EMS Treat-In-Place Initiative Summary		
Category	**Information**	
Main strategic goals	Make rural America healthy again; Sustainable access; Innovative care; Tech innovation	
Uses of funds	A, D, E, F, G, I, K (non-exhaustive)	
Technical score factors	B.1, B.2, C.1, C.2, D.3, F.1, F.2 (non-exhaustive)	
Impacted counties	001, 003, 005, 007, 009, 011, 013, 015, 017, 019, 021, 023, 025, 027, 029, 031, 033, 035, 037, 039, 041, 043, 045, 047, 049, 051, 053, 055, 057, 059, 061, 063, 065, 067, 069, 071, 073, 075, 077, 079, 081, 083, 085, 087, 089, 091, 093, 095, 097, 099, 101, 103, 105, 107, 109, 111, 113, 115, 117, 119, 121, 123, 125, 127, 129, 131, 133	
Estimated required funding	$25M for 5 years	
Key stakeholders	• EMS • Rural hospitals	• Critical Access Hospitals • Rural emergency hospitals

Table XII-H2. EMS Treat-In-Place Initiative Outcomes and Metrics		
	Outcome	**Impact Level**
1	Number of patients treated in place through the treat-in-place program	Number per county Total statewide
2	Number of emergency transports avoided due to treat-in-place	Number per county Total statewide
3	Number of telehealth consultations conducted as part of treat-in-place encounters	Number per county Total statewide
4	Number of EMS providers offering treat-in-place services	Total statewide

9. Mental Health Initiative

Description: Mental healthcare awareness and access to appropriate mental health services is inadequate, especially in rural areas of Alabama, which can exacerbate economic, educational, and other health outcomes. The **Mental Health Initiative** aims to expand two distinct phases of mental health access in rural Alabama.

1. A school-based tele-mental health model will increase awareness to educators, students, and their families while providing the broadest level of access to appropriate services. School-based tele-mental health will help address Alabama's urgent youth mental health needs, as 1 in 6 Alabama youth experience a mental health disorder and 62 percent of Alabama teenagers with depression are not receiving treatment.[xlviii] While initial contract costs can be a perceived barrier to entry for some K-12 schools, initiating contractual services with a tele-mental health provider can establish an

effective and sustainable model of student- and family-centered care that is primarily paid for through service reimbursements. Part of this initiative will allow K-12 schools to initiate a sustainable tele-mental health program. Priority consideration will be given to providers that 1) have a track record of statewide implementation in rural communities; 2) provide evidence of support from Alabama LEAs to participate in the pilot; 3) maximize third party billing with private insurance and Medicaid; and 4) have a track record of providing telehealth services to students, families, and school staff.

2. CCBHCs are designed to ensure access to coordinated comprehensive behavioral health care,[xlix] and are required to serve anyone who requests care for mental health or substance use disorder, regardless of ability to pay. CCBHCs are required to provide Crisis Services, Outpatient Mental Health and Substance Use Disorder treatment, Person and Family Centered Treatment Planning, Community- Based Mental Health Care for Veterans, Peer Family Support and Counselor Services, Targeted Care Management, Outpatient Primary Care Screening and Monitoring, Psychiatric Rehabilitation Services and Screening, Diagnosis, and Risk Assessment for patients. While several CMHCs in Alabama have already begun the process of converting to CCBHCs, many other CMHCs do not have the financial capability to convert to this model. Part of this initiative will allow the remaining CMHCs the opportunity to apply for funding to convert to a CCBHC.

Should Alabama be awarded additional RHTP funding, this initiative could be scaled up to expand adoption of school-based tele-mental health services and support additional CCBHC conversions.

Proposed use of funds:

- Support planning, development, and implementation of school-based tele-mental health programs in rural areas.
- Support planning, development, and implementation for CMHCs to convert to CCBHCs.

Table XIII-I1. Mental Health Initiative Summary		
Category	**Information**	
Main strategic goals	Make rural America healthy again; Sustainable access, Innovative care; tech innovation	
Uses of funds	A, B, C, D, F, G, H, I, K	
Technical score factors	B.1, B.2, C.1, C.2, D.1, E.1, F.1, F.2, F.3	
Impacted counties	003, 015, 039, 043, 047, 055, 069, 073, 077, 081, 089, 091, 095, 097, 099, 101, 103, 109, 117, 121, 125, 127 (Headquarters Locations) 001, 003, 005, 007, 009, 011, 013, 015, 017, 019, 021, 023, 025, 027, 029, 031, 033, 035, 037, 039, 041, 043, 045, 047, 049, 051, 053, 055, 057, 059, 061, 063, 065, 067, 069, 071, 073, 075, 077, 079, 081, 083, 085, 087, 089, 091, 093, 095, 097, 099, 101, 103, 105, 107, 109, 111, 113, 115, 117, 119, 121, 123, 125, 127, 129, 131, 133 (Services provided)	
Estimated required funding	$45.75M for 5 years	
Key stakeholders	• CMHCs • CCBHCs • Telehealth providers • Mental health providers • Hospitals • Critical access hospitals • K-12 education community • Alabama State Department of Education	• Community partners • FQHCs • IHS/Tribal Facilities • Non-profit health care organizations • Community partners • Alabama State Department of Mental Health • Students and families

Table XIII-I2. Mental Health Initiative Outcomes and Metrics		
	Outcome	**Impact Level**
1	Number of CMHCs converted to CCBHC status	Total statewide
2	Number of patients receiving primary care screening and monitoring from CMHCs converted to CCBHCs	Number per county Total statewide
3	Number of patients receiving mental health services with the CCBHC as the primary provider	Number per county Total statewide
4	Number of patients receiving substance use disorder treatment services with the CCBHC as the primary provider	Number per county Total statewide
5	Number of clinics established in schools	Number per county Total statewide

10. Community Medicine Initiative

Description: The **Community Medicine Initiative** serves Alabama rural communities by providing preventative health screenings, navigates connections to appropriate healthcare, addresses food access issues and healthy food choices, promotes healthy lifestyle choices, encourages physical fitness, and broadly disseminates educational materials and teachings to educate Alabamians on how to participate in improving their own health.

Proposed uses of funds:

- Procurement of equipment to allow for mobile wellness screening.
- Procurement of equipment to allow for the provision of mobile grocery units, food pantries, and food banks.
- Provide new or expand existing locations for provision of mobile screening and mobile grocery services.
- Priority consideration will be given to applicants already offering these services as a combined program, offering both mobile wellness screenings and mobile grocery or food bank services while educating patients on healthy living initiatives.

Table XIV-J1. Community Medicine Initiative Summary		
Category	**Information**	
Main strategic goals	Make rural America healthy again; Innovative care	
Uses of funds	A, G, I, K (non-exhaustive), D, E, G, K (non-exhaustive)	
Technical score factors	B.1, B.2, C.1, F.1 (non-exhaustive)	
Impacted counties	005, 007, 009, 011, 013, 017, 019, 021, 023, 025, 027, 029, 031, 035, 037, 039, 041, 043, 045, 047, 049, 053, 057, 059, 063, 065, 067, 071, 075, 085, 087, 091, 093, 095, 099, 105, 107, 109, 111, 119, 121, 123, 127, 129, 131	
Estimated required funding	$5M for 3 years	
Key stakeholders	• Community leaders • Local healthcare providers • Hospitals	• Critical Access Hospitals • Rural emergency hospitals • Primary care physicians

Table XIV-J2. Community Medicine Initiative Outcomes and Metrics		
	Outcome (Program Metrics)	**Impact Level**
1	Number of mobile wellness units procured	Total statewide
2	Number of mobile grocery/market units procured	Total statewide
3	Number of wellness screenings provided through mobile events	Number per county Total statewide
4	Number of mobile grocery visits provided through mobile events	Number per county Total statewide

11. Rural Health Practice Initiative

Description: The **Rural Health Practice Initiative** serves Alabama's rural communities by establishing or expanding networked rural health clinics in rural, underserved areas throughout Alabama. These clinics promote the creation of comprehensive, patient-centered hubs with the ability to combine physical and behavioral health services by emphasizing preventative care and chronic disease management. This initiative enables clinics to offer telehealth services, remote patient monitoring and virtual consultation to allow rural patients to be connected to specialists, and can also serve as "support" centers for other rural health clinics. Additionally, this initiative will offer local healthcare facilities opportunities to partner with K-12 institutions to establish dental and health clinics and provide primary care services to students, parents, teachers, staff and their families. This initiative will provide funding for equipment upgrades and minor building renovations or alterations to prepare providers to provide the care contemplated by this initiative and ensures that long-term costs are commensurate with patient volume.

Proposed uses of funds:

- Establish or upgrade existing clinics to offer networked services in rural areas.
- Expand workforce recruitment, training and pipeline initiatives to expand clinical capacity.

- Develop and implement a shared services model with other clinics to reduce administrative complexity and overhead, reduce unnecessary cost and improve efficiency.
- Promote community engagement efforts and collaboration with other rural clinics.
- Acquire equipment for telehealth and remote patient monitoring services.
- Establish dental and healthcare clinics in rural educational facilities to serve students, teachers, staff and families.

Should Alabama be awarded additional RHTP funding, this initiative could be scaled up to support the establishment of additional school-based rural healthcare clinics if demand exists.

Table XV-K1. Rural Health Practice Initiative Summary		
Category	**Information**	
Main strategic goals	Make rural America healthy again; Sustainable access; Workforce development; Innovative care	
Uses of funds	A, C, D, E, F, G, H, I, K (non-exhaustive)	
Technical score factors	B.1, B.2, C.1, D.1, F.1 (non-exhaustive)	
Impacted counties	005, 007, 009, 011, 013, 017, 019, 021, 023, 025, 027, 029, 031, 035, 037, 039, 041, 043, 045, 047, 049, 053, 057, 059, 063, 065, 067, 071, 075, 085, 087, 091, 093, 095, 099, 105, 107, 109, 111, 119, 121, 123, 127, 129, 131	
Estimated required funding	$30M for 5 years	
Key stakeholders	• Community leaders • Local healthcare providers • Hospitals • Critical Access Hospitals • Rural emergency hospitals	• Primary care physicians • Rural Health Clinics • Federally Qualified Health Centers • Local educational facilities

Table XV-K2. Rural Health Practice Initiative Outcomes and Metrics		
	Outcome	**Impact Level**
1	Number of clinics established or upgraded	Total statewide
2	Number of patients served through established or upgraded clinics	Number per county Total statewide
3	Number of medical trainees placed in established or upgraded clinics	Total statewide
4	Number of telehealth consultations conducted through networked rural health clinics	Number per county Total statewide

IV. Implementation Plan and Timeline

ADECA will serve as the lead agency for the program. ADECA's Director, Kenneth Boswell, will act as the Authorized Organizational Representative (AOR), with authority to execute award documents and official submissions to CMS. The ARHTP will be housed in ADECA's Federal Initiatives and Recreation (FIR) Division, and the FIR Division Chief will serve as the Project Director. The Division Chief will be supported by a team made up of planning and economic development specialists, and an administrative assistant (see Budget Narrative for a detailed breakdown). Additionally, ADECA will hire a consultant to support its administration of ARHTP. This structure will centralize accountability in ADECA (with the Director serving as AOR), ensure strong program leadership by the Project Director, and establish clear lines of supervision, reporting, legal compliance, and subrecipient monitoring to meet CMS requirements.

It is expected that the Alabama Legislature will be required to pass enabling legislation to provide ADECA with the necessary authority and budgetary guidance to administer ARHTP. The Governor's office, in conjunction with ADECA and other entities that worked to develop ARHTP, will present to the legislature a package of bills expected to assist with the process in developing and implementing the plan. The Alabama legislative session is scheduled to begin on January 13, 2026, with a scheduled end date of April 27, 2026. ADECA, in conjunction with the Governor's office, the Alabama Department of Finance, the Alabama Medicaid Agency, and other parties that worked to develop this plan will then utilize the enabling legislation to draft any necessary administrative rules to provide ADECA with all necessary authority and guidance to effectively administer the plan.

The ARHTP was designed as a set of initiatives to solicit innovative solutions to the current problems facing rural Alabama and, as such, does not specifically select awardees as a part of the

plan. It has been designed to allow for various entities who seek to solve these problems, within the parameters established by the plan, to "apply" for funding under the program. By creating the plan this way, Alabama has the ability to vet multiple different proposals for each initiative to guarantee that the money is being spent appropriately, is awarded to the most appropriate applicant(s), will be utilized according to the guidance developed by ADECA that is reflective of the goals of this plan, and that awardees will follow all rules regarding compliance and data submission required by both CMS and the state.

As ARHTP does not specifically select awardees, it is understood that there must be a method created and enforced to select recipients according to each initiative. Alabama will develop a Request for Proposal (RFP) process for each initiative defined in the plan. The RFP process will comply with all federal and state laws and rules related to procurement. Each RFP will require applicants to, among other things, certify that they will comply with all state and federal procurement laws, certify that they will comply with all rules and regulations established as a part of the initiatives and ARHTP, provide concrete evidence that they are an "appropriate applicant" by demonstrating the ability to provide unique and innovative solutions to the current rural health crisis in Alabama based on the parameters established in the plan, and provide a detailed description of what measures will be taken during the development and implementation of their proposal as to how they will work to make their "solution" sustainable beyond the 5-year funding cycle established by this plan. Furthermore, applicants will be required to certify that they will be able to meet certain milestones and timelines on a schedule suggested by ADECA, a copy of which can be found below for each of the proposed initiatives, and will be required to certify that they will supply any information required by ADECA to allow for accurate administration of the initiatives and to determine if initiative success metrics are being met.

It is anticipated that ADECA, in conjunction with the Governor's office, the Alabama Department of Finance, and other interested parties, will work to establish the RFP processes required by these various initiatives and begin the formal RFP processes during Q3 and Q4, FY2026, with the anticipation that "approved" applicants will begin seeing funding FY2026 distributed during Q4 FY2026 and Q1 FY2027. Additionally, the state may partner with academic institutions to evaluate and measure the impact of the initiatives.

Table XVI-1. Collaborative EHR, IT, and Cybersecurity Initiative Timeline and Milestones																				
	FY26				**FY27**				**FY28**				**FY29**				**FY30**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Stage 0																				
Develop implementation plan																				
Stage 1																				
Procure infrastructure & service contracts																				
Stage 2																				
Launch IT-provider based hubs																				
Begin pilot EHR integration																				
Stage 3																				
Expand services to partners																				
Expand contracts to partners																				
Deploy hardware upgrades																				
Stage 4																				
Maintain processes & services																				
Stage 5																				
Transition to sustainable operations																				
Evaluate impact and outcomes																				

Table XVI-2. Rural Health Initiative Timeline and Milestones																				
	FY26				**FY27**				**FY28**				**FY29**				**FY30**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Stage 0																				
Develop telehealth hub framework																				
Stage 1																				
Complete privacy & security reviews																				
Procure infrastructure																				
Stage 2																				

Launch initial tele-stroke, tele-trauma & tele-ICU services					
Pilot tele-behavioral health, eConsult, & RPM programs					
Stage 3					
Expand telehealth coverage & add new clinical pilots (tele-ID, dialysis)					
Extend RPM for maternal & diabetes care					
Stage 4					
Scale specialty telehealth services					
Optimize performance systems					
Stage 5					
Publish Dashboards					
Finalize sustainability plan					

Table XVI-3. Maternal and Fetal Health Initiative Timeline and Milestones

	FY26 Q1 Q2 Q3 Q4	FY27 Q1 Q2 Q3 Q4	FY28 Q1 Q2 Q3 Q4	FY29 Q1 Q2 Q3 Q4	FY30 Q1 Q2 Q3 Q4
Stage 0					
Develop high-risk maternity care regional hub framework					
Stage 1					
Establish clinical partnership agreements					
Implement unified HIE system for bidirectional data sharing					
Deploy data management system for coordination & quality measurement					
Stage 2					
Image transfer and real-time outcome reporting across all facilities					
Train staff on new protocols					
Deploy telerobotic ultrasound devices					
Use device system to optimize telehealth consultations					
Stage 3					
Expand network to include smaller, lower-risk hospitals					
Extend specialized consultation and data-sharing capabilities					
Develop digital platforms reaching patients in rural areas					
Stage 4					
Identify additional centers as smaller hubs and deploy devices					
Deploy digital maternity care platform					
Deploy remaining telerobotic ultrasound devices					

Stage 5					
Evaluate impact and outcomes					

Table XVI-4. Cancer Prevention, Screening, and Treatment Initiative Timeline and Milestones																				
	FY26				**FY27**				**FY28**				**FY29**				**FY30**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Stage 0																				
Develop hub implementation plan																				
Stage 1																				
Acquire mobile care units																				
Stage 2																				
Implement service coordination with local providers																				
Stage 3																				
Expand provider network & service delivery																				
Stage 4																				
Finalize coordination & optimize care delivery systems																				
Stage 5																				
Publish public dashboard																				
Finalize full implementation																				
Finalize sustainability of system																				
Evaluate impact and outcomes																				

TableXVI-5. Rural Workforce Initiative Timeline and Milestones																				
	FY26				**FY27**				**FY28**				**FY29**				**FY30**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Stage 0																				
Develop workforce programs																				
Stage 1																				
Launch workforce programs																				
Stage 2																				
Fully implement & expand programs																				
Stage 3																				
Optimize program operations																				
Stage 4																				
Finalize program operations																				
Stage 5																				
Evaluate impact and outcomes																				

Table XVI-6. Simulation Training Initiative Timeline and Milestones																				
	FY26				FY27				FY28				FY29				FY30			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Stage 0																				
Plan expansion of COACHES																				
Develop new training programs																				
Stage 1																				
Launch COACHES expansion																				
Launch new training programs																				
Stage 2																				
Implementation of COACHES and new training program delivery																				
Stage 3																				
Optimize all training programs																				
Stage 4																				
Finalize all training program operations																				
Stage 5																				
Evaluate impact and outcomes																				

Table XVI-7. Statewide EMS Trauma and Stroke Initiative Timeline and Milestones																				
	FY26				FY27				FY28				FY29				FY30			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Stage 0																				
Plan and develop system creation/ expansion																				
Stage 1																				
Launch full expansion of 1st service line to all hospitals																				
Launch full expansion of all service lines all hospitals																				
Stage 2																				
Implementation of 1st service line																				
Implementation of all service lines																				
Stage 3																				
Optimization of 1st service line																				
Optimization of all service lines																				
Stage 4																				
Finalize 1st service line to all hospitals																				
Finalize expansion of all service lines to all hospitals																				
Stage 5																				
Evaluate impact and outcomes																				

Table XVI-8. EMS Treat-In-Place Initiative Timeline and Milestones																				
	FY26				FY27				FY28				FY29				FY30			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Stage 0																				
Establish baseline levels of 911 call volumes, transport rates, etc.																				
Develop clinical protocols																				
Stage 1																				
Procure materials/equipment																				
Establish and staff telemedicine hub																				
Integrate software interfaces																				
Stage 2																				
EMS training																				
Implement software and equipment																				
Implement treat-in-place protocols																				
Stage 3																				
Optimize treat-in-place protocols																				
Stage 4																				
Finalize treat-in-place program																				
Stage 5																				
Evaluate impact and outcomes																				

Table XVI-9. Mental Health Initiative Timeline and Milestones																				
	FY26				FY27				FY28				FY29				FY30			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Stage 0																				
Develop CMHC conversion to CCBHC plan, procure first set of tablets, create first school-based clinics																				
Stage 1																				
Launch first conversion efforts, distribute fist set of tablets																				
Stage 2																				
Implement conversion efforts of all CMHCs to CCBHCs, procure additional tablets, create additional school clinics																				
Stage 3																				
Continue and optimize conversion efforts, procure third set of tablets, create additional school clinics																				
Stage 4																				
Finalize conversion efforts, procure fourth set of tablets, create additional school clinics																				
Stage 5																				

Evaluate impact and outcomes, procure last set of tablets, create final school clinics					

Table XVI-10. Community Medicine Initiative Timeline and Milestones					
	FY26 Q1 Q2 Q3 Q4	FY27 Q1 Q2 Q3 Q4	FY28 Q1 Q2 Q3 Q4	FY29 Q1 Q2 Q3 Q4	FY30 Q1 Q2 Q3 Q4
Stage 0					
Plan and develop program activities					
Stage 1					
Procure mobile wellness units					
Procure mobile market units					
Stage 2					
Provide wellness services					
Provide market/grocery services					
Provide health education					
Stage 3					
Optimize and continue provision of services					
Stage 4					
Finalize services/visits processes					
Stage 5					
Evaluate impact and outcomes					

Table XVI-11. Rural Health Practice Initiative Timeline and Milestones					
	FY26 Q1 Q2 Q3 Q4	FY27 Q1 Q2 Q3 Q4	FY28 Q1 Q2 Q3 Q4	FY29 Q1 Q2 Q3 Q4	FY30 Q1 Q2 Q3 Q4
Stage 0					
Begin clinic refurbishment planning					
Stage 1					
Begin purchase of equipment					
Begin recruitment of medical personnel and staff					
Stage 2					
Begin actual refurbishment and equipment installation					
Onboard new medical personnel					
Recruit expanded patient population					
Stage 3					
Continue refurbishment and equipment installation					
Continue to offer services to the community					
Stage 4					

Finalize refurbishment and equipment installation					
Finalize service offerings to community					
Complete integration of all medical personnel					
Stage 5					
Evaluate impact and outcomes					

V. Stakeholder Engagement

Governor Kay Ivey's office invited more than 40 stakeholders[1], including hospital and health care executives, health officers, Indian tribe officials, and advocates for children, seniors, and people with disabilities to provide their comments and input on Alabama's rural health needs for the purpose of drafting the ARHTP plan. Their comments were shared with the Governor's core team for consideration and inclusion in the ARHTP plan.

Table XVII - Solicited Stakeholders	
Health care executives from	*Hospital systems with at least one rural hospital*: Community Health Systems, DCH Health System in Tuscaloosa, East Alabama Health in Opelika, Huntsville Hospital Health System, and the UAB (University of Alabama at Birmingham) Health System *Rural hospitals*: Bibb Medical Center in Centreville and J. Paul Jones Rural Emergency Hospital in Camden
	Children's of Alabama, which sees children all across Alabama, Southeast Health in Dothan, which runs rural clinics, University of South Alabama (USA) Health, Cahaba Medical Care, an FQHC and residency program
Providers	A trauma surgeon and professor at UAB's medical school, a pediatrician (owner of Fort Payne Pediatrics), a physician in Dadeville
Advocacy group leaders (patient and consumer)	American Association of Retired Persons (AARP) Alabama, Alabama Arise, The Alabama Disabilities Advocacy Program, VOICES for Alabama's Children
Tribal Organizations	Alabama Indian Affairs Commission, Poarch Band of Creek Indians
State Agencies	Alabama Medicaid Agency, Alabama Department of Mental Health, Alabama Department of Public Health, Alabama Department of Senior Services, State Office of Primary Care and Rural Health, Alabama Board of Nursing
Organizations and associations representing	Ambulance services, hospitals, nursing homes, pharmacists, FQHCs, pediatricians, physicians, and rural health providers, including dentists.
Health education leaders	Alabama Community College System, Alabama School of Healthcare Sciences, Alabama State Department of Education, Alabama Statewide Area Health Education Centers, Auburn University Rural Health Institute, College of Health Sciences at Faulkner University, UAB Montgomery Psychiatric Residency, UAB School of Public Health
Local health departments and organizations	Franklin Primary FQHC, Jefferson County Department of Health

[1] In addition to these stakeholders, the Governor's office and members of the core team received a significant amount unsolicited comments from other stakeholders and interested parties.

Insurers	Blue Cross and Blue Shield of Alabama
Other stakeholders	The Governor also heard from many others, including: the Alzheimer's Association Alabama Chapter, dental providers, community leaders

In addition to seeking input from stakeholders, Governor Kay Ivey appointed a working group to advise and provide ongoing input to the state team tasked with drafting the ARHTP plan and application. The workgroup met regularly since its creation on September 17, 2025, until ARHTP submission to CMS. Governor Ivey has not set a sunset date for the workgroup.

The members of the working group include:

Table XVIII - Working Group	
Name	**Title, Association**
Joseph Marchant	CEO, Bibb Medical Center
Lother (Jim) Peace	President & CEO, Russell Medical Center
Charles (Max) Rogers, IV	Obstetrics, North Baldwin Infirmary
Susan Alverson	Director of Regulatory Affairs, Alabama Board of Pharmacy
Scott Harris	State Health Officer
Greg Nichols	Administrator, EAMC-Lanier Rural Emergency Hospital
John Waits	CEO, Cahaba Medical Care
Jeff Samz	CEO, Huntsville Hospital Health System
Dawn Bulgarella	CEO, UAB Health System
Natalie Fox	Interim CEO, USA Health
Tuerk Schlesinger	CEO, AltaPointe Health
Teresa Grimes	CEO, Washington County Hospital & Nursing Home
Peggy Benson	Executive Officer, Alabama Board of Nursing Representative
Clarence Ball	President and CEO, Ball Healthcare
Senate President Pro Tem Garlan Gudger	Alabama State Senate
State Senator Greg Albritton	Alabama State Senate
State Senator Bobby Singleton	Alabama State Senate
House Speaker Nathaniel Ledbetter	Alabama House of Representatives
State Representative Rex Reynolds	Alabama House of Representatives
State Representative Anthony Daniels	Alabama House of Representatives

ADECA will administer ARHTP. The core team that developed the plan, including Governor's office staff, ADECA, the Alabama Department of Finance, the Alabama Medicaid Agency, and the Alabama State Health Planning and Development Agency, will continue to engage key stakeholders through implementation. Governor Ivey has also pledged to create, by executive order, an advisory group, which, among other duties, will be the state's formal mechanism for

continued stakeholder engagement as ARHTP is implemented. It will also advise ADECA and the Governor on how the plan is serving rural communities and help develop and implement state policy changes. The group will also assist the core team with coordinating deployment of funds, tracking milestones, and assessing impact metrics with relevant stakeholders.

VI. Metrics and Evaluation Plan

Table XIX-1. Collaborative EHR, IT, and Cybersecurity Initiative Metric Tracking and Evaluation				
Metric	**Impact**	**Baseline**	**Target/Timeline**	**Data Source/Timing**
1. Number of regional hubs established and serving as IT provider-based hubs to local providers	State	0	5 by Year 5	Quarterly reporting from subawardees
2. Number of rural providers connected to regional hubs via IT & security operations	State County	0	50 by Year 5	Quarterly reporting from subawardees
3. Number of rural providers connected to regional hubs via HER	State County	0	50 by Year 5	Quarterly reporting from subawardees
4. Number of EHR upgraded to connect with ALOHR HIE	Provider	0	40-60 by year 5	Quarterly reporting from subawardees
5. Cost savings	State Provider	0	Year 5 target to be determined from Year 1 data to determine a baseline.	Quarterly reporting from subawardees
6. Interoperability of rural providers and health care networks over the ALOHR HIE	Provider	0	99% by year 5	Quarterly reporting from subawardees
7 Upgraded systems uptime percentage	Provider	0	99% by year 5	Quarterly reporting from subawardees
8. Number of cybersecurity alerts triaged/worked by IT-provided based hubs	State	0	750 by year 5	Quarterly reporting from subawardees

Table XIX-2. Health Initiative Metric Tracking and Evaluation				
Metric	**Impact**	**Baseline**	**Target/Timeline**	**Data Source/Timing**
1. Number of regional hubs created	State	0	5 by Year 5	Quarterly reporting from subawardees
2. Number of endpoints deployed	State County	0	100 by Year 5	Quarterly reporting from subawardees
3. Number of telehealth consultations provided	State County	0	10,000 by Year 5	Quarterly reporting from subawardees
4. Number of transfers avoided	State County	0	15% reduction by Year 5	Quarterly reporting from subawardees
5. Number of non-emergency transportation services created or expanded	State	0	5 by Year 5	Quarterly reporting from subawardees
6. Number of rural providers joining Rural Health Network pilot	State	0	7 by Year 5	Quarterly reporting from subawardees
7. Number of shared services created in Rural Health Network	State	0	5 by Year 5	Quarterly reporting from subawardees

Table XIX-3. Maternal and Fetal Health Initiative Metric Tracking and Evaluation				
Metric	**Impact**	**Baseline**	**Target/Timeline**	**Data Source/Timing**
1. Number of regional hubs created	State	0	5 by Year 5	Quarterly reporting from subawardees
2. Number of local providers connected with regional providers to receive services	State County	0	30% increase by Year 5	Quarterly reporting from subawardees
3. Number of telehealth consultations provided	State County	0	1,000 by Year 5	Quarterly reporting from subawardees
4. Number of transfers avoided	State County	0	15% reduction by Year 5	Quarterly reporting from subawardees
5. Number of telerobotic ultrasound procedures performed	State County	0	100/unit/year by Year 5	Quarterly reporting from subawardees
6. Number of L&D carts acquired	State County	0	20 by Year 5	Quarterly reporting from subawardees

Table XIX-4. Cancer Prevention, Screening and Treatment Initiative Metric Tracking and Evaluation				
Metric	**Impact**	**Baseline**	**Target/Timeline**	**Data Source/Timing**
1. Number of regional hubs created	State	0	5 by Year 5	Quarterly reporting from subawardees
2. Number of local providers connected with regional providers to receive services	State County	0	10/hub by Year 5	Quarterly reporting from subawardees
3. Number of mobile screening opportunities offered	State County	0	10,000 by Year 5	Quarterly reporting from subawardees
4. Number of patients screened using mobile services	State County	0	10,000 by Year 5	Quarterly reporting from subawardees

Table XIX-5. Rural Workforce Initiative Metric Tracking and Evaluation				
Metric	**Impact**	**Baseline**	**Target/Timeline**	**Data Source/Timing**
1. Number of new students accepted to rural remote training programs	State County	0	1,000 by Year 5	Quarterly reporting from subawardees
2. Number of programs established at existing rural providers to offer remote training for EMS	State	0	2 by Year 5	Quarterly reporting from subawardees
3. Number of programs established at existing rural providers to offer remote training for LPN/RN	State	0	5 by Year 5	Quarterly reporting from subawardees
4. Number of programs established to provide specialized GME in rural areas	State	0	2 by Year 5	Quarterly reporting from subawardees
5. Number of GME-program graduates practicing in rural counties post-education	State County	0	Year 5 target to be determined from Year 1 data to determine a baseline.	Quarterly reporting from subawardees
6. Number of students entering certified nurse midwife training programs created or expanded through this initiative	State County	0	100 by Year 5	Quarterly reporting from subawardees

Table XIX-6. Simulation Training Initiative Metric Tracking and Evaluation				
Metric	**Impact**	**Baseline**	**Target/Timeline**	**Data Source/Timing**
1. Number of simulation programs established or expanded to deliver specialty-specific training	State	0	3 by Year 5	Quarterly reporting from subawardees

2. Number of simulation training sessions conducted	State County	0	50/Year by Year 5	Quarterly reporting from subawardees
3. Number of patient transfers to regional referral centers from specialties with established simulation training	State County	0	Year 5 target to be determined from Year 1 data to determine a baseline.	Quarterly reporting from subawardees
4. Number of patients treated locally by providers in specialties with established simulation training	State County	0	Year 5 target to be determined from Year 1 data to determine a baseline.	Quarterly reporting from subawardees

Table XIX-7. Statewide EMS Trauma and Stroke Initiative Metric Tracking and Evaluation				
Metric	**Impact**	**Baseline**	**Target/Timeline**	**Data Source/Timing**
1. Number of hospitals participating in diversion systems for additional proposed services (Critical Care, CT, L&D, Med/Surg, and Psych)	State County	0	100 by Year 5	Quarterly reporting from subawardees
2. Number of EMS/ambulance services participating in diversion systems	State County	0	Year 5 target to be determined from Year 1 data to determine a baseline.	Quarterly reporting from subawardees
3. Number of additional services included in diversion systems	State	0	4 by Year 5	Quarterly reporting from subawardees
4. Number of calls appropriately diverted to suitable locations through use of diversion systems	State County	0	15% increase by Year 5	Quarterly reporting from subawardees

Table XIX-8. EMS Treat-In-Place Initiative Metric Tracking and Evaluation				
Metric	**Impact**	**Baseline**	**Target/Timeline**	**Data Source/Timing**
1. Number of patients treated in place through the treat-in-place program	State County	0	1,500 by Year 5	Quarterly reporting from subawardees
2. Number of emergency transports avoided due to treat-in-place	State County	0	500 by Year 5	Quarterly reporting from subawardees
3. Number of telehealth consultations conducted as part of treat-in-place	State County	0	1,000 by Year 5	Quarterly reporting from subawardees
4. Number of EMS providers offering treat-in-place services	State	0	10 by Year 5	Quarterly reporting from subawardees

Table XIX-9. Mental Health Initiative Metric Tracking and Evaluation				
Metric	**Impact**	**Baseline**	**Target/Timeline**	**Data Source/Timing**
1. Number of CMHCs converted to CCBHC status	State	0	16	Quarterly reporting from subawardees
2. Number of patients receiving primary care screening and monitoring from CMHCs converted to CCBHCs	State County	0	30% increase by Year 5	Quarterly reporting from subawardees
3. Number of patients receiving mental health services with the CCBHC as the primary provider	State County	0	30% increase by Year 5	Quarterly reporting from subawardees
4. Number of patients receiving substance use disorder treatment services with the CCBHC as the primary provider	State County	0	30% increase byYear 5	Quarterly reporting from subawardees

Table XIX-10. Community Medicine Initiative Metric Tracking and Evaluation				
Metric	**Impact**	**Baseline**	**Target/Timeline**	**Data Source/Timing**
1. Number of mobile wellness units procured	State	0	1 by Year 3	Quarterly reporting from subawardees
2. Number of mobile grocery/market units procured	State	0	2 by Year 3	Quarterly reporting from subawardees
3. Number of wellness visits provided through mobile events	State County	0	30% increase by Year 3	Quarterly reporting from subawardees
4. Number of mobile grocery visits provided through mobile events	State County	0	30% increase by Year 3	Quarterly reporting from subawardees

Table XIX-11. Rural Health Practice Initiative Metric Tracking and Evaluation				
Metric	**Impact**	**Baseline**	**Target/Timeline**	**Data Source/Timing**
1. Number of clinics established or upgraded	State	0	25 by Year 5	Quarterly reporting from subawardees
2. Number of patients served through established or upgraded clinics	State County	0	30% increase by Year 5	Quarterly reporting from subawardees
3. Number of medical trainees placed in established or upgraded clinics	State	0	Year 5 target to be determined from Year 1 data to determine a baseline	Quarterly reporting from subawardees
4. Number of telehealth consultations conducted through networked clinics	State County	0	10,000 by Year 5	Quarterly reporting from subawardees

Alabama will fully cooperate with all CMS-led evaluations and monitoring activities to support assessment of the implementation, outcomes, and impact of all initiatives proposed in this application. Additionally, the state will partner with academic institutions to evaluate and measure the impact of the initiatives.

VII. Sustainability Plan

By FY2030, ARHTP will establish durable shared-service and group purchasing models to sustain IT and telehealth operations without ongoing federal funding. Participating facilities will leverage established reimbursement mechanisms (e.g., telehealth billing, group purchasing agreements, and shared cybersecurity services) to maintain operations. Workforce initiatives will continue through institutional partnerships with the ASHS and community colleges. All program components are designed to transition from grant-supported implementation to self-funded maintenance through efficiency gains and collaborative governance structures.

To ensure long-term financial and operational stability for IT, cybersecurity, telehealth and operations (e.g. the Collaborative EHR, IT and Cybersecurity and Rural Health Initiatives), regional hubs will operate under a shared-service model that pools resources to improve efficiency and reduce costs. In parallel, these regional partners will develop group purchasing mechanisms to strengthen financial sustainability and maintain cost-effective access to technology and services. Participating facilities will partner through cooperative purchasing agreements to secure reduced per-unit costs for technology, equipment, and infrastructure.

Sustainability for initiatives relying on telehealth and remote care will be achieved through established reimbursement mechanisms across multiple payers. Rural Health, Maternal and Fetal Health, Rural Health Practice, and EMS Treat-in-Place Initiatives will sustain operations by billing for virtual visits, electronic consultations, remote patient monitoring (RPM), and tele-behavioral health services, once implemented. Within the Maternal and Fetal Health Initiative, telerobotic ultrasound services and digital prenatal monitoring will continue through diagnostic imaging and evaluation codes already reimbursed by Alabama Medicaid and other payers.

Establishing CCHBCs will promote long-term sustainability of behavioral health integration activities using accurate and timely billing though the prospective payment system.

Workforce development efforts will remain sustainable through a combination of institutional support, philanthropic investment, and ongoing commitments from payers. Medical student pathways, health profession programs, and continuing education partnerships will be maintained through similar mechanisms, supplemented by potential state tuition offsets and other long-term funding sources. New residency programs will be supported long-term through Medicare GME cap increases and Indirect Medical Education adjustments. ASHS, community colleges, and academic medical institutions will remain core partners in maintaining these rural training

pipelines, ensuring a continuous supply of qualified healthcare professionals dedicated to rural practice.

Through these mechanisms, ARHTP will ensure the long-term viability and sustainability of quality rural healthcare access, technology infrastructure, and workforce systems.

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[i] Calculated using Health Resources and Services Administration (HRSA) data and 2020 Census data.
[ii] Alabama Medicaid, using census tracts defined as rural by the Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy.
[iii] Ibid.
[iv] Ibid.
[v] Alabama Medicaid used census tracts defined as rural by the Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy in determining Alabama's rural population and 58 fully or partly rural counties. The Data Overview also used information from the Alabama Department of Public Health (ADPH) and several other sources, as noted in the Data Overview.
[vi] Alabama Medicaid, using census tracts defined as rural by the HRSA Federal Office of Rural Health Policy.
[vii] Ibid. The percentage of rural Alabamians was derived from the rural population divided by the U.S. Census Bureau's 2020 population for Alabama.
[viii] 2020 Census.
[ix] "Per Capita Personal Income by State, Annual" for 2023 posted by the Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/release/tables?rid=110&eid=257197&od=2023-01-01#; "State Fact Sheets – State Data, for Alabama", updated March 11, 2025, by the Economic Research Service of the U.S. Department of Agriculture. Please note that in determining rural and urban areas of Alabama, the Economic Research Service counted counties that are part of a metropolitan statistical area as urban and counties that are not as rural. The Service said metropolitan statistical areas are county-based regions defined by the Office of Management and Budget (OMB), based on the OMB Bulletin No. 23-01. https://data.ers.usda.gov/reports.aspx?ID=4035&StateFIPS=01&StateName=Alabama Note that the USDA report put the state per-capita income at $54,209.
[x] State and U.S. rates: "Poverty in States and Metropolitan Areas: 2023, American Community Survey Briefs, U.S. Census Bureau, published in September 2024. shttps://www2.census.gov/library/publications/2024/demo/acsbr-022.pdf?stream=top The rural/urban comparison within Alabama came from "State Fact Sheets – State Data, for Alabama" Ibid. Note that this USDA report put the state poverty rate at 15.7 percent.
[xi] The state comparison was based on the table "Educational Attainment, Annual: Bachelor's Degree or Higher by State" for 2023 (estimates were for five-year periods), posted by the Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/release/tables?rid=330&eid=391444&od=2023-01-01#
The rural/urban comparison within Alabama came from "State Fact Sheets - State Data, for Alabama". Ibid. Note that this USDA put the state percentage at 27.8 percent.
[xii] Ibid.
[xiii] Source: U.S. Census Bureau, 2019-2023 5-Year American Community Survey
[xiv] "Infant Mortality in the United States, 2023: Data from the Period Linked Birth/Infant Death File", published June 12, 2025, in the National Vital Statistics Reports by a part of the Centers for Disease Control and Prevention (CDC). https://stacks.cdc.gov/view/cdc/174592. The comparison of urban and rural rates came in a statement in October by State Health Officer Scott Harris to David White, Governor Ivey's senior policy advisor.
[xv] https://assets.americashealthrankings.org/app/uploads/allstatesummaries-ahr24.pdf
[xvi] "U.S. State Life Tables, 2021, published Aug. 21, 2024, in the National Vital Statistics Reports by part of the CDC. https://www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-07.pdf The 2023 life expectancies for Alabama and each county were published in "Alabama County Health Profiles 2023" by ADPH.
https://www.alabamapublichealth.gov/healthstats/assets/chp2023.pdf A review of the report found the six lowest life

expectancies for counties.

[xvii] America's Health Rankings 2024 annual report, published by UnitedHealth Foundation. https://www.americashealthrankings.org/learn/reports/2024-annual-report The information for 2023 was based on the Centers for Disease Control's Behavioral Risk Factor Surveillance System. Chronic conditions included arthritis, asthma, chronic kidney disease, chronic obstructive pulmonary disease, cardiovascular disease, cancer, depression, or diabetes.

[xviii] "Cancer Statistics: Mortality – All Cancer Sites Combined, U.S. Cancer Statistics Working Group, CDC and National Cancer Institute. Mortality rates are adjusted.
https://gis.cdc.gov/Cancer/USCS/#/explore/mortality?cancer=1&datatype=2&dataset=standard&indicator=value&area=1&timeperiod=26&sexes=1&races=1&ages=23&tab=1&view=table&xaxis=sexes&shownational=1

[xix] www.alabamapublichealth.gov/healthranking/diabetes.html

[xx] "Heart disease mortality" in Stats of the States published Aug. 20, 2025, by the CDC's National Center for Health Statistics. Mortality rates are age-adjusted to account for differences in age distribution and population size between states. https://www.cdc.gov/nchs/state-stats/deaths/heart-disease.html

[xxi] cdc.gov/nchs/state-stats/deaths/hypertension.html

[xxii] https://www.alabamapublichealth.gov/awa/trends.html

[xxiii] A review by the Alabama Hospital Association (AlaHA) shared with the Governor's office in October 2025, based on AlaHA surveys of hospitals.

[xxiv] A review in October 2025 by Alabama Medicaid and shared with the Governor's office.

[xxv] "At a Glance", posted on the web page of the Office of Primary Care and Rural Health at ADPH. ADPH officials said the entry was based on a 2022 report by the March of Dimes and American Hospital Association.

[xxvi] Ibid.

[xxvii] America's Health Rankings 2024 annual report, published by UnitedHealth Foundation. https://www.americashealthrankings.org/learn/reports/2024-annual-report The information was based on the Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System for September 2024.

[xxviii] Ibid.

[xxix] Ibid.; At A Glance | Alabama Department of Public Health (ADPH)

[xxx] At A Glance | Alabama Department of Public Health (ADPH)

[xxxi] Ibid.; https://www.americashealthrankings.org/explore/measures/costburden/AL

[xxxii] https://assets.americashealthrankings.org/app/uploads/allstatesummaries-ahr24.pdf

[xxxiii] "Rural Hospitals at Risk of Closing,'' published in August 2025 by the Center for Healthcare Quality & Payment Reform. https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf The report said there were 48 open rural inpatient hospitals. ADPH in its "At a Glance" put the number at 54.

[xxxiv] Clarke County: https://www.thethomasvilletimes.com/articles/thomasville-regional-medical-center-shuts-down-amid-financial-struggles/ Pickens County: https://yellowhammernews.com/alabama-hospital-to-close-17th-to-shut-down-in-10-years/ Butler County: https://www.wsfa.com/2019/02/11/alabama-lose-another-rural-hospital/ Lawrence County:
https://www.lawrencemedicalcenter.com/news-a-events/news-archive/item/lawrence-medical-center-to-close-emergency-department-on-may-23
Jackson Hospital: https://www.wvasfm.org/wvas-local/2025-02-05/jackson- hospital-files-bankruptcy

[xxxv] https://www.al.com/news/2024/07/babies-are-going-to-die-says-one-of-last-doctors-delivering-babies-in-rural-southwest-alabama.html Reporter Amy Yurkanin wrote that without Grove Hill Memorial Hospital's labor and delivery unit in Clarke County, the closest hospital to Grove Hill with a labor and delivery unit was about 80 minutes away, in Brewton. She reported on July 12, 2024, that the Hospital in Marengo County planned to reopen its labor and delivery unit that fall. It has not.

[xxxvi]From ADPH's facilities directory:
https://dph1.adph.state.al.us/FacilitiesDirectoryReports/Reports/ReportDirectory-2025-11-02-1724239080620.pdf

[xxxvii] xxxvii "State of Rural Health in Alabama", a slide deck produced in August 2025 by Manatt Phelps & Phillips and the Alabama Hospital Association. Shared by Association President Danne Howard.

[xxxviii] "Alabama Hospitals by the Numbers," published Oct. 17, 2024, by the Alabama Hospital Association. https://www.alaha.org/app/uploads/2024/12/AL-Hospitals5-9By-the-Numbers-10-17-24-FINAL.pdf

[xxxix] "Health insurance coverage of population ages 0-64" for 2023, published by KFF, an independent source for health-policy research.
https://www.kff.org/state-health-policy-data/state-indicator/health-insurance-coverage-population-064/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[xl] "Commercial reimbursement benchmarking 2025", published July 24, 2025, by Milliman, a consultancy. Milliman reported what insurers paid for in-patient care as a percentage of Medicare fee-for-service payments. https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking-medicare-ffs-rates-2025

[xli] "2023 Poverty Rate by State, Per the Latest Census Data", published Nov. 9, 2023, by Forbes. https://www.forbes.com/sites/andrewdepietro/2023/11/09/2023-poverty-rate-by-state-per-the-latest-census-data/

[xlii] America's Health Rankings 2024 annual report, op. cit.

[xliii] A comparison of Medicaid-eligible people in those counties and the state in January 2024 to populations in those counties and Alabama in July 2024. Medicaid eligibility came from the "Demographic Breakdown of Medicaid Eligibles" for January 2024 posted by Alabama Medicaid. https://medicaid.alabama.gov/documents/2.0_Newsroom/2.6_Statistics/2.6_Eligibility_by_County_July_9-1624.pdf. County population totals and growth or gains in population came from "These were Alabama's fastest growing counties in 2024", published March 17, 2025, by al.com https://www.al.com/news/2025/03/these-were-alabamas- fastest-growing-counties-in-2024.html

[xliv] The Alabama Medicaid Agency is a recipient of the TMaH grant. Alabama will not allow duplication of the TMaH grant services.

[xlv] Alabama Department of Labor, Labor Market Information Division. Accessed October 22, 2025. https://www2.labor.alabama.gov/workforcedev/Default.aspx

[xlvi] HPSA Shortage Area Designations. ADPH. Accessed October 22, 2025: https://www.alabamapublichealth.gov/ruralhealth/hpsa.html

[xlvii] www.operatonwipeout.org

[xlviii] AlabamaStateFactSheet.pdf

[xlix] https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics