Rural Health Needs and Target Population

Georgia is proud to introduce the Georgia Rural Enhancement And Transformation of Health (GREAT Health) program. GREAT Health will create stabilizing conditions for long-term success as the state transitions to value-based care across payers and delivery systems via the Achieving Healthcare Efficiency through Accountable Design (AHEAD) model. This significant shift in the delivery of rural health services will foster financial durability for rural health providers and meaningfully improve health outcomes for rural patients. The GREAT Health Program will weave systems reforms, one-time investments, and a shift to valuing health into the fabric of rural communities. GREAT Health impacts will be felt statewide; however, Georgia's impact is focused on 126 counties and rural portions of counties, as listed in the state map (*Attachment C*) and county list (*Attachment D*), as described by the Health Resources and Services Administration (HRSA).

Rural Demographics: Rural communities in Georgia are uniquely positioned to embrace opportunities to improve their health and healthcare delivery systems. Compared to urban counterparts and to the nation as a whole, rural areas have higher rates of poverty (including higher numbers of children living in poverty) (Farrigan, 2016), lower educational attainment, (U.S. Department of Agriculture, 2017), and lower rates of employer-sponsored health insurance (NewKirk, 2014). These factors impact healthcare delivery and rural Georgians' access to care. Specifically, the state has a rural population of 2.4 million and a rural population density of 55 residents per square mile (590 nonrural) (National Institute on Minority Health and Health Disparities, 2025); the poverty rate in rural communities is 19% (13% nonrural and 14% statewide), and 16% of Georgia's rural residents have not graduated from high school (10% nonrural) (U.S. Department of Agriculture, 2025). Rural areas in Georgia have a higher

proportion of uninsured residents compared to nonrural areas (14% of rural residents are uninsured versus 12% nonrural) (National Institute on Minority Health and Health Disparities, 2025). Rural Georgians experience additional economic disadvantages that affect their ability to maintain health and wellbeing. Despite a rural unemployment rate of 3.3% in 2023 (3.2% for non-rural areas), per capita income was lower in rural areas ($45,276 for rural versus $62,787 for nonrural) (United States Department of Agriculture, 2025). The service industry employs more people than any other sector in rural Georgia, collectively employing five times more people than the next highest sectors of manufacturing, healthcare, retail, and food services/hospitality (Georgia Department of Labor, 2025).

Health Outcomes: The fragile systems of care and provider shortages in rural Georgia have directly impacted the lifespan of rural Georgians. There are no obstetrician-gynecologists in 82 of Georgia's 159 counties and 63 counties had no pediatricians in 2024 (Georgia Board of Health Care Workforce, 2024). There are no birthing facilities in 108 of Georgia's 126 HRSA-designated rural counties/portions of counties (Georgia Department of Public Health, 2025). As rural residents grow into adulthood, they are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts (Garcia, 2017). Georgia's all-cause mortality (2019-2023) was 1,048 per 100,000 people in rural areas compared to 854 per 100,000 in nonrural areas (National Institute on Minority Health and Health Disparities, 2025). The same trend was seen for health conditions:

- Major cardiovascular diseases: 12,200 per 100,000 population in rural versus 8,300 nonrural (Institute of Public and Preventive Health, 2025)
- Cancers: 481 per 100,000 population in rural versus 469 statewide (Georgia Rural Health Innovation Center, 2025a)

- Suicide: 19 per 100,000 population in rural versus 15 nonrural (Georgia Rural Health Innovation Center, 2025a)

For older adults in rural communities, 188,300 individuals over 65 are living with Alzheimer's or another type of dementia. Older adults in rural areas face serious gaps in care, with dementia diagnoses often delayed and services fragmented—driving avoidable hospitalizations (1,573 ED visits per 1,000 people with dementia in 2018), avoidable hospital readmission rates (22.5% for dementia patients in 2018), and higher Medicaid costs (Alzheimer's Association, 2025). The AHEAD model presents an opportunity to develop a cohesive plan to combat the growing incidence of chronic conditions and population needs for more integrated and coordinated care.

Healthcare Access: Fifty-three rural Georgia counties do not have a hospital, creating significant time and distance barriers to accessing care (Georgia Rural Health Innovation Center, 2025b). Georgia currently has 67 rural hospitals—defined as located in a rural county or meeting rural-specific Centers for Medicare & Medicaid Services (CMS) definitions—including 30 Critical Access Hospitals, 36 rural Inpatient Prospective Payment System hospitals, and one rural emergency hospital. In addition to hospitals, rural residents rely heavily on Federally Qualified Health Centers (FQHCs), rural health centers, and Rural Health Clinics (RHCs) for clinical care. There are 21 FQHCs that operate one or more clinics per organization, providing healthcare services in 100 rural counties, and 98 RHCs provide services in 58 of 126 rural counties (Georgia Primary Care Association, 2024). These examples represent opportunities to expand general and specialty care that rural Georgians need for meaningful healthcare integration.

A clear example of limited access to care for many rural communities is evident in the central and southwestern areas of the state where several rural counties rely heavily on a limited number of FQHCs and local emergency medical services (EMS) to provide routine and urgent

medical care. Primary care providers are also limited in Georgia, with 41 rural counties having no internal medicine physicians and 19 counties with no family medicine physicians in 2024 (Georgia Board of Health Care Workforce 2024).

Rural Facility Financial Health: Over the last twenty years, rural healthcare entities have faced financial uncertainty leading to facility closures or reduced bed counts. Overall, total rural set up and staffed beds decreased from 4,972 in 2001 to 3,236 in 2024— a net reduction of 1,736 beds or roughly 35%. Georgia rural hospitals see 35 emergency department visits per 100,000 people compared to 26 per 100,000 people for nonrural areas. Inpatient admissions from emergency departments are also higher for rural communities (38% versus 21% for nonrural) (National Institute on Minority Health and Health Disparities, 2025).

Conclusion: With this context in mind, the proposed GREAT Health Program was developed to address the five overarching Rural Health Transformation Program (RHT Program) strategic goals and the GREAT Health Program's vision of transforming health for rural *populations*, in rural *places*, for rural *progress*. These strategies work in concert with the future shift to the AHEAD model requirements and improved health outcomes tied to risk. Georgia will use this funding opportunity to improve the health of its residents in the 126 HRSA-designated rural areas, making rural communities more conducive to improved collective wellbeing. The implementation of the RHT Program has been carefully planned in response to the realities of rural Georgians' health needs and the infrastructure, workforce, and service gaps. Stakeholders across Georgia are ready to embark on the mission to uplift rural areas of the state to meet their potential and make Georgia a leading example of rural health innovation and transformation.

Rural Health Transformation: Goals and Strategies

The GREAT Health Program is the result of connecting, listening, and strategizing with rural communities to build a strong foundation of transformed health in rural Georgia that is aligned with the needs of rural populations, in rural places, for rural progress. Given that 126 of Georgia's 159 counties/portions of counties are designated as rural by HRSA, transforming the health of rural Georgians will make an impact that reaches far across the state. By knitting together the vital assets, strengths, and unique knowledge from rural communities, with the expertise and support of health providers, academic institutions, state agencies, and other partners, GREAT Health is driving toward a new value-based, risk-bearing model of care under the AHEAD model. Achieving this vision means:

- Rural *populations* are healthier, live longer, have an improved quality of life, and can both live and work in the communities they love.
- Rural *places* have healthcare that is high quality, more abundant, and more effective.
- Rural *progress* creates systems-level change that leverages technology, drives innovation, and improves quality, while maintaining a patient focus and embracing patient voice.

The GREAT Health Program will move the state toward this vision by focusing on five *goals* that reflect the five RHT Program strategic goals with a Georgia lens, tracking five *objectives* that direct manageable steps to progress and outcomes, and implementing five project *initiatives* that organize multiple, synergistic *strategies* for each initiative. To advance this vision of health aligned with needs of rural Georgians, the GREAT Health Program goals, objectives, initiatives, and associated strategies are further described in Section 4.

Strategic Goal 1: Innovative Care

GREAT Health Goal 1: Use Evidence-Based Models for Value-Based Care to Innovate and Strengthen the Healthcare Delivery System in Rural Georgia

Objective 1: Implement innovations in health care delivery that improve health outcomes and quality of life.

Initiative 1: Transforming for a Sustainable Health System in Rural Georgia: Under this initiative, the state will prepare rural healthcare facilities and Georgia to succeed in the CMS-driven AHEAD Model for hospitals and AHEAD primary care programs to align with the vision of rural progress. Many of the initiatives that are related to sustainable access, workforce, and technology innovation are focused on providing opportunities, resources, technology, and system-level shifts to increase the readiness of providers, hospitals, RHCs, and FQHCs to shift to value-based care contracting and global payments. As part of this initiative, the state's strategy is to dedicate resources to work collaboratively with healthcare facilities and leaders to assess readiness, identify gaps, provide technical assistance, and mitigate fiscal risk, particularly for already vulnerable hospitals and small rural clinics.

Strategic Goal 2: Make Rural America Healthy Again

GREAT Health Goal 2: Make Rural Georgia Healthy Again

Objective 2: Focus on root causes of disease to prevent illness and coordinate care for enhanced chronic disease management.

Initiative 2: Strengthening the Continuum of Care in Rural Georgia: Initiative 2 includes nine strategies, which focus on improving behavioral health programs; enhancing infrastructure related to emergency response to mitigate trauma risks; improving public health initiatives related to inter-hospital transportation and strengthening newborn screenings; expanding support for acquired brain injury survivors; creating a nutrition and weight management eligibility category to Georgia's Planning for Healthy Babies demonstration program; and increasing access to nutrition services for children with autism spectrum disorder (ASD).

Strategic Goal 3: Sustainable Access

GREAT Health Goal 3: Increase and Sustain Access to Healthcare in Rural Georgia

Objective 3: Provide sustainable access to healthcare.

Initiative 3: Connecting to Care to Improve Healthcare Access in Rural Georgia: Initiative 3 includes six strategies that align with the vision of increasing access in rural places to ensure residents have more opportunities for primary, specialty, dental, and behavioral healthcare. Several strategies use technology to expand access to care, including deploying mobile health units; integrating telehealth point-of-care pods; implementing and expanding telehealth for specialty care access; expanding access to provider-to-provider consultations through telehealth for pediatric psychiatry and postpartum behavioral health; and enhancing public health telehealth infrastructure. Georgia is also proposing to improve access to maternal care by placing obstetric carts in rural, non-delivering emergency departments and implementing patient bundles to improve quality outcomes. Furthermore, Georgia is enhancing the state's legislatively established Rural Hospital Stabilization Grant Program to create a track specifically aligned to the RHT Program goal of increasing access. Grantees for this program will be asked to commit to aligning with innovative care strategies that are focused on improving health outcomes and transitioning providers to participate in value-based care contracts.

Strategic Goal 4: Workforce

GREAT Health Goal 4: Build and Sustain a Highly-Skilled Rural Healthcare Workforce

Objective 4: Recruit and retain a healthcare workforce that is empowered to make decisions that engage patients for improved outcomes.

Initiative 4: Growing a Highly Skilled Healthcare Workforce in Rural Georgia: Initiative 4 has five strategies that are grounded in increasing and incentivizing healthcare providers to work in

rural Georgia and directly associated with the GREAT Health vision for rural populations in rural places. Implementation of Georgia's graduate medical education (GME) strategy includes incentives for physicians, doctoral-level providers, and GME programs to strengthen the primary care workforce. The state is also focused on increasing access to paramedics through an emergency medical services (EMS) scholarship program. Additionally, a partnership with the Area Health Education Centers (AHECs) will allow GREAT Health to engage with future doctors and nurses, and telehealth technology will be utilized to train and mentor all provider types in dementia care best practices. The proposal also includes several strategies to address critical nursing shortages, focusing on improvements in clinical faculty recruitment and retention, enhancing clinical training, and identifying and motivating the next generation of nurses.

Strategic Goal 5: Technology Innovation

GREAT Health Goal 5: Use Technology Resources to Improve Healthcare Access, Delivery, and Information in Rural Georgia

Objective 5: Integrate technology that improves care delivery and gives providers and patients real time, secure access to health data information.

Initiative 5: Leveraging Technology for Healthcare Innovations in Rural Georgia: Georgia is committed to scaling up innovation with a focus on improving care delivery in alignment with the vision of advancing rural progress. There are eight technology-based strategies incorporated into the GREAT Health Program. The state will partner with the Advancing Access to Robust Care and Health in Rural Georgia (ARCHER) Tech Catalyst Fund to invest in the development of rural technology. This collaborative effort will focus on four components: rural healthcare needs delivery, company scouting and validation, investment in rural deployment, and long-term

monitoring and impact assessment of deployed technology. Additionally, under this initiative Georgia will dedicate resources to improving cybersecurity, enhancing electronic medical record (EMR) systems to ensure rural hospitals, clinics, and facilities use data to drive population health initiatives, streamlining the Medicaid eligibility system, and deploying a consumer facing product that engages patients in wellness and preventive health actions. Funds are also dedicated to integrating robotic technology in rural places to increase access to surgical services and contribute to surgeon recruitment and retention. Georgia will also engage in a behavioral health technology assessment that can inform future behavioral health innovations.

Statutory Elements

Improving Access: One of the GREAT Health Program pillars is a focus on improving access to care in rural places. Initiative 3 of the project will create access points in rural, underserved communities by collaborating with local rural healthcare providers to place telehealth point-of-service primary care pods where a brick-and-mortar clinic is not feasible. The state will work with hospitals and clinics to deploy mobile units focused on expanding access to primary care, specialty care, dental care, behavioral care, and preventive health screenings. The state is also providing financial support for hospitals and rural clinics to ensure financial solvency by developing strategies to improve quality care and foster collaboration to enhance available services through the rural stabilization grants. GREAT Health will also use telehealth technology to improve access to specialty care services and increase provider-to-provider consultations for pediatric and postpartum psychiatry, allowing patients to receive needed behavioral health care from primary care providers in their communities. Telehealth strategies also include infrastructure improvements to increase public health departments' telehealth capacity. The

GREAT Health Program also aims to strengthen perinatal systems of care by integrating obstetric carts into rural non-delivering emergency departments to address emergent delivery needs.

Improving Outcomes: Targeted outcomes in the GREAT Health Program include increased compliance with preventive health screenings related to chronic conditions, improved chronic disease control, and decreased chronic disease prevalence rates. These target outcomes will be realized by enacting strategies such as using mobile units to increase preventive health screening access, engaging primary care clinics in quality improvement strategies (e.g., care management to improve preventive screening compliance), increasing access to care and reach rates through telehealth programs, and increasing the workforce capacity for preventive healthcare. Additionally, maximizing participation in and success under the AHEAD program will improve the quality of chronic disease care. Medical providers will engage in enhanced communication, better care coordination, and data-driven approaches to population health management that will improve patient-level health outcomes and clinical quality metrics. The above strategies will contribute to overall declines in rural Georgia's all-cause mortality rate.

Technology Use: One pillar of the GREAT Health vision is rural progress through the use of technology, and multiple strategies support innovation and integration of technology. The ARCHER fund is solely focused on supporting innovation, including those that incorporate artificial intelligence, to improve healthcare efficiencies. Another strategy includes a consumer-facing technology that prompts patients to engage in preventive health care and provides education focused on wellness initiatives, such as nutrition and weight loss strategies. Other technological innovations in the GREAT Health Program include streamlining the eligibility process for Medicaid enrollment, improving rural hospitals cybersecurity, and installing telehealth capabilities into EMS units to implement a treat versus transport approach to care.

Additionally, the program provides an opportunity for rural hospitals to enhance surgical services recruitment through the purchase of robotic surgical instruments.

The state will evaluate the suitability for new technologies for rural providers and patients through stakeholder, provider, and patient feedback; technology assessments; and competitive grant application processes. Healthcare entities and providers will apply for funding for innovative technology. As part of that process, the applicants will need to address the readiness of the organization to adopt new technology, the ability of providers to integrate the new technology into practice, steps for change management, and the will of the community or patients to engage in the use of new services available. Additionally, Georgia will offer technical assistance and training in conjunction with planning and implementation to ensure the successful adoption and integration into practice.

The seed-funding and initial costs of equipment and technology are integrated into the GREAT Health Program budget. However, fund recipients will need to focus on implementation practices and develop strategies for long-term sustainability. Part of the grant application process will require applicants to address sustainability needs such as upgrades, maintenance, data security, long-term support and vendor reliability, energy consumption, and future cost considerations.

Partnerships: The GREAT Health Program is comprehensive in scope and provides opportunities for partnership engagement at the local, state, and regional levels. A key stakeholder advisory council that consists of at least 60% rural representation will ensure a focus on rural health and provide opportunities for information sharing, data reviews and reflections, and discussion of lessons learned during implementation. This advisory council is discussed in greater detail in the key stakeholder section of the proposal. Georgia will also strive to form

AHEAD hospital and AHEAD primary care networks with all participating entities. These networks will have separate and combined meetings that will encourage hospitals and primary care providers to collaborate to move the work forward. Participating healthcare organizations will promote measurable quality improvement, discuss strategies for financial stability, and share best practices. Bringing these entities together will provide the opportunity for a more robust discussion around developing a more formal structure, such as a clinically aligned network.

Georgia will leverage current structures such as its public health districts, hospital associations, and primary care associations to engage hospitals, primary care clinics, public health partners, and FQHCs. Regional partner engagement will include opportunities to share best practices, discuss quality initiatives, provide training, and explore how to formalize regional approaches to consortia and networks. Most of the initiatives include strategies for grant opportunities at the local level. In the grant proposal phase, local healthcare organizations and partners will be encouraged or required to demonstrate a consortium or network approach to the work with at least two additional partner agencies or organizations. At the local, regional, and state levels, the partners will focus on ensuring clinical shifts, engaging in cross-sector planning, providing training, developing data accountability systems, and sharing outcomes.

Workforce: The GREAT Health Program has an initiative entirely dedicated to recruiting, training, and developing a pipeline for clinicians with a focus on doctoral-level providers, nurses, and paramedics as well as programs for current practitioners in the workforce to advance their skills and training. Georgia will work in collaboration with academic institutions to develop and implement both new and enhanced GME and incentive programs to recruit health professionals to practice in rural areas. Additionally, the state will engage the regional AHECs to create a high school and college healthcare workforce pipeline with a focus on the Preceptor Tax Incentive

Program. Nursing strategies seek to increase faculty capacity at the academic level in order to train additional nurses. Funds will also be used to provide tuition assistance, purchase simulation equipment, and develop toolkits for nurse faculty orientation.

Data-driven Solutions: Data-driven solutions are at the core of the GREAT Health Program. Most of the program initiative strategies are focused on increasing the capacity of rural hospitals and clinics for the AHEAD program, which is a data-driven program. The state is investing in multiple assessments to gather state-level data on gaps in behavioral workforce, AHEAD readiness, and for the deployment of telehealth and mobile service expansions based on data indications. At the hospital and clinic levels, the GREAT Health Program will provide resources to enhance EMR systems specifically focused on building capacity around population health reporting and development of data-driven solutions to improve care metrics, enhance case management, and improve overall population health outcomes. Additionally, growing the population with access to a consumer engagement platform through participation in the AHEAD model will allow patients to engage with their own health metrics and provide greater insights to providers on individual health and risk factors, allowing health professionals and payers to utilize AI technology to stratify risk and identify patients who need care ahead of major health events. The GREAT Health Program will bring technology into rural communities to expand access to services through telehealth, point-of-care pods, the ability for paramedics to treat in the field with telehealth equipped ambulances, and for expansion of behavioral health services.

Financial Solvency Strategies: The GREAT Health Program's strategies are aimed at building capacity and financial solvency of both hospitals and rural clinics, including FQHCs, by investing in innovation, technology, and workforce development. The GREAT Health Program will drive down costs using technology, focusing on primary care, expanding access to care

(which will increase market share), and increasing revenue through value-based quality care initiatives. The primary metric for financial solvency is successfully creating a fiscally sound value proposition for rural entities to participate in AHEAD and transitioning to a value-based model of care that maximizes financial success and improves patient outcomes.

Cause Identification: Standalone rural hospitals are at risk of service reduction or closure due to a combination of financial, demographic, and systemic challenges. Some key reasons include low patient volume due to isolated or aging populations in Georgia's rural communities, relatively high rates of uninsured patients contributing to high levels of uncompensated care, a patient mix with low commercial payer coverage and heavy reliance on Medicaid and Medicare, workforce shortages that impact the ability to expand services, and facility infrastructure needs (e.g., updates and upgrades in equipment and buildings). Overall, standalone rural hospitals operate on thin margins, serve high-need populations, and face structural and fiscal challenges that urban hospitals can more easily manage. The GREAT Health Program addresses these challenges by encouraging regional collaboration, strengthening workforce, increasing revenue by increasing access to services, and working towards value-based care models to change the traditional paradigm away from fee-for-service care.

Program Key Performance Objectives: The overarching GREAT Health Program rural outcome metrics demonstrate the program vision of healthier populations, access to care in rural places, and leveraging technology to drive progress in the following metrics by FY31.

- Increased access to 10% of rural residents measured by increased use of telehealth services and reduced travel time and distance to services
- Decrease in all-cause mortality in rural areas by 15%
- Decrease in readmissions in 75% of rural hospitals

- 20% increase in the ratio of rural primary care providers to rural population
- 10% increase in the number of patients in participating rural counties with preventative screenings at evidence-based intervals

Initiative-specific metrics can be found in the metrics and evaluation section of this proposal.

Strategic Goals Alignment: The GREAT Health Program's strategic goals, initiatives, and strategies are directly aligned to the five RHT Program strategic goals and the above statutory elements. The five GREAT Health Program Goals mimic the RHT Program strategic goals but reflect a focus on Georgia. The program design is intentionally focused, as discussed above, on increasing access, achieving health outcomes, using technology, enhancing partnerships, developing workforce, implementing data-driven solutions, and addressing financial solvency and causes for hospital closures. This alignment is further illustrated in the evaluation plan.

Legislative or Regulatory Action

B.4. Nutrition Continuing Medical Education: While Georgia does not presently have nutrition as a mandated factor for Continuing Medical Education (CME), Georgia is committed to exploring opportunities for nutrition related CME for all providers. As displayed in the strategies laid out for the GREAT Health Program, Georgia is actively pursuing more avenues for increased medical education on this topic. Regulatory change through the Composite Medical Board to encourage provider CME will be explored in the upcoming year. This will demonstrate to providers the commitment the state has to health and encourage providers to educate their patients on the value of healthy lifestyle and nutrition. Ensuring medical providers have this education will provide a new lens of wellness to Georgia's medical community to improve outcomes for rural residents. This change will take place before the final Board meeting of 2028.

F.1. Remote Care Services: Improving maternal outcomes in Georgia is a policy arena that stretches across branches of government and party lines. Informed by the successes of a pilot program which began as a result of legislation passed in 2023, DCH is pursuing a regulatory change to institute statewide benefits for these services. Services include remote blood pressure, glucose, and weight monitoring during pregnancy and up to 90 days postpartum and eligibility is determined by diagnoses and at provider discretion. This additional remote monitoring benefit connects rural mothers to more targeted care and promotes prevention-driven interventions for those with the most high-risk pregnancies. This change will be pursued ahead of the final Board meeting in 2027.

Other Required Information: State Policies

B.2. Health and Lifestyle: Georgia currently has a state-specific Presidential Physical Fitness Test in place called *Fit Georgia*. Under State Board Rule 160-4-2-.12, each local board of education is required to use a fitness assessment approved by Georgia Department of Education (DOE). Students in grades 4-12 are required to complete all five assessment components. Additionally, O.C.G.A. § 20-2-777 codifies the Student Health and Physical Education Act (SHAPE Act) which requires annual fitness testing in public schools and that school systems report results to parents and aggregate data to the state.

C.3. Certificate of Need (CON): The Cicero Institute report from 2024 lists a total CON score of 95/100 for Georgia. However, it is important to note that Georgia's CON law was amended in the 2024 legislative session of the Georgia General Assembly by House Bill 1339, which was signed into law by Governor Kemp on April 19, 2024. The regulations for these changes were adopted by the Board of Community Health in December of 2024 and June of 2025; thus, these changes are not reflected in the Cicero score. The updated CON law provides several new exemptions

targeted at rural communities, including an exemption for new or expanded perinatal services in rural counties, new general acute hospitals in rural counties and new acute care hospitals in rural counties where a short stay hospital has been closed for more than one year without the opening of a replacement. The law also adds an exemption for new or expanded psychiatric or substance use inpatient programs and an exemption for new or expanded birthing centers. Finally, the law raises the total limit on tax credits for donations to rural hospital organizations to $100 million. These new flexibilities demonstrate Georgia's continued focus on rural access to care.

D.3. Scope of Practice: *Dental Hygienists:* In the 2025 legislative session, House Bill 567 expanded scope of practice for teledentistry functions for dental hygienists, and House Bill 322 allowed foreign-trained dentists and hygienists to apply for a license to teach. Rule 150-5-.08 of the Georgia Board of Dentistry also became effective on December 24, 2024 and allows dental hygienists to utilize a dental diode laser, which expanded the permissible scope of practice. Further amendments to this rule and Rule 150-5-.03, which authorizes the use of general supervision of dental hygienists, are under review and will broaden permissible procedures.

Nurse Practitioners and Physician Assistants: The 2024 and 2025 legislative sessions both included law changes that increased the scope of practice for nurse practitioners and physician assistants. House Bill 36 in 2025 included both professions as signatories in guardianship and conservatorship proceedings. House Bill 557 in 2024 allows Schedule II prescribing abilities to both professions in emergency situations, and House Bill 1046 in 2024 gave both professions the authority to sign death certificates.

E.3. Short-term, limited duration insurance (STLDI): State policies on STLDI mirror current administration policy and can be found in O.C.G.A. § 33-24-21.1.

Factor A. 2: As of application submission, there are no CCBHCs operational in Georgia. However, three CCBHCs will open in January 2026 to serve patients, with two located in rural areas and more to come.

Factor A. 7: 112 hospitals received DSH payments in 2025. The total number of hospitals eligible for DSH is 131 (85% receive); however, including psychiatric and inpatient rehab facilities, Georgia has 189 hospitals. The percentage of all hospitals that receive DSH is 59%.

Proposed Initiatives and Use of Funds

There are five transformative initiatives in the GREAT Health Program which will use RHT Program funding to support the health and wellbeing of rural Georgians. Aligned with the RHT Program strategic goals and the GREAT Health Program vision of transforming health to meet the needs of rural populations, in rural places, for rural progress, these initiatives are: *Transforming for a Sustainable Health System in Rural Georgia; Strengthening the Continuum of Care in Rural Georgia*; *Connecting to Care to Improve Healthcare Access in Rural Georgia*; *Growing a Highly Skilled Healthcare Workforce in Rural Georgia;* and *Leveraging Technology for Healthcare Innovations in Rural Georgia.* To implement GREAT Health, the state will develop competitive, grant-based programs that correspond with the initiatives in order to ensure the funds flow fairly and transparently from the state into rural communities and organizations.

Initiative One: Transforming for a Sustainable Health System in Rural Georgia

RHT Program Strategic Goal: Innovative Care

GREAT Health Vision Alignment: Needs for Rural Progress

Innovations in healthcare delivery, quality, payments, and long-term systemic sustainability are within reach for Georgia as preparation gets underway for future application and desired participation in the AHEAD (Achieving Healthcare Efficiency through Accountable Design) model. This model supports innovative healthcare by transforming how care is paid for,

delivered, and measured, especially at the state, hospital, and primary care levels. By aligning incentives across payers, AHEAD enables states and providers to innovate in care delivery and population health. Benefits are shown in Table 4 below.

Table 1: ***Overall Benefits of the AHEAD Models for Rural Communities***

Challenge in Rural Areas	AHEAD Response
Hospital closures	Financial stability via global budgets
Provider shortages	Team-based care and funding for expanded services
High rates of chronic disease	Emphasis on prevention and population health
Access to care	Support for telehealth and meaningful care coordination
Fragmented services	Integrated care models with community partnerships
Waste and abuse	Use of technology for fraudulent claims monitoring
Duplicative/ Unnecessary Care	Increased data sharing with universal data platform

To prepare for participation in the AHEAD Hospital Global Budget Model, hospitals and state agencies will need to undertake a series of strategic, operational, and technical steps. Because AHEAD is a state-led, multi-payer model, preparation involves coordination between state government, hospitals, payers (Medicaid, Medicare, and private insurers), and community stakeholders. Likewise, to prepare for the Primary Care Model, primary care providers, including FQHCs and CCBHCs, and state agencies, need to discuss how those providers will fit into the model and what they need to do to prepare for participation.

The GREAT Health Program will make it possible for more rural hospitals, providers, and payers to participate in the AHEAD model, mitigate their start-up costs, and increase the provision of primary care and prevention services in rural counties that participate in the model. Specifically, the GREAT Health Program would include strategies to (1) conduct a statewide financial and technological assessment of all eligible model participant sites; (2) provide grants to bring on technical support and project management for years 2–5 which will represent a shift in focus from the Rural Stabilization Grants in year 1; (3) receive funds to initiate projects to ensure long-term success of AHEAD model participation; and (4) be eligible for risk mitigation

funds for RHT Program years 4 and 5 to allow for real-time experiential learning to encourage long-term success of global budgeting.

The following are key outcome metrics associated with this initiative. Additional metrics are included in the Metrics and Evaluation plan section. Unless otherwise indicated, baseline measures are zero and will be established at year 0 of the program; the proposed outcomes will be observed by FY31. **The outcomes of this initiative will be measured by:** rural hospital participation in AHEAD (target is 10% of rural hospitals); primary care providers participating in AHEAD (target is 100); private payers participating in AHEAD (target is 2); and an increase in number of patients participating in annual wellness visits at the county-level (target is 10%).

Overall Funding for this Initiative: [redacted]

Table 2: Strategies of *Transforming for a Sustainable Health System in Rural Georgia*

AHEAD Model Assessment, Consideration, and Preparation	
Use of Funds	**D.** Training and Technical Assistance, **G.** Appropriate Care Availability, **I.** Innovative Care
Technical Score Factors	**C.1.** Rural Provider Strategic Partnerships **E.1.** Medicaid Provider Payment Incentives **E.2.** Individuals dually eligible for Medicare and Medicaid
Key Stakeholders	All provider types in rural areas, community-based organizations, FQHCs, hospitals, patients, SORH
Measurable Outcomes	• Number of rural hospitals participating in the AHEAD program (desired trend increase) • Number of rural primary care providers participating in the AHEAD program (desired trend increase)
Counties Impacted	126 HRSA-rural Georgia counties/portions of counties

Sustainability Efforts: The *Transforming for a Sustainable Health System in Rural Georgia* initiative will prepare Georgia's hospitals, providers, and payers for participation in the AHEAD models. Money spent assessing rural hospitals for capacity and financial viability and determining prerequisites for primary care participation will mean that AHEAD model funding from CMS can be spent more efficiently once the model is implemented. In addition, funds spent in RHT Program years four and five to mitigate hospitals' losses during AHEAD years one and two as they adjust to global payments will ensure a more successful transition to the new funding

structures of the model. By maximizing the potential for the AHEAD model to succeed into the future, Georgia can revolutionize how healthcare is delivered in rural communities and ensure its viability and availability for successive generations.

The combined strategies of the GREAT Health Program *Transforming for a Sustainable Health System in Rural Georgia* initiative and the RHT Program Innovative Care strategic goal support Georgia's objective of ensuring a future in which all rural Georgians will benefit from innovations in healthcare delivery that improve quality health outcomes and quality of life.

Initiative Two: Strengthening the Continuum of Care in Rural Georgia

RHT Program Strategic Goal: Make Rural America Healthy Again

GREAT Health Vision Alignment: Needs of Rural Populations

The strategies within the *Strengthening the Continuum of Care in Rural Georgia* initiative are synergistic — they increase access and fill gaps in a continuum of care across:

- Life stages (infants, children, pregnant women, adults, older adults)
- Settings (home, school, hospitals, nursing homes, community, online)
- Needs (mental health, nutrition, transportation, emergency safety)

Together, they form a holistic, wraparound approach to preventing and managing chronic illness and disease, identifying and addressing root causes of diseases, and improving physical and mental health and wellbeing for rural Georgians**.** Core strategies of this initiative focus on improving the overall health of children and families by strengthening integration between schools, community behavioral health, and primary care providers. Other strategies include reducing wait times, preserving availability, expanding capabilities of EMS, and improving child health outcomes through newborn screenings, prevention, and nutrition services.

The following are key outcome metrics associated with this initiative. Additional metrics are included in the Metrics and Evaluation plan section. Unless otherwise indicated, baseline measures are zero and will be established at year 0 of the program; the proposed outcomes will be observed by FY31. **The outcomes of this initiative will be measured by**: improved physical infrastructure for healthcare facilities at the county level (target 100%); increased referrals to behavioral health services (target 20%); increased screenings for individuals served under this initiative (target for each is 20%: behavioral, newborn, upstream drivers), and number of emergency preparedness baseline assessments completed (target is 249).

Overall Funding for this Initiative: [redacted]

Table 3: Strategies of *Strengthening the Continuum of Care in Rural Georgia*

Public Health Investments: Georgia Newborn Screening Program	
Key Metrics	• 35 screenings in the first few days of life for blood disorders, hearing issues, congenital heart disease and other conditions • 127,143 infants screened in 2024 with 545 infants diagnosed with a genetic or hearing loss condition (Georgia Department of Public Health, 2024).
Transformative Care Solution: *Proposed public health laboratory upgrades*	• Currently Atlanta is the only screening lab for the entire state; quick screening and referral is critical to improving long term health outcomes • Expanding services at the laboratory in Waycross ensures faster access for rural families • Ongoing costs will be covered by the newborn screening fee for sustainability
Key Activities	Equipment purchase and installation, ramp-up operations, staff training
Use of Funds	**A.** Prevention and Chronic Disease
Technical Score Factors	**B.1.** Population health clinical infrastructure **B.2.** Health and Lifestyle
Key Stakeholders	Georgia Department of Public Health (DPH), newborns, and families
Measurable Outcomes	Average wait times for required newborn screening test results in counties served by laboratory (desired trend decrease)
Counties Impacted	Statewide
Estimated Funding	[redacted]
Results and impact	• Improved wait times for rural infant screening • Contingency plan for statewide backup for the Atlanta lab
Public Health Investments: Inter-hospital Transportation	
Key Metrics	• Long wait times for Emergency Medical Services (EMS) in rural Georgia put patients at risk • Hospital transfers of stable patients keep EMS occupied when emergencies are occurring
Transformative Care Solution: *Specialized vehicles for inter-hospital transfers*	• Provide Type 2 ambulances to hospitals to use when transferring stable rural patients between hospitals and to fill other non-emergency medical transportation gaps • Six rural hospitals each year will apply and be selected to receive Type 2 ambulances, for a total life-of-program impact of 30 rural hospital participants and 180 new ambulances

	• Hospitals will use billing to cover maintenance and other costs for sustainability
Key Activities	Hiring staff, purchasing ambulances, providing training, and assisting hospitals with billing structure to ensure sustainability
Use of Funds	**E.** Workforce
Technical Score Factors	**C.1.** Rural Provider Strategic Partnerships **C.2.** EMS
Key Stakeholders	DPH, rural hospitals, providers, payers, ambulance providers, EMS
Measurable Outcomes	• Average wait times for ambulances providing emergency transport as compared to counties with and without the service (desired trend decrease)
Counties Impacted	126 HRSA-rural Georgia counties/portions of counties
Estimated Funding	[redacted]
Results and Impact	• Free up hospital beds • Improve patient satisfaction • Reserve EMS Type 1 vehicles for 911 calls
Support for Acquired Brain Injury (ABI) Survivors	
Key Metrics	• Number of ABI injuries annually: 30,000 • Total cost (incl. medical expenses and lost wages): $1.5 billion
Innovative Care Solution: *Acquired Brain Injury (ABI) clubhouse approach to survivor-centered care*	• Side-By-Side (SBS) Clubhouse's Day Program provides: Vocational training, Life skills counseling, Caregiver support, and Community support • Open first rural clubhouse network (currently only in metro Atlanta) to expand to statewide capacity
Key Activities	Assessment, planning, and capacity building for SBS to be statewide, open the first rural ABI Clubhouse, expansion and evaluation, innovate within new and existing clubhouse
Use of Funds	**G.** Appropriate Care Delivery, **H.** Behavioral Health
Technical Score Factors	**B.1.** Population health clinical infrastructure **B.2.** Health and lifestyle
Key Stakeholders	Acquired brain injury survivors and their families
Measurable Outcomes	Number of unique individuals in rural areas served by ABI Clubhouses (desired trend increase)
Counties Impacted	126 HRSA-rural Georgia counties/portions of counties
Estimated Funding	[redacted]
Results and Impact	• Reduced ER utilization • Lower hospital and follow up care costs • Improved patient safety • Community independence • Enhanced life quality
Transportation to Treatment Pilot for Mental Health Crisis	
Key Challenge	• Individuals experiencing acute mental and behavioral crises in rural areas face significant travel distances to appropriate facilities and need safe transport to treatment, a task that often falls to law enforcement who have limited mental health training
Innovative Care Solution: *Pilot program expansion*	• A successful program in Southwest Georgia places mental health professionals in charge of transportation to Emergency Receiving Facilities (ERF) • Law enforcement, probate court, or private hospitals notify the provider when transportation is needed
Key Activities	Develop funding model, evaluate regions and partners for expansions, expand program, and evaluate results
Use of Funds	**G.** Appropriate Care Delivery, **H.** Behavioral Health, **K.** Fostering Collaborations
Technical Score Factors	**C.1.** Rural Provider Strategic Partnerships **C.2.** EMS

Key Stakeholders	Individuals experiencing mental and behavior health crises; Georgia Sheriff's Association; Georgia Crisis and Access Line; Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD); ERFs
Measurable Outcomes	Percent of all law enforcement calls in counties used to provide emergency transport to mental health crisis facility (desired trend decrease)
Counties Impacted	126 HRSA-rural Georgia counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Faster access to appropriate care • Less diversion of law enforcement from primary duties
Building Bridges (School-Based Health Care Services Infrastructure)	
Key Challenge	• Barriers to accessing quality healthcare in rural areas
Transformative Care Solution: *Multistakeholder Cooperative utilizing schools as entry-point*	• Leverage proven frameworks such as the Pediatric Collaborative Care Model and existing state-funded programs, Georgia Apex (mental health resource), and School-based Health Centers • Create a customized health information exchange (HIE) for each collaborative to support communication and referrals • Utilize a multi-generation approach focused on the behavioral health needs of students in pre-K through 5th grade as entry point
Key Activities	• Form program cooperative to leverage infrastructure • Integrate care across multiple sectors • Develop HIE
Use of Funds	**A.** Prevention and Chronic Disease, **D.** Training and Technical Assistance, **E.** Workforce, **F.** IT Advances, **H.** Behavioral Health, **K.** Fostering Collaboration
Technical Score Factors	**B.1.** Population Health Clinical Infrastructure **C.1.** Rural provider strategic partnerships **F.2.** Data infrastructure
Key Stakeholders	Public elementary schools, primary care clinics, community health clinics, certified community behavioral health clinics (CCBHCs), safety net mental health providers, community-based organizations, nonprofits, state agencies (DOE, DPH, DECAL, DBHDD)
Measurable Outcomes	Number of referrals of students to mental health, physical health, or social services (desired trend increase)
Counties Impacted	126 HRSA-rural Georgia counties/portions of counties
Estimated Funding	[redacted]
Results and impact	Faster access to appropriate care
Emergency Preparedness — Shelter-in-Place	
Key Challenges	• Georgia's prevalence of severe weather and disasters leaves patients especially vulnerable when they are unable to relocate. • High cost, risk, and logistical complexity of relocating vulnerable patients and residents during disaster situations • Interruptions in dialysis or oxygen therapy • Heightened risk of falls or pressure injuries • Increased hospitalizations and double the probability of death (Dosa, 2012) • High relocation costs (as much as $600,000 for a 100-bed facility) (Desai, 2019).
Transformative Care Solution: *Improved Disaster Resilience for SIP and Receiving Facility Capacity*	Establish a comprehensive infrastructure assessment and strengthening program that enhances the capacity of rural hospitals and skilled nursing facilities (SNFs) to either safely shelter-in-place (SIP) or act as designated receiving facilities for evacuees from other locations
Key Activities	• Planning and assessment of rural facilities • Grant administration with metrics tied to safe SIP capacity

	• Implementation of assessment findings[1] including electrical grid enhancements, generator purchases, roof repairs and environmental improvements (water and air quality reviews) • Follow up assessments and demonstration of sustainability
Use of Funds	**J.** Capital Expenditures & Infrastructure, **K.** Fostering Collaboration
Technical Score Factors	**C.1.** Rural Provider Strategic Partnerships **E.2.** Individuals dually-eligible for Medicare and Medicaid
Key Stakeholders	Healthcare facilities, DCH, UGA Institute of Disaster Management, Georgia Emergency Management Agency, DPH, State Fire Marshal's Office, DCH Healthcare Facility Regulation, Georgia's Healthcare Coalitions, SORH
Measurable Outcomes	Percent of rural facilities completing infrastructure enhancements to become eligible shelter-in-place facilities (desired trend increase)
Counties Impacted	126 HRSA-rural Georgia counties/portions of counties
Estimated Funding	[redacted]
Results and impact	Reduction in unnecessary patient/resident transfers, while evacuee-receiving facilities expand surge capacity across county and state lines, allowing for more efficient, regionally-based disaster response
Regional Nursing Home Transportation Enhancement	
Key Challenges and Metrics	• Traditional Medicaid non-emergency medical transportation (NEMT) service is not designed for frail, compromised nursing home residents who require support with activities of daily living • Georgia has over 21,000 residents in skilled nursing facilities who require NEMT for dialysis, consultations, imaging, and specialty appointments • Typical NEMT limitations on wait times and assistance into physician offices or diagnostic settings are problematic, leading to delayed or missed appointments and challenges with drop-off and pick-up of potentially confused and dependent residents
Innovative Care Solution: *Regional hubs*	• Leverage community partners to establish regional transportation hubs to coordinate with NEMT brokers
Key Activities	Assessment, policy and contract review, program design, education and training, purchase vehicles, regional pilot implementation, expansion, sustain, evaluate
Use of Funds	**A.** Prevention and Chronic Disease, **K.** Fostering Collaboration
Technical Score Factors	**B.1.** Population health clinical infrastructure **B.2.** Health and lifestyle
Key Stakeholders	Skilled nursing facilities, Georgia Health Care Association, Nursing facility residents
Measurable Outcomes	Average wait times for skilled nursing facility patients to be transported to non-emergency services (desired trend decrease)
Counties Impacted	126 HRSA-rural Georgia counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Improved continuity of care • Reductions in hospitalizations and adverse outcomes
Rural Provider Nutrition Training for Autism Spectrum Disorder (ASD)	
Key Challenges	• Need for long-distance specialist referrals to address feeding issues and nutrition management in children with ASD • Children with ASD have special nutritional challenges that affect their health and treatment. This service is not available in most rural communities without long wait times and travel.
Transformative Care Solution: *Nutrition training for rural*	• Centralized training platform delivering accredited continuing medical education modules with online toolkits and clinical resources • Tele-consults with registered dieticians and therapists

[1] While such work may lead to unexpected infrastructure areas of concern and improvements, no new construction or patient care-related footprint expansions are authorized.

physicians to support children with ASD	
Key Activities	• Curriculum development, training and implementation • Planning, patient and provider marketing • Referral network expansion • Evaluation and monitoring
Use of Funds	**A**. Prevention and Chronic Disease, **C.** Consumer Tech Solutions, **D.** Training and Technical Assistance, **E.** Workforce
Technical Score Factors	**B. 4.** Nutrition Continuing Medical Education **D. 1.** Talent recruitment **F. 3.** Consumer-facing tech
Key Stakeholders	Pediatricians, dietitians, patient advocacy groups, GA-AAP
Measurable Outcomes	Number of rural providers participating in training (desired trend increase)
Counties Impacted	Statewide
Estimated Funding	[redacted]
Results and impact	• Reduction of gastrointestinal issues and behavioral challenges • Improved developmental outcomes • Sustainability based on billing uptake, utilization of codes and provider feedback
Planning for Healthy Babies: Nutrition & Weight Management Eligibility Category	
Key Challenges	• Prenatal and interpregnancy health is an important and significant determinant of pregnancy and birth outcomes • State agencies and legislature have maternal mortality prevention as top priorities
Innovative Care Solution: *New Eligibility Category for 1115 Demonstration Waiver- Planning for Health Babies (P4HB)*	• Adding fourth category of eligibility for women between ages 19-44 who meet certain clinical requirements (e.g. over a certain weight/BMI threshold) to qualify for additional services to decrease likelihood for dangerous pregnancy complications • Services will include, but are not limited to, dietician/nutritionist support, primary healthcare case management, and weight loss drugs (e.g.GLP-1s)
Key Activities	• Waiver planning and policy development • Actuarial development of the proposed waiver changes
Use of Funds	**A.** Prevention and Chronic Disease
Technical Score Factors	**B.2.** Health and Lifestyle
Key Stakeholders	Women 19-44 who meet clinical guidelines and have income up to 211% of the FPL, OBGYNs, primary care physicians, dietitians, patient advocacy groups
Measurable Outcomes	Number of referrals for the service (desired trend increase)
Counties Impacted	Statewide
Estimated Funding	[redacted][2]
Results and impact	• Reduction of maternal mortality • Better overall health for women in Georgia

Sustainability Efforts: There are a variety of sustainability efforts for the strategies included in the *Strengthening the Continuum of Care in Rural Georgia* initiative. Examples include user fees and private donations for the SBS Clubhouse, which, once operational, is a self-sustaining model, and payer reimbursable services for newborn screenings, school-based health and behavioral health services, and nutrition therapy training and services. In addition, there are

[2] While this coverage change will be cost-neutral as mandated for 1115 demonstration waivers, costs associated with actuarial development of the proposed changes will be funded by the GREAT Health Program.

sustained impacts from the investment of funding to improve infrastructure and remove upstream barriers, such as transportation concerns. The legacy of these impacts is future cost avoidance from preventive care, early identification of need, and quicker access to treatment, thus avoiding more complex, long-term illness and disease. Similarly, infrastructure improvements remain in the rural community long past the funding cycle and are expected to reduce illness, injury, and trauma from disasters, resulting in long-term savings for patients and the system.

The strategies of the GREAT Health Program *Strengthening the Continuum of Care in Rural Georgia* initiative support Georgia's objective of ensuring a future in which all rural Georgians benefit from a focus on root causes of disease to prevent illness and coordinated care for enhanced chronic disease management, as well as the RHT Program goal of Make Rural America Healthy Again.

Initiative Three: Connecting to Care to Improve Healthcare Access in Rural Georgia

RHT Program Strategic Goal: Sustainable Access

GREAT Health Vision Alignment: Needs in Rural Places

The galvanizing concept of the strategies in this initiative are to close geographic, economic, and systemic gaps in access to timely, high-quality healthcare by leveraging innovation, technology, and targeted investments. Each initiative contributes to building a seamless, person-centered care-delivery system that meets people where they are— whether through mobile units, virtual care platforms, or strengthened local care networks. Data flows between services, follow-up is built into the model, and support is sustained through stabilization funding and infrastructure investments. Together, these strategies form a cohesive framework for improving access, continuity, efficiencies, and outcomes, particularly in rural populations.

The following are key outcome metrics associated with this initiative. Additional metrics are included in the Metrics and Evaluation plan section. Unless otherwise indicated, baseline measures are zero and will be established at year 0 of the program; the proposed outcomes will be observed by FY31. **The outcomes of this initiative will be measured by:** increased access to prenatal and postpartum visits (target is 25%); reduced 30-day readmission rates for inpatient visits (target is 10%); decreased non-emergent ED visits (target is 24%); and increased use of primary care services at the county level (target is 30%).

Overall Funding for this Initiative: [redacted]

Table 4: Strategies of *Connecting to Care to Improve Healthcare Access in Rural Georgia*

Care to Consumer – Point of Care Telepods & Mobile Clinics	
Key Challenges	• Rural access to primary, dental, behavioral, and preventive care • Urgent need for services, such as substance use treatment, cancer screenings, and alternatives to emergency department overuse
Innovative Care Solution: *Rural Mobile Health Units*	• Mobile health units will be supported through grants administered by the Georgia Board of Health Care Workforce (GBHCW) with collaboration between local clinics, hospitals, and academic institutions • Tailored to specific needs with follow-up systems and opportunities for undergraduate and graduate medical education clinical rotations
Innovative Care Solution: *Point-of-Care Telepods*	• Deployed through a vendor selection process by the SORH and staffed by/connected to regional hospitals for follow up • Located in community areas, such as libraries and workplaces • Will offer rural residents 24/7 access to providers
Key Activities	• Develop grant funding proposal with key stakeholders • Award grants to rural hospitals and clinics • Design mobile units and develop system for clinical rotations • Ensure interoperability for pods • Evaluate outcomes
Use of Funds	**A.** Prevention and Chronic Disease, **D.** Training and Technical Assistance, **E.** Workforce, **G.** Appropriate Care Availability, **H.** Behavioral Health
Technical Score Factors	**B.1.** Population health clinical infrastructure **C.1.** Rural provider strategic partnerships **F.1.** Remote care services
Key Stakeholders	Free and charitable clinics, rural hospitals, schools of medicine/nursing/allied health, AHECs, DPH, FQHCs, CCBHCs, SORH, EMS, community-based partners
Measurable Outcomes	• Number of unique individuals served by mobile units (desired trend increase) • Number of unique individuals served by point-of-care pods (desired trend increase) • Number of pods and mobile units placed in rural areas (desired trend increase) (baseline FY25 = zero)
Counties Impacted	126 HRSA-rural counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Meet care needs closer to home • Reduce strain on rural emergency departments for non-emergencies • Supports rural workforce development

	• Supports rural transformation for success under AHEAD by providing additional and alternative primary care access points • Sustainability through billable services, continuity of care and improved health data collection to demonstrate impact and drive future improvements
Telehealth Enhancements	

Innovative Care Solution: *Rural Health Digital Transformation through multi-hub design*	• DCH will form a statewide network through a multi-hub architecture
	  ○ 1st hub: Local hospital as primary anchor for patient care
	  ○ 2nd hub: Interconnected network of rural hospitals
	  ○ 3rd hub: Digital ecosystem provides framework for patient placement, clinician education and training for scalability
	• Rural hospitals, universities, public health, and rural service providers will be connected into a coordinated system of care
	• Digital infrastructure of rural facilities, including servers, storage and networks will be modernized

Special Features	• Subspecialty telemedicine consults • Remote Patient Monitoring (RPM) for chronic disease management • 24/7 patient-facing digital platform • AI integration for real-time advanced analytics • Workforce development and education, including virtual mentorships and use of the Extension of Community Healthcare Outcomes (ECHO) model to facilitate case-based learning in virtual clinics
Key Activities	• Assessment and workforce preparation • Initiation of remote specialty care • Cohort implementation and equipment placement • Capacity expansion and scaling • Evaluation
Use of Funds	**A.** Prevention and Chronic Disease, **C.** Consumer Tech Solutions, **D.** Training and Technical Assistance, **E.** Workforce, **F.** IT Advances, **G.** Appropriate Care Availability, **H.** Behavioral Health
Technical Score Factors	**C.1.** Rural Provider Strategic Partnerships **F.1.** Remote Care Services
Key Stakeholders	Rural hospitals, rural clinics, academic medical centers, county health departments, primary care, specialty care, and behavioral health providers
Measurable Outcomes	• Percent of rural hospitals connected to digital access for remote specialty care (desired trend increase) • Rate of county residents accessing digital specialty care stated as number per 1,000 residents/month (desired trend increase)
Counties Impacted	126 HRSA-rural counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Expansion of medical services available within rural communities • Allows clinicians to manage more complex cases at the local level • Supports workforce development and education for rural physicians, nurses, and advance practice providers • Provides rural hospitals with data analytics on capacity, population health and patient risk
Rural Stabilization Grants (RSG)	
Key Context: *Current Program*	• Per state statute, the State Office of Rural Health (SORH) created a grant program to provide resources for rural hospital stabilization. • Due to the increasing pressures on rural hospitals, the state received more applications than funds available in recent years. • The current program has four goals, pursuant to priorities identified under state law: increase access to care, increase market share, reduce inpatient readmissions, and decrease inappropriate emergency department utilization.

Transformative Care Solution: *RSG Dual-track program*	• SORH will add a second track of grants focused exclusively on preparing rural hospitals and primary care for transitioning to the AHEAD model
Key Activities	Develop new stream and align grants with AHEAD strategies, launch funding opportunity, fund hospitals, collect/monitor data, scale program
Use of Funds	**A.** Prevention and Chronic Disease, **D.** Training and Technical Assistance, **G.** Appropriate Care Availability, **K.** Fostering Collaboration
Technical Score Factors	**B.1.** Population health clinical infrastructure
Key Stakeholders	Rural hospitals, rural health clinics, FQHCs, SORH, community-based organizations
Measurable Outcomes	• ED 30-day readmission rates for inappropriate utilization (desired trend decrease) • Percent hospital inpatient 30-day readmission rate (desired trend decrease)
Counties Impacted	126 HRSA-rural counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Hospital flexibility to align needs with AHEAD transition • Cross-sector collaboration to resolve upstream barriers to care, improve quality metrics, and enhance care coordination.
Strengthening Perinatal Systems of Care	
Key Challenges	• Critical gaps in maternal healthcare in rural communities due to continued closure of labor and delivery units • 108 counties in Georgia lack a birthing facility (Georgia Department of Public Health, 2025)
Transformative Care Solution: *Non-delivering hospitals Strategy*	• Provide fully stocked, mobile, color-coded obstetrical emergency carts to aid in urgent or unexpected delivery needs. Carts will include essential medications and supplies for hemorrhage management and preeclampsia/eclampsia treatment, neonatal resuscitation equipment, and visual job aids
Transformative Care Solution: *Birthing hospitals Strategy*	• Standardized, evidence-based patient safety bundles will be distributed and implemented in all 66 birthing hospitals, with emphasis on 15 rural hospitals each year • Bundles will provide structured protocols and practice changes to improve early recognition and treatment of OB emergencies
Key Activities	• Assess existing efforts at non-delivering hospitals • Deploy mobile carts • Develop standard operating procedures, train staff, run drills, and implement bundles • Collect and evaluate data with coordination from DPH and DPH perinatal nurse educators
Use of Funds	**D.** Training and technical assistance, **G.** Appropriate care availability
Technical Score Factors	**C.1.** Rural provider strategic partnerships **D.1.** Talent Recruitment
Key Stakeholders	DPH, rural non-delivering hospitals, EDs, regional perinatal centers, local health departments, FQHCs, EMS
Measurable Outcomes	Percent targeted rural EDs equipped with OB emergency carts within first six months (desired trend increase)
Counties Impacted	126 HRSA-rural Georgia counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Reduction in risk of severe maternal morbidity and mortality
Public Health Telehealth Infrastructure	
Key Challenge	• Statewide technology assessment found that 162 of 167 health department offices and clinical sites lacked sufficient infrastructure to host telehealth services (National Institute of Standards and Technology, 2024) • Telehealth services in most rural county health departments across Georgia are either limited or non-existent due to the absence of start-up resources.

Transformative Care Solution: *Telehealth for PH*	As a crucial provider in many counties, outfitting these facilities with telehealth capabilities can greatly expand coverage.
Key Activities	Launch competitive application process, baseline assessment, procure equipment, expand infrastructure in all rural health departments, communicate with public, evaluate, integrate billing
Use of Funds	**A.** Prevention and Chronic Disease, **C.** Consumer Tech Solutions, **D.** Training and Technical Assistance, **K.** Fostering Collaboration
Technical Score Factors	**C.1.** Rural provider strategic partnerships **F.1.** Remote care services
Key Stakeholders	DPH, local health departments, Georgia Technology Authority, patients, providers
Measurable Outcomes	• Number of county health department offices and clinic sites equipped with telehealth-ready infrastructure (desired trend increase) • Number of trained workforce capable of delivering and billing for telehealth services (desired trend increase)
Counties Impacted	126 HRSA- rural Georgia counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Increased access in high-touch point, familiar location
Rural Telepsychiatry: Consultations and Primary Care Provider Training	
Key Challenge	Due to the lack of access to psychiatrists, rural primary care providers, including pediatricians and obstetricians (OBs), are often the front-line for detecting and treating behavioral health conditions, though they have limited training in the conditions.
Innovative Care Solution: *Ped. Psychiatry ECHO Model*	• Begin pediatric telepsychiatry training program through DBHDD • Project ECHO model in partnership with pediatric psychiatrists to train rural physicians and advanced practice providers via telehealth on treating complicated cases, including medication management and linkage to patient-centered resources
Innovative Care Solution: *PEACE for Moms*	• Scale DPH's existing Perinatal Psychiatry, Education, Access, and Community Engagement (PEACE) for Moms program from small pilot to statewide rural access • Provider to provider consultations for OBs around treating pregnant and post-partum women who are experiencing mental health and/or substance use concerns, with on-demand consultations within a 30-minute response time
Key Activities	Implement Project ECHO model with DBHDD and pediatric psychiatrists, communicate to provider for training opportunity, scale PEACE for Moms with DPH, communicate to providers across state
Use of Funds	**E.** Workforce, **G.** Appropriate Care Availability, **H.** Behavioral Health, **K.** Fostering Collaboration
Technical Score Factors	**F.1.** Remote care services
Key Stakeholders	Rural providers, psychiatrists, youth, parents, pregnant women, DPH, DBHDD
Measurable Outcomes	• Number unique providers participating in Project ECHO trainings (desired trend increase) • Number of providers that access PEACE for Moms telepsychiatry consultations (desired trend increase)
Counties Impacted	126 HRSA- rural Georgia counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Increased PCP comfort in treatment of mental health conditions • Increased access to psychiatry care in rural areas

Sustainability Efforts: The *Connecting to Care to Improve Healthcare Access in Rural Georgia* initiative is focused on increasing access and efficiencies through the implementation of technology, the integration of telehealth services, and system shifts and practices to improve

workflows, partner collaborations, and quality efforts. Once the telehealth infrastructure is established and equipment is installed, each facility will develop sustainability plans for equipment maintenance and updates. The initial funding will assist facilities and partners to collaborate and develop sustainable workflows for referrals, communication, and provider-to-provider consultations and training. Aligning the Rural Stabilization Grants with local hospital, clinic, community need, and AHEAD priorities ensures readiness for moving facilities towards the AHEAD model, which is focused on value-based care and global payments to stabilize rural hospitals and clinics.

The combined strategies of the GREAT Health Program *Connecting to Care to Improve Healthcare Access in Rural Georgia* initiative will support Georgia's objective of ensuring a future in which all rural Georgians will benefit from a focus on sustainable access to healthcare, as well as the RHT Program Sustainable Access strategic goal.

Initiative Four: Growing a Highly Skilled Healthcare Workforce in Rural Georgia

RHT Program Strategic Goal: Workforce

GREAT Health Vision Alignment: Needs of Rural Populations. In Rural Places.

Together, these strategies form a coordinated approach to strengthening Georgia's healthcare workforce pipeline, particularly in rural and underserved areas. Each strategy addresses a distinct stage of healthcare education, training, and retention, forming a comprehensive system that builds, supports, and sustains the workforce from early interest in health careers to advanced clinical practice and continuing education. Strategies include scholarships to recruit and train EMS professionals, efforts that encourage rural Georgians to work where they live, and programs that expand access to and depth of training across multiple provider types. Collectively, these efforts aim to increase not only the quantity but also the

quality of Georgia's rural healthcare workforce. By supporting every phase of the workforce journey, including education, training, placement, and retention, Georgia is establishing a pipeline that ensures rural communities have access to highly skilled providers committed to serving for years to come.

The following are key outcome metrics associated with this initiative. Additional metrics are included in the Metrics and Evaluation plan section. Unless otherwise indicated, baseline measures are zero and will be established at year 0 of the program; the proposed outcomes will be observed by FY31. **The outcomes of this initiative will be measured by:** improved retention of students retained as rural providers (target rate is 15%); increased number of rural students trained in rural areas (target rate is 30%); decreased non-emergent ED visits (target is 24%); and reduced EMT turnover rates at the county-level (target is 15%) (Georgia Department of Community Health, 2024).

Overall Funding for this Initiative: [redacted]

Table 5: Strategies of *Growing a Highly Skilled Healthcare Workforce in Rural Georgia*

Rural Medical Workforce & GME Enhancements	
Key Context	• Clinicians trained in rural areas are more likely to remain in those communities (Ogden, 2020) • Early placement and engagement of student providers in rural communities can increase the number of primary care providers available to rural residents.
Transformative Care Solution: *Four Strategies to Strengthen the Rural Medical Workforce*	• Expanding graduate medical education (GME) residencies by funding 75 new residency slots per year in family medicine, obstetrics, internal medicine, pediatrics, psychiatry, and gerontology • Increasing funded fellowship opportunities by 12 per year • Establishing the state's rural recruitment incentive grant program[3] to recruit doctoral-level providers (e.g. physicians, optometrists, audiologists, and clinical psychologists) to rural areas for at least 5 years and providing up to $250,000 for relocation costs, equipment, technology, or clinic expansion • Enhancing current programs by providing funding to two GME programs to expand primary care residencies to rural Georgia
Key Activities	Establish a statewide consortium, build tracking systems, launch first recruitment and incentive grants, train first cohort of residents, scale up, conduct evaluation throughout, full implementation of training slots

[3] The Georgia Board of Health Care Workforce's statutory authority provides for the provision of various provider assistance programs. Their current, time-tested guidelines for ensuring provider compliance with service agreements includes annual reporting on service and 2x award recoupment if service is not completed.

Use of Funds	**E.** Workforce
Technical Score Factors	**C.1.** Rural provider strategic partnerships **D.1.** Talent Recruitment
Key Stakeholders	Academic medical institutions and teaching hospitals, FQHCs, physicians, doctoral level students and graduates, GA Board of Health Care Workforce (GBHCW)
Measurable Outcomes	• Number of GME residency slots (desired trend increase) • Number of fellows and distribution percentages across multiple specialties (desired trend increase)
Counties Impacted	126 HRSA-rural counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Georgia will become a nationwide leader in rural health innovation for provider recruitment, due to strong collaboration with the medical community, legislature, and state agencies.
Nursing Care Improvements	
Key Metrics	• Georgia will be facing the second highest nursing shortage by 2030 at 21% (Georgia Nurses Association, 2024) • The majority of University System of Georgia (USG) institutions are in rural areas. • Lack of qualified nursing faculty restricts program expansion and results in hundreds of qualified applicants turned away each year: between Q3 2024 and Q1 2025, USG denied admission to at least 583 qualified ASN & BSN applicants
Transformative Care Solution: *Five-Part Nursing Workforce Strategy*	• Advancing Nursing Degrees program to support faculty advancement through work release time and tuition assistance • Clinical faculty orientation toolkit to standardize training and improve instruction • GA-CARE (Commitment to Assist in Recruitment of Educators) Tuition Reimbursement and Stipend Program[4] to provide financial support for nurses wishing to earn teaching degrees • Nurse Summer Camps to inspire students to pursue nursing careers • Simulation Training Expansion at Georgia College & State University to grow the Healthcare Simulation Certification Program and provide rural nursing schools with simulated patient mannequins
Key Activities	• Establish program infrastructure and partnerships • Implement toolkit and camps • Expand program • Strengthen simulation training • Evaluate, refine, scale statewide
Use of Funds	**E.** Workforce
Technical Score Factors	**D. 1.** Talent Recruitment
Key Stakeholders	High schools, colleges and universities, nursing faculty, health systems
Measurable Outcomes	• Number of nursing faculty earning an advanced degree (desired trend increase) • Number of attendees at nurse summer camp (desired trend increase)
Counties Impacted	Statewide
Estimated Funding	[redacted]
Results and impact	• Creating sustainable pathways for recruiting, training, and retaining nursing faculty and students • Ensuring rural communities have the skilled nursing force they need

[4] Collaboration with the Georgia Board of Healthcare workforce will ensure existing provider rules for length of service are accounted for in benefits.

Telehealth Mentoring for Dementia	
Key Metrics	• Number of adults 65 or over with Alzheimer's and related dementias in Georgia: 188,000 or more (Alzheimer's Association, 2025) • Projected Medicaid cost in 2025 for dementia in rural areas: $1.7 billion (Division of Aging Services, 2024)
Transformative Care Solution: *Expand dementia care capacity*	• Launch statewide Telehealth Mentoring Program • Establish Dementia Training Hub for education & resource delivery • Deploy micro learning modules and virtual convenings • Expand access to online training platforms (ALZPro)
Key activities	Establish training hub, launch mentoring program with ECHO model, expand participation, deploy learning modules, introduce online training platform, evaluate, scale statewide
Use of Funds	**A.** Prevention and Chronic Disease, **D.** Training and Technical Assistance, **E.** Workforce
Technical Score Factors	**B.1.** Population health clinical infrastructure **C.1.** Rural provider strategic partnerships **E.2.** Individuals dually eligible for Medicare and Medicaid
Key Stakeholders	Patients and families of those with dementia, hospital associations, universities and academic medical centers, local hospital administrators
Measurable Outcomes	Number of Project ECHO Learning Collaborative cohorts (desired trend increase)
Counties Impacted	126 HRSA-rural counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Create strong, ongoing network of professionals • Ensure high quality & consistent dementia care • Expand support for family caregivers • Reduce avoidable hospitalizations and costs • Strengthen rural health systems • Enhance quality of life
Area Health Education Center (AHEC) Training & Housing	
Key Context	• Georgia's Area Health Education Centers (AHECs) coordinate community-driven solutions through student-centric programming
Innovative Care Solution: *Workforce recruitment through AHEC Network*	• Offer short-term (less than 6 months) housing for job shadowing & professional learning opportunities in rural areas • Update *Health Careers in Georgia* manual and expand/digitize informational resources on healthcare careers • Hold workforce transformation meetings & events and conduct rural workforce needs assessment • Expand Preceptor Tax Incentive program[5] to support rural rotations and provide continuing education for preceptors • Train students as Digital Health Navigators to teach in the community
Key Activities	Digitize manual, update videos, expand housing support, conduct needs assessment, expand high school and college pipeline programs, conduct regional meetings, train medical students as navigators, conduct evaluation
Use of Funds	**E.** Workforce
Technical Score Factors	**C.1.** Rural provider strategic partnerships **D.1.** Talent Recruitment
Key Stakeholders	Healthcare students, universities, Georgia Board of Health Care Workforce (GBHCW), providers, and patients

[5] In 2014, Georgia became the first state to institute a Preceptor Tax Incentive Program, allowing a tax deduction to community-based physicians who provide uncompensated training to medical students. Retrieved from: https://www.augusta.edu/ahec/ptip.php

Measurable Outcomes	• Number of continuing education and workforce development opportunities in rural counties (desired trend increase) • Number of community members reached through Digital Health Navigator student trainings (desired trend increase)
Counties Impacted	126 HRSA-rural counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Increased exposure to rural health opportunities for students • Increased engagement for rural students • Expanded training, recruitment, & continuing education efforts • Enhanced professional satisfaction for preceptors
Emergency Services Scholarships	
Transformative Care Solution: *Establishing new scholarship program*	• Funding rural student participation in certification/Earn While You Learn programs removes financial barriers for new Emergency Medical Technicians (EMTs) and paramedics • Creates sustainable pipeline of responders • Requires at least 5-year commitment to servicing rural communities • Regulations will be developed in coordination with GBHCW for maximum impact
Key Activities	Develop criteria for scholarships, launch program, select first cohort with EMS training programs and colleges, expand, offer mentor program, refine, scale, evaluate
Use of Funds	**E.** Workforce
Technical Score Factors	**C.2.** EMS **D.1.** Talent Recruitment
Key Stakeholders	EMS associations, communities, payers, training organizations/colleges
Measurable Outcomes	Number of scholarships to qualified EMT and paramedic applicants (desired trend increase)
Counties Impacted	126 HRSA-rural counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Expanded access to emergency care • Improved response times for better patient outcomes • Lasting impact on public health & safety

Sustainability Efforts: Sustainability planning for workforce development programs is essential to building a resilient, long-term healthcare workforce, ensuring continued impact beyond the initial infusion of support provided by RHT Program funding. In Georgia, these plans include creating public-private partnerships in which private organizations absorb training and residency activities in exchange for return-for-service commitments or tailored workforce pipelines. Some training opportunities may be embedded into revenue-generating services, such as clinical training within billable departments. Once the value of trainings is established, course fees may serve as a future funding source. The state's Preceptor Tax Incentive Program, providing tax credits to providers who train medical students, will also ensure the viability of training

programs. Additional options include income-sharing agreements and employer-sponsored tuition models, where learners commit to serving with the organization post-training.

The combined strategies of the GREAT Health Program *Growing a Highly Skilled Healthcare Workforce in Rural Georgia* initiative and the RHT Program workforce goal will ensure a future where all rural residents benefit from the recruitment and retention of a healthcare workforce that is empowered to engage patients for improved outcomes.

Initiative Five: Leveraging Technology for Healthcare Innovations in Rural Georgia

RHT Program Strategic Goal: Technology Innovation

GREAT Health Vision Alignment: Needs for Rural Progress

Each of the strategies in this initiative plays a specific role in healthcare, but when strategically integrated, they work together to create a modern, efficient, secure, and patient-centered healthcare system. For example, cybersecurity efforts will safeguard patient data, telehealth platforms, and connected medical devices; an innovation fund is planned to provide capital investments to support both starting up and scaling up technology innovations in rural communities; and EMR and consumer engagement technology enhancements will promote engagement in data analysis activities supporting population health efforts. With this initiative, rural Georgia will have access to a healthcare system that harnesses the power of technology to improve consumer access to information, improve training and skills of the healthcare workforce, and foster an environment of data sharing that results in collaborative, coordinated care for the patient.

The following are key outcome metrics associated with this initiative. Additional metrics are included in the Metrics and Evaluation plan section. Unless otherwise indicated, baseline measures are zero and will be established at year 0 of the program; the proposed outcomes will

be observed by FY31. **The outcomes of this initiative will be measured by:** increased number of hospitals with population health reporting capacity (target based on assessment); reductions in health IT staff position vacancies (target is 20%); increase in number of consumers directly engaged in new health technology (target based on program enrollment); and reduction in number of reportable cybersecurity incidents at the county-level (target based on assessment).

Overall Funding for this Initiative: [redacted]

Table 6: Strategies of *Leveraging Technology for Healthcare Innovations in Rural Georgia*

Cybersecurity Enhancements	
Key Challenges	• Rural hospitals face growing cybersecurity risks, threatening continuity of patient care, security of PHI, and integrity of systems that support operations • Many rural hospitals lack resources to address the HIPAA Security Rule and CMS's July 2021 guidance on Medicaid security • Insufficient cybersecurity workforce pool in Georgia
Innovative Care Solution: *Cybersecurity Workforce Pipeline and Enhancements*	• Based on a highly successful pilot project[6], DCH will collaborate with academic institutions and private-sector partners to implement a comprehensive and scalable strategy to deliver cybersecurity risk assessments, managed threat detection, and strategic cyber support services to high-risk rural healthcare providers in Georgia • Services provided by end-degree internship pipeline via partnerships with accredited academic institutions
Key Activities	• Development of two-phase support model providing foundational assessments and continuous, long-term security management • Model will be offered to all at-risk rural hospitals lacking robust cybersecurity systems • Conducting assessment and strategy for baseline understanding of cybersecurity • Assess existing technology and infrastructure • Software deployment • Developing cybersecurity policies • Training staff
Use of Funds	**D.** Training and Technical Assistance, **E.** Workforce, **F.** IT Advances
Technical Score Factors	**D.1.** Talent Recruitment **F.2.** Data infrastructure
Key Stakeholders	Rural hospitals, accredited academic institutions and universities, internship programs, cybersecurity firms and organizations
Measurable Outcomes	Percent of rural hospitals implementing a modern endpoint detection and response (EDR) solution on critical servers and endpoints (desired trend increase)
Counties Impacted	126 HRSA-rural counties/portions of counties
Estimated Funding	[redacted]
Results and impact	Strengthened security systems within rural hospitals throughout the state
Advancing Access to Robust Care and Health in Rural Georgia (ARCHER) Tech Catalyst Fund	
Key Challenges	Need for sustained, improved access and quality in health outcomes for rural healthcare populations, which are disproportionately affected by chronic diseases and healthcare access shortages

[6] Reports from the hospital pilot site detailed the activity of 531 monitored devices, providing complete visibility into their connected systems. As a result, the hospital has achieved a 94% detection rate of threat actors upon initial contact, while also preventing a coordinated exploitation attempt in early July.

Transformative Care Solution: *ARCHER Fund*	Establish an investment fund dedicated to rural health technology that is high-impact, consumer-facing, care-enabling, and tailored to rural needs
Key Activities	• Identify gaps through data analysis and provider engagement • Identify/validate eligible companies to receive up to $3 million in non-dilutive funding and critical support • Deploy/support selected technology in rural systems such as AI-driven diagnostics • Conduct evaluation and monitor outcomes for enhanced rural healthcare delivery, attract follow-on investment, and produce scalable, evidence-backed models for use in other rural regions
Use of Funds	**A.** Prevention & Chronic Disease, **C.** Consumer Tech Solutions, **F.** IT Advances
Technical Score Factors	**F.3.** Consumer-facing Tech
Key Stakeholders	Rural health systems, providers, patients and consumers, private investors and venture capital firms, tech industry
Measurable Outcomes	Total dollars of funding for technology innovations in rural Georgia (desired trend increase)
Counties Impacted	126 HRSA-rural counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Improvements in chronic disease management, patient care, and healthcare system capacity for rural populations • A collaborative effort between state and universities to enhance technology validation, investment, deployment, and long-term impact tracking of rural healthcare needs • Rapid implementation to align with community priorities (within 6 months of intake)
EMR Enhancements	
Key Challenges	• Need to comprehensively assess and enhance EMR capabilities of state's 159 hospitals, which currently operate across 11 different systems, with varying functionalities to avoid exclusion of rural hospitals from AHEAD participation and widen the gap in healthcare access and quality
Transformative Care Solution: *EMR enhancement for population health metrics*	• Assess hospital EMR capabilities and identify rural hospitals most in need of support, particularly ones with poor health outcomes and limited financial resources • Support transition to value-based care & global payment models under AHEAD model to ensure hospitals and clinics can leverage population health modules to identify at-risk populations, promote proactive care, and integrate services across all healthcare areas
Key Activities	• Year 1, hospital assessments and release Request for Grant Applications (RFGA) • Years 2-5, expand to rural health clinics & FQHCs as budget permits • Funded entities develop population health strategic plans with process for selecting and purchasing EMR enhancement via alignment with AHEAD reporting and quality metrics • Collaboration among Chief Information Officers, healthcare leadership, and GREAT Health leads supported by quarterly stakeholder meetings promoting interoperability with upgrades to EMRs
Use of Funds	**A.** Prevention and chronic disease, **F.** IT advances, **I.** Innovative care
Technical Score Factors	**B.1.** Population health clinical infrastructure **F.2.** Data infrastructure
Key Stakeholders	Rural hospitals, health clinics and FQHCs, chief information officers, EMR systems, providers
Measurable Outcomes	Percent of hospitals completing EMR population health enhancements (desired trend increase)
Counties Impacted	126 Georgia counties/rural counties designated as rural by HRSA
Estimated Funding	[redacted]
Results and impact	• Improved interoperability by promoting equitable access to value-based care tools and reducing unnecessary service duplication

	• Enablement of data-driven strategies aligning with AHEAD objectives, including financial sustainability, enhanced care coordination, and investment in preventive care
Workforce Retention Technology	
Key Challenges	• Insufficient surgical services promoting smaller rural hospital financial stability due to lack of equipment and related issues
Transformative Care Solution: *Surgical Robotics Procurement*	• Provide grant funding opportunity to rural hospitals for initial costs of surgical robots to allow surgeons to perform more complex procedures, resulting in more precise and less invasive results, reduced client recovery time and pain, less blood loss, lower risks of infection, and shorter hospital stays • Costs beyond initial funding will be funded by respective hospital(s) pursuant to plans provided with their application(s), along with an analysis by applicant(s) of baseline case volume/predicted revenue metrics with demonstrated financial stability • Goal of placing 2 robots per year for total of 10 robots in rural hospitals
Key Activities	Determine rural hospital candidates, develop grant process, purchase surgical robots, train staff and providers, provide technical assistance, maintain systems
Use of Funds	**D.** Training and Technical Assistance, **E.** Workforce, **G.** Appropriate Care Availability
Technical Score Factors	**D.1.** Talent Recruitment
Key Stakeholders	Rural hospitals, surgeons, academic institutions, vendors
Measurable Outcomes	Number of procedures performed by surgical robots in rural hospitals (desired trend increase)
Counties Impacted	126 HRSA-rural Georgia counties/portions of counties
Estimated Funding	[redacted]
Results and impact	Significant enhancement of patient care and hospital capabilities with sustainability through billing
Eligibility System Enhancements	
Key Challenge	Backlogs in eligibility determinations create financial risk for rural providers
Transformative Care Solution: *Streamlining Medicaid Eligibility*	• Beginning in 2026, Georgia will begin to modify its integrated eligibility system (Gateway) in order to transition the Modified Adjusted Gross Income (MAGI) population to a determination state, thereby automating approval for applicants who meet eligibility requirements • Gateway will interface with Georgia Access (state-based exchange, managed by the Office of Commissioner of Insurance and Safety Fire, or OCI) so those found to be Medicaid eligible can have their approved application automatically transferred and those who are ineligible can be referred to an exchange plan
Key Activities	• Determine enhancements needed for Gateway system to automate MAGI applications • Build interface with Georgia Access and implement enhancements • Test system and monitor data
Use of Funds	**C.** Consumer Tech Solutions, **F.** IT Advances
Technical Score Factors	**F.2.** Data Infrastructure
Key Stakeholders	State agencies (DHS, DCH, OCI) and all constituents seeking public benefits
Measurable Outcomes	• Number of eligible applicants auto approved for Medicaid and transferred to Gateway system (desired trend increase) • Number of applicants referred to case worker for remedy (desired trend decrease)
Counties Impacted	Statewide
Estimated Funding	[redacted]
Results/Impact	• Reduction in pending eligibility backlog
Consumer Engagement Enhancements	
Key Challenge	• Lack of personal engagement in wellness is a contributing factor in poor population health
Key Context: *Success of current wellness platform*	• State Health Benefit Plan (SHBP) offers a wellness platform to improve care engagement, consumer coaching, and data collection.

used by state employees	• In the last 5 years, the program reduced overall health risk by 10%, including a 14.7% decrease in preventive risk, a 10.1% decrease in lifestyle risk, and a 1.4% decrease in biometric risk. (State Health Benefit Plan, 2025)
Transformative Care Solution: *Expansion with AHEAD model*	• Extend this consumer-facing technology to the full population anticipated to participate in AHEAD to encourage healthy lifestyles and preventive care • Includes diet/nutrition and wellness coaching • Adds an AI-generated Geospatial Health Risk Profile for the projected AHEAD counties; this personalized assessment will utilize artificial intelligence to analyze various data points about an individual (eg. medical history, lifestyle, genetics, environment, social determinants of health, and biometric data) to identify potential health risks and provide insights or recommendations.
Key Activities	• Assessment and identification of gaps • Define user requirements and ensure interoperability with existing systems • Develop protocols, marketing, and educational materials • Evaluate and plan for sustainability as part of AHEAD
Use of Funds	**A.** Prevention and chronic disease, **C.** Consumer Tech Solutions
Technical Score Factors	**B.2.** Health and Lifestyle **F.3.** Consumer Facing Tech
Key Stakeholders	Healthcare consumers, insurers— including public insurers and involved state agencies (DCH, OCI, DHS), providers
Measurable Outcomes	Percent of members completing online wellness activities (desired trend increase)
Counties Impacted	126 HRSA-rural counties/portions of counties
Estimated Funding	[redacted]
Outcomes	• Improved health indicators for rural Georgians • Consumer empowerment and motivation
Behavioral Health State Assessment of Technology (BHSAT)	
Key Challenge	• Lack of a quick and accurate means to assess and respond to behavioral health needs, particularly in underserved rural areas
Transformative Care Solution: *BHSAT*	• Invest in modern, scalable health information technology systems with secure, compliant data sharing • Leverage existing data sources, such as the GA All Payer Claims Database (APCD) • Create a real-time system to enable the aggregation and analysis of data across multiple regions, identifying critical gaps in technology that support mental health, substance abuse disorder, ASD, and primary care services
Key Activities	• Develop behavioral health technology system • Conduct assessment of technology • Analyze data and deploy predictive analytics
Use of Funds	**A.** Prevention and Chronic Disease, **E.** Workforce, **F.** IT Advances, **G.** Appropriate Care Availability, **H.** Behavioral Health
Technical Score Factors	**B.1.** Population health clinical infrastructure **F.1.** Remote care services **F.2.** Data infrastructure
Key Stakeholders	Behavioral healthcare facilities, behavioral health providers, advanced degree behavioral health providers, DBHDD
Measurable Outcomes	Number of system participants completing data sharing agreements (desired trend increase)
Counties Impacted	Statewide
Estimated Funding	[redacted]
Outcomes	• Improved data to identify ongoing workforce shortages • Enhanced care integration and service delivery statewide • Reduction in provider burnout for a more resilient and responsive behavioral health system
EMS Treat-versus-Transport (TVT)	

Key Challenges	• Access to care in rural settings
Transformative Care Solution: *Telehealth TVT*	• "Treat versus Transport" telehealth model to integrate telehealth into emergency response for non-emergency/low-acuity 911 calls • Model allows EMS to conduct real-time, on-scene evaluations to help direct care for rural patients, while getting telehealth feedback from broader licensed providers for approval
Key Activities	• Procure and utilize 'Starlink' satellite tech in rural health areas • Enable real-time telehealth consultations between EMS team and remote healthcare staff via training, protocols, integration, and billing • Monitor and evaluate data
Use of Funds	**D.** Training and Technical Assistance, **F.** IT Advances, **G.** Appropriate Care Availability, **K.** Fostering Collaboration
Technical Score Factors	**C.2.** EMS
Key Stakeholders	DPH, EMS, rural hospitals, physician networks, Starlink/broadband providers
Measurable Outcomes	• Number of EMS units equipped with kits (desired trend increase) • Dollar amount of EMS-to-provider billing claims reimbursed for telehealth services (desired trend increase)
Counties Impacted	126 HRSA-rural counties/portions of counties
Estimated Funding	[redacted]
Results and impact	• Ensuring access to timely medical guidance regardless of location

Sustainability Efforts: Within this technology innovation initiative, there are multiple efforts related to sustainability, including: partner absorption of ongoing maintenance of the technology enhancements, revenue generated from billable services due to technological enhancements (such as increased rural resident eligibility for coverage), and more efficient use of population health tracking for additional savings due to improved management of risk. In addition, grant awards will require sustainability planning as part of the application and implementation cycle.

The combined strategies of the GREAT Health Program *Leveraging Technology for Healthcare Innovations in Rural Georgia* initiative and the RHT Program Technology Innovation strategic goal will support Georgia's objective of ensuring a future in which all rural Georgians will benefit from technology that improves care delivery and gives providers and patients real time, secure access to health data information.

GREAT Health Program Implementation Plan and Timeline

DCH has developed a bold plan with detailed timeline to ensure success of the GREAT Health Program. Upon award receipt in January 2026 (Q2, FY26), DCH will begin the

implementation process with pre-identified partners and begin the request for assistance process for projects without identified partners. Staff included in the grant will be hired and contracts for administrative support and oversight will be executed.

For Initiative 1, *Transforming for a Sustainable Health System*, DCH will begin preparations for the AHEAD model. Hospital assessments will inform work in all initiatives, so stage 1 will begin with assessing hospitals and educating providers of the state's AHEAD plans and participation benefits. Stage 2 will continue the hospital portion and initiate primary care provider discussions, education, and engagement. Technical assistance to all provider types will comprise the next stage, concurrent with the state's implementation of the AHEAD model. This will usher in stages 4 and 5, completing hospital transformation plans to align with AHEAD and transitioning all components to a fully implanted value-based care model.

Initiative 2, *Strengthening the Continuum of Care*, will be implemented in three major phases, with varying timelines based on the specific strategy. Assessments will begin stages 0 and 1, depending on partner agency timelines and limitations. These assessments will inform the work done in stages 1-3, which involve partner purchasing of materials- such as newborn screening equipment, ambulances, and transport vans- and fostering collaboration by formalizing partnerships- school based health services, emergency preparedness changes, support for ABI survivors, and autism nutrition education. Stages 4 and 5 require these strategies to evaluate and grow their reach based on the first stages of learning, implementing differing continuity strategies and plugging into current avenues for continued support and funding.

Connecting to Care to Improve Healthcare Access, Initiative 3, will take place in five distinct stages. To ensure resources are sent to areas most in need, assessments- for point-of-care telepods, mobile clinics, and hospital and health department telehealth enhancements- will also

begin this initiative's implementation through stages 0 and 1. Stages 2 and 3 will ensure hospital and provider partners are informed and aligned with strategies, leading to the next stage of service delivery and change management. From perinatal care changes to telehealth to additional in-person care access points, all strategies in Initiative 3 will require changes to normal operating procedures for the entities involved. DCH is committed to providing change management and technical assistance to aid in the uptake of services and provide a seamless transition to the final stage (5) of service transition to billing.

The strategies of Initiative 4, *Growing a Highly Skilled Healthcare Workforce*, fall into two distinct categories: rural provider education and funding for provider incentives and scholarships. Stage 0 will involve DCH establishing working guidelines and protocols with the five partner organizations, all of which are well-established and respected within their individual fields. Stage 1 will incorporate advisory groups of providers and rural constituents to ensure effective protocols are established, with stage 2 implementing the advised recommendations. Continued stages will focus on scaling and evaluation of the programs within their respective agencies. Outcomes will be reported to state entities upon completion of the strategies in stage 5 to help inform future state investments in rural provider recruitment.

Leveraging Technology for Healthcare Innovations, Initiative 5, will begin with agency engagement of partner organizations. This will ensure all timelines are aligned, deliverables are understood, and continuity plans are realized from the beginning. Evaluations (cybersecurity, EMRs, workforce retention technology, BHSAT), planning (eligibility system enhancements, EMS TVT), and contracting (ARCHER fund, consumer engagement platform) will comprise the initial stages of implementation. Stages 2 and 3 will involve DCH check-ins on progress and grants for equipment purchase based on initial findings (EMR upgrades, EMS TVT technology,

workforce retention technology). Scaling projects and improvement will be the final action step for this initiative, with stage 5 comprising of final evaluations and fund distribution (ARCHER fund) and integration into current workstreams (cybersecurity, EMR, EMS TVT) and funding sources (eligibility and consumer engagement enhancements).

For successful project implementation, tracking and monitoring of the initiatives by strategy will be necessary. Detailed breakdowns of timing and stages by strategy can be found in *Attachment E: FY26 – FY31 GREAT Health Program Implementation Milestones and Timeline*.

Governance and Project Management: Georgia has established a strong governance and project management structure, supported by a multidisciplinary team prepared to lead, coordinate, and sustain implementation of the GREAT Health Program. The Department of Community Health (DCH) will serve as the lead agency, working closely with the Department of Public Health (DPH), the State Office of Rural Health (SORH), the Department of Human Services (DHS), the Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Georgia Board of Health Care Workforce (GBHCW) to ensure alignment across agencies and with external partners.

The financial and administrative management functions associated with the GREAT Health Program operations will be the responsibility of DCH and affiliated subcontractors and will include project initiation, planning, execution, monitoring and closeout. DCH, with partners and the CMS Project Officer, will develop processes to ensure appropriate and consistent communication, perform multiple tasks concurrently, complete tasks within narrow timeframes, and assure quality services.

In year one, DCH will hire nine new staff members to oversee statewide implementation and stakeholder coordination, including one rural health manager (RHM), three rural health

specialists, three rural behavioral health specialists, and two attorneys. These positions will be located at DCH to best collaborate with executive leadership and partner agencies. Additionally in year one, the State Office of Rural Health (SORH) will hire one rural health grant manager and three rural health grant specialists. These positions will work out of the SORH office in rural Georgia, ensuring direct availability of subject-matter experience and to further encourage community participation and buy-in. Lastly in year one, GBHCW will hire a Graduate Medical Education (GME) program manager and a data analyst. Positioning of new roles within the agencies can be seen in organizational charts provided in *Attachments F-H*.

The principal investigator of the project will be the Medicaid Director to ensure all federal funding requirements are met and that DCH is adhering to the project as specified and approved by CMS. In addition, regular progress reports will be generated for distribution to CMS as agreed upon and in accordance with funder requirements.

The RHM, a subject matter expert and supervisor in health policy, will serve with the SORH as lead officials in assessing Georgia's rural health needs. The RHM will supervise the new Medical Assistance Program Rural Health team for the policy oversight of all GREAT Health Program initiatives and oversee the overall policy implementation of the grant areas, ensuring alignment with the grant objectives. The RHM will manage the project's strategic direction, maintain communication with key partners, and ensure timely and accurate reporting to CMS. This role will provide efficient execution of the project while meeting all Medicaid Policy compliance standards. This position will attend monthly calls with the CMS project and/or grants management specialists and be responsible for coordinating all aspects of the project to ensure successful outcomes. The RHM will report to the Director of Provider Services and supervise three rural health specialists. These specialists will direct policy

and oversight for each assigned area of the GREAT Health Program, ensure compliance, and provide technical assistance to awardees. They will coordinate with grantees, contractors, and the SORH GREAT Health team to ensure continuity and consistency across the program and offices.

The rural health behavioral specialist team will provide direct policy and oversight for each position's assigned area of the behavior health initiatives in the rural transformation grant (Building Bridges, Behavioral Health Assessment, Integrated Mobile Clinics, and others). The Medicaid division will maintain a direct partnership with partner organizations in implementation of behavioral health projects to ensure consistency with Medicaid policy, effective implementation, and desired outcomes. These positions will be supervised by the Director of Behavioral Health and Member Services, who is an experienced Licensed Clinical Social Worker (LCSW), with a master's in healthcare administration.

All positions listed above fall within the existing structure of the Medical Assistance Plans (MAP) Division within DCH, which focuses on Medicaid. Ultimate policy direction and division oversight will be provided by the Medicaid Director.

Two attorneys will provide primary direct contractual support to the subrecipient agreements and provider agreements that are referenced in this grant proposal. The proposal has the potential to add over 300 agreements (grants or subrecipient agreements) to the annual workload of the General Counsel's office. The office presently has no capacity for the additional contract or grant reviews that are contemplated.

At the SORH, the rural health grant manager will coordinate strategic planning and policy creation for the addition of up to 126 rural hospital grants for initiatives to address gaps in service delivery and preparation for the AHEAD transition for each hospital projected to participate. This manager will supervise three grant specialists, who will partner directly with the

hospitals to ensure successful grant implementation and provide technical assistance directly to hospitals as needed. Grant specialists will be responsible for implementation and technical assistance to specific hospitals, as assigned by the manager. The SORH team currently administers similar grants on a smaller scale; these additional staff expand capacity of the office to include the 126 counties necessary for AHEAD operations.

Both DCH staff and SORH staff will be time-limited, benefits-eligible employee positions that are planned for transition to the AHEAD administration funds in year three of AHEAD, which is projected to be the first year without Rural Health Transformation funding.

The GME program manager at GBHCW, which is an administratively attached agency to DCH, will assist in strategic planning and implementation for GME and rural recruitment incentive grant programs for GREAT Health. This position will ensure expanded GME residency and fellowship slots are appropriately prioritized and lead the effort in coordinating between the agency and GME programs. The program manager will report to the Executive Director of the GBHCW and supervise the data analyst. The data analyst at the GBHCW will be an additional resource for data analytics and will assist in data gathering for healthcare workforce projects in the GREAT Health Program. Hospitals will need assistance with data analytics to expand the proposed GME slots by specialty and to assist with fellowship slots determination, physician specialty need prioritization, and physical recruitment.

DCH has policies and protocols in place for fiscal and quality assurance management of subcontractor services. These protocols include strict adherence to federal funding requirements, required project reporting format and timeline, and project budget tracking and specificity in invoicing. The Georgia Department of Administrative Services (DOAS) oversees contracts with the state on most matters and retains a list of approved contractors for a variety of purposes.

DCH will utilize DOAS in procurements, as is state policy, to ensure fairness, appropriateness, and quality of fit. At the time of application, RSM and Deloitte are the professional services contractors identified for the GREAT Health Program. RSM will work in collaboration with DCH leadership and GREAT Health staff as an external grants manager, while Deloitte will provide actuarial evaluation and assessment. In collaboration with DOAS, DCH will work to retain services for external project management according to state law and processes.

To ensure coordination in deploying funds, tracking milestones, and assessing project impact, a multisector collaborative, including DCH, DPH, SORH, and other involved state agencies, will be developed as the GREAT Health Advisory Council. The GREAT Health Advisory Council will comprise of representatives from each initiative-based workgroup and rural patients, guaranteeing that at least 60% of members represent rural entities to ensure community involvement in program governance. The GREAT Health Advisory Council will meet regularly, and meetings will provide a forum for sharing data, identifying challenges, and recommending adjustments for implementation and sustainability. Additionally, rural providers, patients, residents, and other rural entities will be part of initiative-based workgroups.

In the first year of the grant award, the GREAT Health Program leadership team will meet to adopt methods for shared decision-making, conflict resolution, internal and external communications, and other governance strategies necessary for effective operations.

Stakeholder Engagement

As the designated lead agency for the GREAT Health Program, DCH is committed to robust stakeholder engagement. Prior to developing this proposal, DCH solicited input through multiple channels, including an 18-day public comment period, four town hall meetings, solicitation of stakeholder submissions, and direct outreach to state agencies. Town hall meetings

were strategically convened in rural towns across regions of the state designated as Rural Health Clinic–eligible, Health Professional Shortage Areas, or medically underserved areas, representing diverse demographic and economic contexts. To encourage broad participation, DCH also hosted a virtual town hall and provided additional opportunities for the submission of letters and feedback. Over 50 townhall stakeholders and 150 public submissions from hospitals, nursing homes, charitable care clinics, community behavioral health providers, and community organizations shared ideas, concerns, and hopes for rural health transformation in Georgia. All input was carefully reviewed and published online for transparency— this feedback directly led to the creation of proposed initiatives.

Engagement Framework: Moving forward, DCH is committed to continuing its practice of engaging diverse stakeholders at every stage of the process through a robust engagement framework built around four key steps: Preparing, Establishing, Maintaining, and Developing.

Table 7: *GREAT Health Program Engagement Framework*

Stage	Short Description	Example(s)
Preparing	Assess key stakeholder engagement	Town halls, open feedback channels, RHT Program webpage and online form for submissions, meetings with DHS, DBHDD, DPH, SORH, academic institutions, rural partners, and the Governor's Office
Establishing	Determine stakeholder engagement processes, including accessible opportunities for participation	Multisector collaborative (GREAT Health Advisory Council) and five initiative-based workgroups focused on key objectives that align with the strategic goals
Maintaining	Implement initiatives, ensuring continuous engagement of stakeholders across every phase of each strategy throughout the funding period	Adding public inbox for feedback on the project; intentional rural travel of program leadership to engage in two-way communication with local partners and stakeholders, including rural residents
Developing	Refine engagement strategies over time, guided by ongoing stakeholder input	Update stakeholder engagement processes based on stakeholder input to improve engagement opportunities and transparency

To ensure coordination and community engagement, the GREAT Health Advisory Council, as described above, will be established. The Council will include representatives from DCH, DPH, and SORH, along with rural patients and providers, ensuring that at least 60% of members represent rural entities. The GREAT Health Advisory Council will meet regularly, which will

provide a forum for sharing data, identifying challenges, and recommending adjustments to improve implementation and sustainability. The five initiatives-based workgroups of the Council will align with the strategic goals and will include key stakeholders engaged in or affected by each specific initiative – such as state agencies, rural providers, nonclinical partners, and rural residents. Members will collaborate within their focus areas and across initiatives to ensure alignment and shared impact.

Governance: The Department of Community Health (DCH), as the state Medicaid agency, will have administrative oversight responsibilities over all operational aspects of the GREAT Health Program. To ensure project governance reflects rural communities, the GREAT Health Advisory Council will include patients and residents as members. DCH will share this application and initiative details with the public, and a dedicated GREAT Health Program specific inbox will be available for public feedback during every stage of the process. Feedback will be reviewed during the developing stage of the engagement framework, ensuring that rural Georgians have an active role in the governance and continuous improvement of the initiatives.

Evidence of stakeholder support: In addition to public comments reviewed from town halls and survey submissions, DCH has engaged the following stakeholders in the formation of this proposal: SORH, GBHCW, DHS, DBHDD, DPH, academic institutions, rural partners, and the Governor's Office. Evidence of formal support includes the Governor's Endorsement and letters of support from the Georgia General Assembly, SORH, state health agencies, and other stakeholders (*Attachments M-R*).

Metrics and Evaluation Plan

Plans for Evaluation: Georgia will conduct a comprehensive program evaluation across the five initiatives. The focus of the evaluation plan will include overall outcomes per initiative as well as

opportunities for improvement throughout program implementation. Georgia will cooperate with any CMS-led evaluation and monitoring and recognizes that CMS and/or third-party evaluators may assess outcomes across the States. The state will contract with Georgia State University (GSU) to study the program's impact on the health of the state. GSU's strong history of federal and state-specific evaluations and an understanding of program implementation. The state and GSU will work closely to produce a comprehensive evaluation plan during Year 0.

The GREAT Health Program will use a mixed methods Implementation Science Framework for evaluation, called RE-AIM. RE-AIM has historically been used in large-scale innovative implementations to measure the effectiveness of funding mechanisms to reach desired outcomes, as well as information about how positive outcomes were achieved, and how outcomes can be replicated in other similar circumstances. RE-AIM assists evaluators in considering and formulating plans to measure reach, effectiveness, adoption, implementation, and maintenance among large scale implementations. Measuring outcomes through RE-AIM will allow evaluators to produce reports that can lead to year-to-year modifications for programs who may be underperforming and understanding needs of the various initiative strategies.

Using the RE-AIM framework, the evaluation team will conduct annual reporting and create data dashboards per initiative to monitor progress at least bi-annually. Evaluators will ensure in year 0 that baseline measures and annual goals are submitted from sites to ensure program alignment with predicted targets. The evaluation team will confirm appropriate data mechanisms are used to develop baseline and goals, and all data sources will be documented to ensure consistency in sources and collection methodology across all aspects of the program.

Data sources include, but are not limited to, the All-Payer Claims Database (APCD), a statewide repository that collects claim data from public and private employers, as well as

Electronic Medical Record (EMR) Threat Detection and Response systems, federal level data tracked through HRSA, and other available sources throughout the state, such as annual reports from sub-grantees and hospital surveys. Program partners and grantees will be required to submit outcome metrics twice a year to gauge improvement and barriers each year. Plans for data aggregation will be finalized as part of the comprehensive evaluation plan during Year 0. In addition to quantitative data collection, the evaluator may also conduct qualitative data collection strategies to reflect stories of impact, such as focus groups with hospital leaders, providers, and rural community members. The evaluation team will meet at least quarterly with the Program leadership team to understand progress and needs and create plans for technical assistance.

Overall GREAT Health Program Project Outcomes: The overarching GREAT Health Program outcome metrics below align with the program vision of healthier populations, abundant access to care in rural places, and leveraging technology to drive progress in rural areas by FY31.

- Increased access to 10% of rural residents measured by increased use of telehealth services and reduced travel time and distance to services
- Decrease in all-cause mortality in rural areas by 15%
- Decrease in readmissions in 75% of rural hospitals
- 20% increase in the ratio of rural primary care providers to rural population
- 10% increase in the number of patients in participating rural counties with preventative screenings at evidence-based intervals

Initiative Key Outcome Metrics and Addressing Overlapping Metrics: Each initiative has key performance outcome metrics that will indicate the impact of the project on the health of Georgia. The initial evaluation plan, which includes metrics for each of the five initiatives, is in

Attachment I: Evaluation Plan Initiative Metrics. In year 0, a comprehensive evaluation plan will be developed that will also include metrics for each strategy associated with the five initiatives to ensure the strategies are on time and target.

Georgia acknowledges that all health is interconnected; as such, metrics overlap between initiatives. This overlap represents the goals of the larger project at utilizing multiple streams of investment to provide a measurable and sustainable outcome. The first metric in multiple initiatives is year-over-year improved physical health outcomes for populations receiving care in participating hospitals. This metric is found both in *Transforming for a Sustainable Health System* and *Strengthening the Continuum of Care*. Improved physical health outcomes for large scale populations will require several different strategies to make measurable differences in rural areas in the state, as poor health is not determined by one factor. The *Transforming for a Sustainable Health System* initiative focuses on preparing to implement the AHEAD model in hospitals throughout the state. Simplified reimbursements models dependent on value-based care are imperative to population health and should have an impact on health outcomes in areas where initiatives are taking place. Similarly, *Strengthening the Continuum of Care* has several strategies that focus on improved outcomes for different populations, including but not limited to children with behavioral health challenges through the Building Bridges strategy, newborns through the Newborn Screening strategy, and children with ASD through the nutrition support services strategy.

The second metric in multiple initiatives is decreased emergency department visits for non-emergency concerns in rural counties. This outcome falls under both *Connecting to Care to Improve Healthcare Access* and *Leveraging Technology for Healthcare* since strategies target rural access to care for preventative health services, alleviating unnecessary use of emergency

services. The *Connecting to Care to Improve Healthcare Access* initiative has multiple strategies strengthening capabilities of rural health entities to bring increased preventative care access to rural populations with the intention of decreasing the use of emergency care services. These strategies focus on mobile units, building and strengthening rural telehealth service infrastructures, and uniting health entities to coordinate systems of care to get the right patient to the right location at the right time. Complementing these strategies, those in the *Leveraging Technology for Healthcare Innovations* initiative strengthen the EMR systems of hospitals and invest in consumer-facing, care-enabling technologies. EMR system improvements, as preparation for the AHEAD model, give insights into identifying at-risk patient populations. Technology company investments will address the burdens of chronic disease and care access in rural areas. Both strategies display, alert, and educate providers (EMR system enhancements) and patients (consumer engagement enhancements, ARCHER fund innovations) alike on trends and habits, flagging concerning patterns before requiring ED support.

The third metric increases use of primary care/preventative care services related to physical health, chronic disease, and mental/behavioral health. This outcome falls under both *Growing a Highly Skilled Healthcare Workforce* and *Leveraging Technology* for *Healthcare Innovations*, since strategies target rural access to care for primary care and preventative health services. The *Growing a Highly Skilled Healthcare Workforce* initiative will increase and strengthen the rural health workforce by incentivizing health professionals to practice in rural areas, improving access for those living in surrounding rural areas. While incentives vary, many include strengthening the technological innovation in rural areas, reducing the burden and cost of opening a practice in rural areas, allowing practices to have a wider service area through telehealth services, and providing similar technologies to those in urban training centers, such as

robotic surgical instruments. The intention of both initiatives is to improve access to primary and preventative care and see an increase in visits related to improving management of disease, particularly chronic disease and mental/behavioral health.

Sustainability Plan

The GREAT Health Program aims to increase resources, optimize services, and expand the healthcare workforce to improve health outcomes and access to care. By leveraging technology and policy solutions, the program will close the rural-urban divide, improve health outcomes, and advance Georgia's transition towards value-based care.

Strategy to ensure lasting change: There are four key sustainability factors woven into the GREAT Health Program to include: (1) self-sustained infrastructure, (2) integrated telehealth services, (3) a shift to value-based care/AHEAD model, and (4) financial diversification.

Self-Sustaining Infrastructure- IT and Workforce Development: The *Leveraging Technology for Healthcare Innovations* initiative of the GREAT Health Program focuses on strengthening IT infrastructure and workforce systems to create a foundation that can sustain itself over time. The state is investing in these improvements to ensure that rural hospitals and clinics have the IT infrastructure required to advance value-based care and meet quality metrics. Once these improvements are complete, the technology will be self-sustaining, supported by commitments from funded organizations to cover future costs associated with maintenance, upgrades, and depreciation expenses. These upgraded systems are expected to generate increased revenue, cost-savings, and decreased readmissions and emergency department utilization, all of which will contribute to sustaining improved systems.

Workforce-focused efforts in the GREAT Health Program will similarly build self-sustaining models by creating an influx of providers into rural communities through incentives,

scholarships, and expansion of faculty. Sustainability will be achieved through public-private partnerships that continue to support training and residency programs beyond the initial funding period. Healthcare facilities benefitting from recruitment and retention efforts will increase revenue from billable services and adopt employer-sponsored tuition models that "grow their own" workforce, ensuring a pipeline of trained providers in rural Georgia. These strategies, combined with early exposure to healthcare careers and rural settings for healthcare students, provide avenues to remedy immediate provider shortages and prepare for future needs.

Integrated Telehealth Services: The GREAT Health Program has embedded telehealth components as part of the *Connecting to Care to Improve Healthcare Access*, *Growing a Highly Skilled Healthcare Workforce,* and *Leveraging Technology for Healthcare Innovation* initiatives. The state realizes the critical role of telehealth in expanding access to care and providing essential provider training, particularly across a landmass as vast as Georgia. The state will ensure telehealth is integrated into future AHEAD payment models with Medicaid, Medicare, and private payers. Facilities receiving infrastructure resources for telehealth equipment will have realized billing revenue to assist with sustaining the equipment, staffing, and any future associated expenses. Georgia will monitor and support policies that apply to telehealth reimbursement for program improvement.

A Shift to Value-Based Care – AHEAD: Georgia will implement a value-based care model that incorporates populations covered by Medicaid, Medicare and commercial payers through the AHEAD model, transforming the way that rural care is provided and paid for in the state. By participating in the GREAT Health Program initiatives and strategies, rural hospitals, providers, and payers will build the necessary technology, infrastructure, and clinical shifts to pursue full participation in the AHEAD model. In three years, Georgia will assess hospital readiness,

encourage participation, and review risk in early adoption with the goal of having facilities qualify for enrollment in the AHEAD program and increasing revenue from value-based metrics and global payments.

Funding Diversification to Sustain Programs and Services: Funding diversification is one of the factors associated with sustainability. Several funding diversification strategies were mentioned in the initiatives section of the proposal. These strategies include efforts such as charging user fees, soliciting private donations, seeking reimbursement for billable services once pathways are established, negotiating global payments, and creating other value-based reimbursement mechanisms. Additionally, the state and organizations benefiting from RHT Program funding can also pursue public-private partnerships, niche revenue generation (e.g., fees for consulting services), and absorption of programs by collaborative partners or organizations. The state will also focus on leveraging additional fiscal support for AHEAD implementation.

Integrate Lessons Learned into Ongoing Policy: Georgia's current policy allows limited state funds to support GME, which is statutorily assigned to the GBHCW in O.C.G.A. 31-34. Results and learning from the workforce initiatives will illuminate opportunities in the following policy arenas: streamlining program approvals and reducing administrative barriers for training programs, updating training requirements to align with technology-enabled care delivery, and pursuing legislative authority to expand funding mechanisms to address the current program caps. Lessons learned from provider recruitment and retention over the five-year program will inform enhancements to the state's provider recruitment plans moving forward. The state will also monitor and disseminate lessons learned around shifting to value-based care and global payments to inform future policy alignment that influences care delivery for improved health

outcomes. Through the implementation of the AHEAD model, state Medicaid and employee health benefit policies will be adjusted to allow value-based purchasing and better incentivize whole-person health. Policy changes for other strategies in this proposal are not envisioned as Georgia law is already consistent with their activities. However, should the need for other policy changes arise, they will be pursued to the extent necessary to ensure program success.

References

Al-Beltagi, M. (2024). Nutritional management and autism spectrum disorder: A systematic review. *World Journal of Clinical Pediatrics, 13*(4), 99649. https://doi.org/10.5409/wjcp.v13.i4.99649

Alzheimer's Association. (2025). 2025 Alzheimer's disease facts and figures. *Alzheimer's & Dementia,* 21(5).

Centers for Medicare & Medicaid Services. (n.d.) *Quality, Certification & Oversight Reports.* https://qcor.cms.gov/main.jsp.

Desai SP, Gordon J, Harris CA. The economic impact of hurricane evacuations on a coastal Georgia hospital: A case study. *Front Public Health*. 2019;7:149. doi:10.3389/fpubh.2019.00149

Division of Aging Services. (2024) Georgia's 2024 report on Dementia. Retrieved October 3, 2024, from State of Dementia Report Final 12.31.24.pdf.

Dosa D., Hyer K., Thomas K., et al. (2011) To evacuate or shelter in place: Implications of universal hurricane evacuation policies on nursing home residents. *Journal of the American Medical Directors Association*. 2012;13(2):190.e1-190.e7. doi:10.1016/j.jamda.2011.07.011

Farrigan, T., & Hertz, T. (2016). *Understanding the rise in rural child poverty, 2003–2014.* Washington, DC: Department of Agriculture, Economic Research Service. Retrieved October 3, 2025, from https://www.ers.usda.gov/publications/pub-details/?pubid=45543.

Garcia, M. C., M. Faul, G. Massetti, C. C. Thomas, Y. Hong, U. E. Bauer, & Iademarco, M. F. (2017). "Reducing potentially excess deaths from the five leading causes of death in the rural United States." *MMWR Surveillance Summary*, 66 (2): 1-7.

Georgia Board of Health Care Workforce. (2024). *Georgia counties without primary care/core practitioners.* https://healthcareworkforce.georgia.gov/counties-without-pcps.

Georgia Department of Community Health. (2024). *2024 annual hospital questionnaire. https://www.effinghamhealth.org/wp-content/uploads/2025/05/1.-DCH-AHQ-Final-2024.pdf*

Georgia Department of Labor. (2025). *Georgia employment and wages: 2022 averages.*

Georgia Department of Public Health, Division of Women, Children, & Nursing Services. (2025).

Georgia Department of Public Health. (2024). *Georgia newborn screening program annual report 2024*. https://dph.georgia.gov/NBS.

Georgia Department of Public Health. (2025, July 30). *Newborn screening (NBS)*. https://dph.georgia.gov/NBS.

Georgia Primary Care Association. (2024). Georgia Primary Care Association 2024 Member Directory.

Georgia Rural Health Innovation Center (2025-a). *Georgia rural health data hub.* Retrieved October 3, 2025, from https://www.georgiaruralhealth.org/rural-health-information/health-indicators-report/.

Georgia Rural Health Innovation Center. (2025-b). *Georgia rural health data hub.* Retrieved October 3, 2025, from https://www.georgiaruralhealth.org/rural-health-information /georgia-map-room/.

Georgia Nurses Association. (2025). The nursing shortage and the advocacy to end it. October 3, 2025, from https://georgiapca.org/wp-content/uploads/2023/05/Georgia-Nursing-Workforce-Updates.pdf

Health Resources & Services Administration. (2025, September). *Georgia: State newborn screening panel*. https://newbornscreening.hrsa.gov/your-state/georgia.

Institute of Public and Preventive Health. (2025, January). *Healthy Georgia: Our state of public health*. Retrieved October 3, 2025, from HealthyGaReport.org.

Malone, T.L., Pink, G.H., Thompson, K., & Holmes, M. (2024). *Using the updated financial distress index to describe relative risk of hospital financial distress.* (Findings Brief). NC Rural Health Research Program. https://www.ruralhealthresearch.org/publications/1658.

National Advisory Committee on Rural Health and Human Services. (2022, November). *Access to emergency medical services in rural communities: Policy brief and recommendations to the secretary*. https://www.hrsa.gov/sites/default/files/hrsa/advisorycommittees/rural/access-to-ems-rural-communities.pdf.

National Center for Health Workforce Analysis. (2024, November). *HRSA health workforce: Nurse workforce projections, 2022-2037*. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nursing-projections-factsheet.pdf.

National Institute on Minority Health and Health Disparities. (2025, October 6). *HDPulse: An ecosystem of minority health and health disparities resources.* Retrieved October 3, 2025, from https://hdpulse.nimhd.nih.gov.

National Institute of Standards and Technology. (2024). *The NIST cybersecurity framework (CSF) 2.0.* National Institute of Standards and Technology. https://doi.org/10.6028/NIST.CSWP.29

NewKirk, V., & Damico, A. (2014). *The Affordable Care Act and insurance coverage in rural areas.* San Francisco: Henry J. Kaiser Family Foundation. Retrieved October 3, 2025,

from https://www.kff.org/ uninsured/issue-brief/the-affordable-care-act-and-insurance-coverage-in-rural-areas/.

Ogden J, Preston S, Partanen RL, Ostini R, Coxeter P. (2020). Recruiting and retaining general practitioners in rural practice: systematic review and meta-analysis of rural pipeline effects. *Med J Aust*. Sep 213(5):228-236. doi: 10.5694/mja2.50697.

State Health Benefit Plan, A Division of the Georgia Department of Community Health. (2025). SHBP Q1/Q2 2025. *Quarterly Review*

United States Department of Agriculture. (2017). *Rural education at a glance.* Retrieved from October 3, 2026, from https://www.ers.usda.gov/webdocs/publications/83078/eib-171.pdf?v=42830.

United States Department of Agriculture. (2025). *State fact sheets - state data.* Retrieved October 3, 2025, from https://data.ers.usda.gov/reports.aspx?ID=4035&StateFIPS=13&State Name=Georgia#.

United States Department of Health and Human Services. (2022). *The security rule.* Retrieved October 3, 2025, from https://www.hhs.gov/hipaa/for-professionals/security/index.html.

University of New Mexico Health Sciences (n.d.). *The ECHO model*. Retrieved October 3, 2025, from https://projectecho.unm.edu/model/.

STATE OF GEORGIA
OFFICE OF THE GOVERNOR
ATLANTA 30334-0090

Brian P. Kemp
GOVERNOR

November 3, 2025

Dr. Mehmet Oz
Administrator
U.S. Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Dr. Oz:

I am pleased to submit Georgia's Rural Health Transformation (RHT) Program application to you. Georgia's Rural Enhancement And Transformation of Health (GREAT Health) program is our state's innovative and outcomes driven program that aligns with the needs of rural populations, in rural places, for rural progress. Through listening to rural communities and their advocates and by using our many and varied subject matter experts in and around state government, we have built a vision of transformative health and financial stability in rural Georgia's healthcare delivery system.

I have chosen the Georgia Department of Community Health (DCH) to submit this proposal on behalf of the state. DCH is Georgia's lead agency for the Medicaid and PeachCare for Kids, our Children's Health Insurance, Programs. DCH also oversees the State Health Benefit Plan, healthcare facility licensure and regulation, and importantly our State Office of Rural Health (SORH).

DCH is uniquely positioned to manage the GREAT Health program. Under Medicaid, PeachCare for Kids, and the State Health Benefit Plan, DCH provides healthcare to one in four Georgians. In addition to managing SORH, DCH also licenses and certifies healthcare facilities and oversees several health-related attached agencies, including the Georgia Board of Health Care Workforce.

As the designated lead agency for the GREAT Health program, DCH is committed to continued stakeholder engagement. Prior to developing this proposal, DCH solicited input through multiple channels, including an 18-day public comment period, three live town hall meetings (Cordele, Jasper, and Vidalia), one virtual town hall meeting, and direct outreach to state agencies. Town hall meetings were strategically convened in cities and towns across regions of the state designated as Rural Health Clinic–eligible, Health Professional Shortage Areas, or Medically Underserved Areas that represent diverse demographic and economic sectors. To encourage broad participation, DCH also hosted a virtual town hall and provided additional opportunities for feedback. All input was carefully reviewed and informed the final selection of proposed initiatives. Moving forward, DCH is committed to engaging diverse stakeholders, including rural representation at every stage of the

process. More details about this framework can be found in the Stakeholder Engagement section of this proposal.

My administration has demonstrated a commitment to promoting access to quality, affordable healthcare for hardworking Georgians. Over the last six and a half years, we have worked hard to support legislation and policies that support the health and wellbeing of all Georgians at all stages of life, with a focus on efficiency, affordability, and innovation to address the health care needs of our citizens in rural areas. The GREAT Health program reflects our ongoing dedication to a healthy Georgia and builds on the track record of policies we have established over the past six and a half years. Examples of these policies are listed below by year:

2025

- Launch of our state-based exchange facilitating the Georgia Access Program for the individual health insurance market
- Tort reform to limit damages in medical malpractice litigation, a much-needed relief for rural health care providers
- Fund expanded perinatal home visits to improve maternal and infant health
- Restrictions on pharmacy benefit managers that stabilized independent rural pharmacies and lowered drug costs for state employees
- Streamline oversight of drug abuse treatment and education programs, narcotic treatment programs, community living arrangements, and adult residential mental health programs

2024

- Expansion of Rural Physician Tax Credit, loans for dental students, and loan repayment for mental health professionals
- Creation of new exemptions to Certificate of Need laws for psychiatric or substance abuse inpatient programs, new acute care hospitals in rural counties, and new or expanded perinatal services in rural counties
- Increase in the total limit on tax credits for donations to rural hospitals to $100 million

2023

- Launch of the Pathways to Coverage program in July 2023, making Georgia the only state in the nation to offer Medicaid coverage with a requirement of a qualifying activity
- Creation of a grant program to address broadband access in rural areas

2022

- Unanimous passage of the Georgia Mental Health Parity Act to address barriers to mental health treatment with enforcement mechanisms to hold insurance carriers accountable
- Extension of postpartum Medicaid coverage to 12 months through a state plan amendment

2020

- Implementation of the Georgia All-Payer Claims Database

2019

- Passage of the Patient's First Act leading to the creation of the Pathways to Coverage and Georgia Access programs

The GREAT Health program will build on these years of our innovative work and bring transformation of health that is aligned with the needs of rural Georgia. Achieving this vision means rural *populations* are healthier, have an improved quality of life, and can both live and work in the communities they love; rural *places* have healthcare that is high quality, more accessible, and more

effective; and rural *progress* creates systems-level change that leverages technology, drives innovation, and improves quality, while maintaining a patient focus and embracing patient voice. The GREAT Health program will do this through five initiatives:

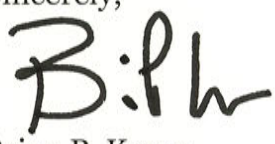
1. *Transforming for a Sustainable Health System* focuses on preparing rural healthcare facilities and providers to qualify for the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model from CMS. As part of this initiative, the state's strategy is to dedicate resources to working collaboratively with healthcare facilities and leaders to assess readiness, identify gaps, and provide technical assistance to address other strategic gaps in the proposal while mitigating fiscal risk that could cause some facilities and providers to delay engagement in these reforms. Georgia Medicaid intends to apply in 2026 to be a part of the AHEAD program beginning in 2028. The majority of the strategies outlined across initiatives will support the care delivery and financial situations of rural providers to ensure long-term, meaningful participation in AHEAD and positive health outcomes for Georgians.
2. *Strengthening the Continuum of Care* includes nine strategies that focus on addressing behavioral health program needs, improving infrastructure related to emergency preparedness to mitigate injury and trauma risks, improving public health initiatives related to interhospital transportation and strengthening newborn screenings, expanding support for traumatic brain injury survivors, and increasing access to nutrition services for children with autism spectrum disorder (ASD) and pregnant women.
3. *Connecting to Care for Improved Healthcare Access* includes six strategies that align with the vision of increasing access to ensure rural residents have more opportunities for primary, specialty, dental, and behavioral healthcare.
4. *Growing a Highly Skilled Healthcare Workforce* includes five strategies that are grounded in increasing and incentivizing healthcare workers to work in rural Georgia and directly associated with the vision for rural people in rural places through expanded scholarship, recruitment incentives, and GME programs.
5. *Leveraging Technology for Healthcare Innovation* consists of eight technology-based strategies incorporated into the GREAT Health program that will scale up innovation that focuses on improving care delivery in alignment with the vision of advancing rural progress through technological advances in areas including cybersecurity, robotics, electronic medical records, and artificial intelligence.

Georgia contains 126 counties that are either fully or partially designated as rural by the U.S. Health Resources and Services Administration. We will ensure that rural Georgians in all of these designated areas benefit from the GREAT Health program. To ensure coordination in deploying funds, tracking milestones, and assessing project impact, a multisector collaborative, including DCH, the Georgia Department of Public Health, and SORH, will be established as the GREAT Health Advisory Council. The GREAT Health Advisory Council will add representatives from each of the five initiative-based workgroups, along with rural patients, ensuring that at least 60% of members represent rural entities. The GREAT Health Advisory Council will meet regularly to provide a forum for sharing data, identifying challenges, and recommending adjustments to improve implementation and sustainability.

Finally, because the GREAT Health program is aimed at transforming health and healthcare in rural Georgia, I am committed to supporting the bold and innovative steps to make the most of this opportunity. Furthermore, I hereby certify that the state will not spend any funds on activities prohibited under 42 U.S.C. 1397ee(h)(2)(A)(ii).

Thank you for allowing the state of Georgia to submit this application for RHT Program funding. I fully support this work and am happy to speak with you further about this proposal. Please let me or my staff know if we may provide any additional information or support related to these endeavors.

Sincerely,



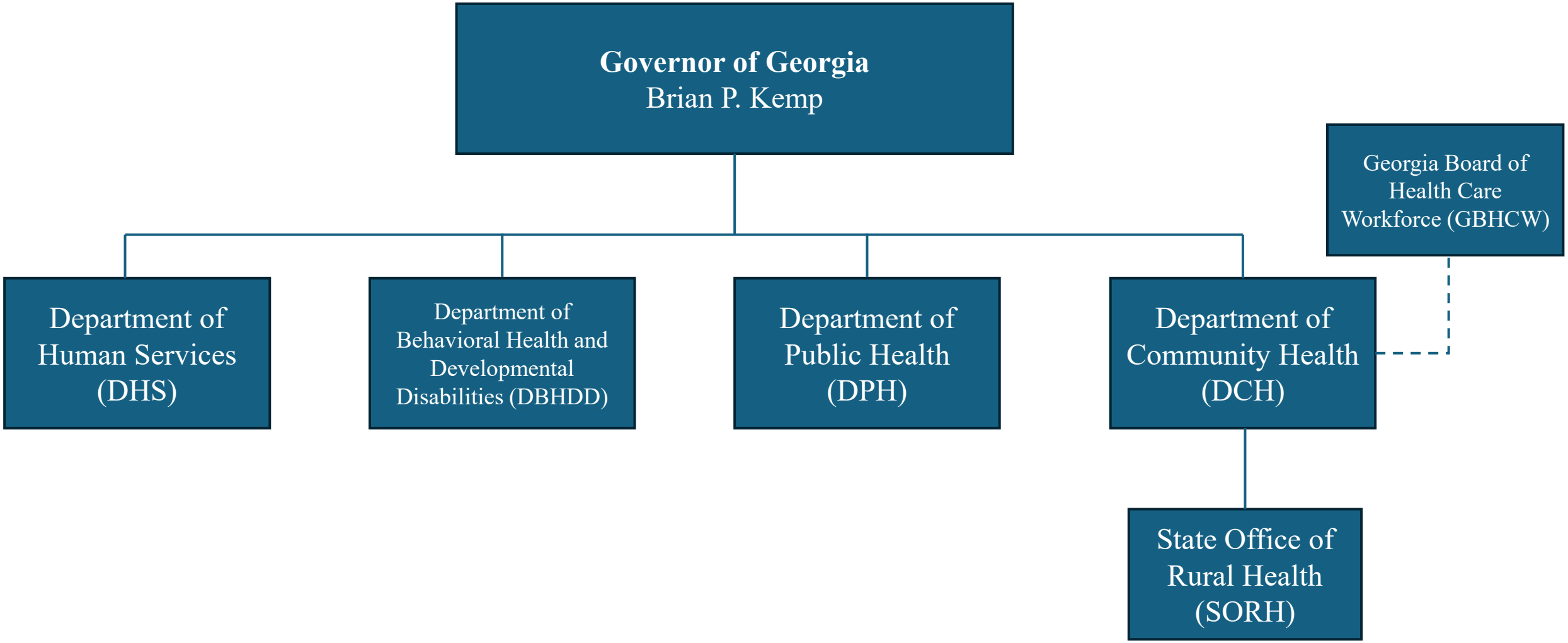
Brian P. Kemp

Attachment A: GREAT Health Acronym Guide

AAP/GA-AAP	American Academy of Pediatrics; Georgia Chapter of the American Academy of Pediatrics
ABI	Acquired Brain Injury
AHEAD	Achieving Healthcare Efficiency through Accountable Design
AHEC(s)	Area Health Education Center(s)
AI	Artificial Intelligence
APCD	All Payer Claims Database
ARCHER Tech Catalyst Fund	Access to Robust Care and Health in Rural Georgia Tech Catalyst Fund
ASD	Autism Spectrum Disorder
ASN	Associate of Science in Nursing
BHSAT	Behavioral Health State Assessment of Technology
BSN	Bachelor of Science in Nursing
CCBHC	Certified Community Behavioral Health Clinics
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
CON	Certificate of Need
DBHDD	Georgia's Department of Behavioral Health and Developmental Disabilities
DCH	Georgia's Department of Community Health
DECAL	Georgia's Department of Early Care And Learning
DHS	Georgia's Department of Human Services
DOE	Georgia's Department of Education
DPH	Georgia's Department of Public Health
DSH	Disproportionate Share Hospital
ECHO	Extension of Community Healthcare Outcomes
ED	Emergency Department
EDR	Endpoint Detection and Response
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ERF	Emergency Receiving Facilities
FPL	Federal Poverty Line
FQHC(s)	Federally Qualified Health Center(s)
FY	Fiscal Year
GBHCW	Georgia Board of Health Care Workforce

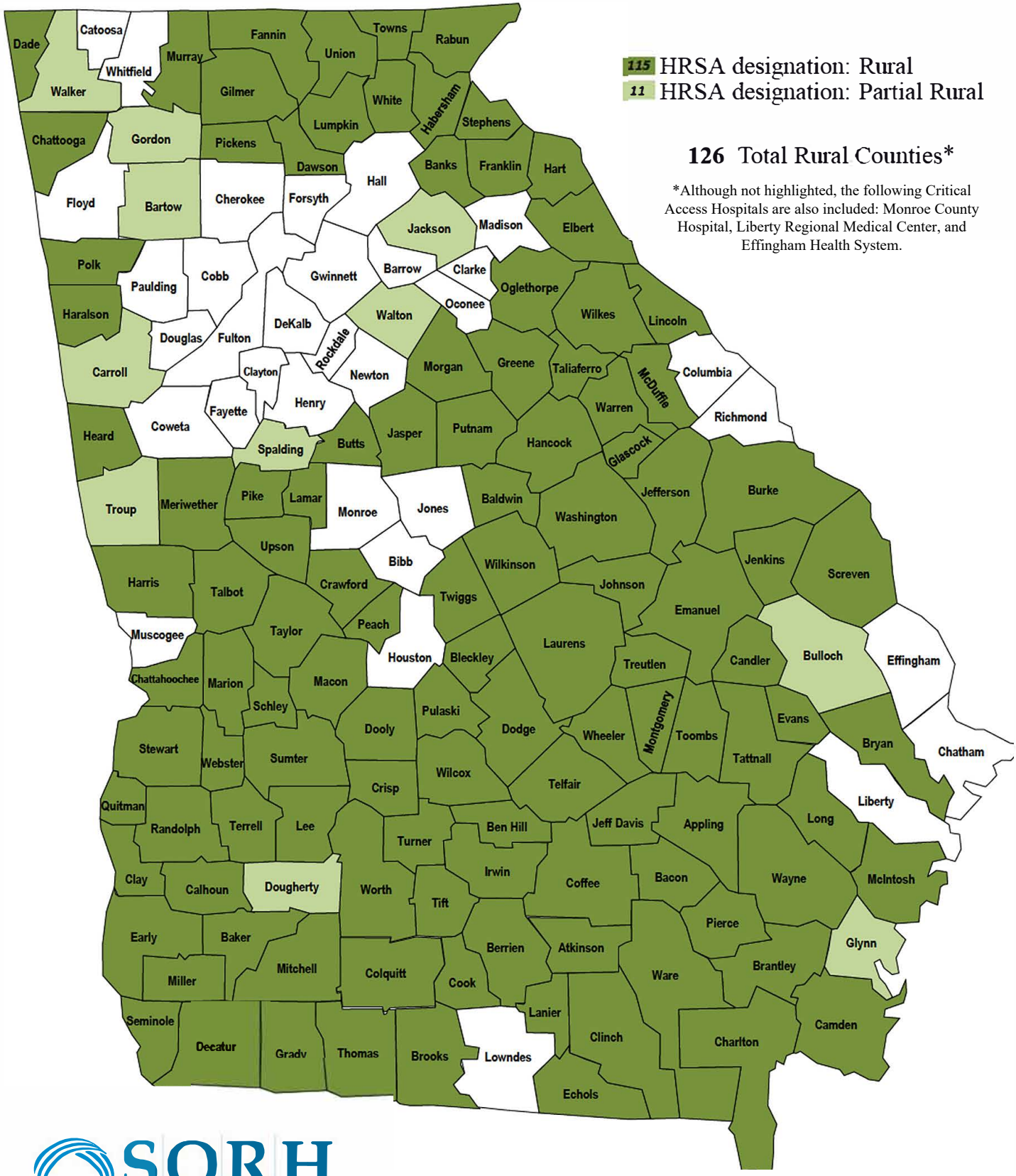
GME	Graduate Medical Education
GREAT Health	Georgia Rural Enhancement And Transformation of Health
GTA	Georgia Technology Authority
GTRI	Georgia Tech Research Institute
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
IDD	Intellectual and Developmental Disability
MAGI	Modified Adjusted Gross Income
MAP	Medical Assistance Plans Division of DCH
MH	Mental Health
NEMT	Non-Emergency Medical Transport
OB/OBGYN	Obstetrician; Obstetrician and Gynecologist
OCI	Georgia's Office of Commissioner of Insurance and Safety Fire
PCP	Primary Care Provider
PEACE for Moms	Perinatal Psychiatry, Education, Access, and Community Engagement for Moms
PHI	Protected Health Information
PTIP	Preceptor Tax Incentive Program
P4HB	Planning for Health Babies
RFGA	Request for Grant Applications
RHC	Rural Health Clinic
RHM	Rural Health Manager
RHT Program	Rural Health Transformation Program
RPM	Remote Patient Monitoring
RSG	Rural Stabilization Grant
SBS	Side-By-Side Clubhouse
SHBP	State Health Benefit Plan
SIP	Shelter-in-Place
SLTDI	Short-term, limited duration insurance
SNF	Skilled Nursing Facilities
SORH	State Office of Rural Health
TA	Technical Assistance
TBD	To Be Determined
TVT	Treat-versus-Transport
UGA IDM	University of Georgia Institute for Disaster Management

Attachment B: State of Georgia Health Agencies Organization Chart



Dashed line indicates an administratively attached agency

Attachment C: Georgia Rural Counties



SORH
State Office of Rural Health
A Division of the Georgia Department of Community Health

October 2025

Attachment D: Georgia Counties and Portions of Counties Indicated Rural by HRSA Rural Health Grants Eligibility Analyzer

FIPS Code	County Name
13001	Appling
13003	Atkinson
13005	Bacon
13007	Baker
13009	Baldwin
13011	Banks
13015	Bartow
13017	Ben Hill
13019	Berrien
13023	Bleckley
13025	Brantley
13027	Brooks
13029	Bryan
13031	Bulloch
13033	Burke
13035	Butts
13037	Calhoun
13039	Camden
13043	Candler
13045	Carroll
13049	Charlton
13053	Chattahoochee
13055	Chattooga
13061	Clay
13065	Clinch
13069	Coffee
13071	Colquitt
13075	Cook
13079	Crawford
13081	Crisp
13083	Dade
13085	Dawson
13087	Decatur
13091	Dodge
13093	Dooly
13095	Dougherty
13099	Early
13101	Echols
13105	Elbert
13107	Emanuel
13109	Evans
13111	Fannin
13119	Franklin
13123	Gilmer
13125	Glascock
13127	Glynn
13129	Gordon
13131	Grady
13133	Greene
13137	Habersham
13141	Hancock
13143	Haralson
13145	Harris
13147	Hart
13149	Heard
13155	Irwin
13157	Jackson
13159	Jasper
13161	Jeff Davis
13163	Jefferson
13165	Jenkins
13167	Johnson
13171	Lamar
13173	Lanier
13175	Laurens
13177	Lee
13181	Lincoln
13183	Long
13187	Lumpkin
13189	Macon
13191	Madison
13193	Marion
13197	McIntosh
13199	Meriwether
13201	Miller
13205	Mitchell
13209	Montgomery
13211	Morgan
13213	Murray
13221	Oglethorpe
13225	Peach
13227	Pickens
13229	Pierce
13231	Pike
13233	Polk
13235	Pulaski
13237	Putnam
13239	Quitman
13241	Rabun
13243	Randolph
13249	Schley
13251	Screven
13253	Seminole
13255	Spalding
13257	Stephens
13259	Stewart
13261	Sumter
13263	Talbot
13265	Taliaferro
13267	Tattnall
13269	Taylor
13271	Telfair
13273	Terrell
13275	Thomas
13277	Tift
13279	Toombs
13281	Towns
13283	Treutlen
13285	Troup
13287	Turner
13289	Twiggs
13291	Union
13293	Upson
13295	Walker
13297	Walton
13299	Ware
13301	Warren
13303	Washington
13305	Wayne
13307	Webster
13309	Wheeler
13311	White
13315	Wilcox
13317	Wilkes
13319	Wilkinson
13321	Worth

*While not included in the counties above, the following Critical Access Hospitals are captured within the rural definition for this application and as such are eligible for AHEAD model- related funding and activities: Monroe County Hospital, Liberty Regional Medical Center, and Effingham Health System.

Attachment E: Proposed Implementation Timeline

All FY reference the federal Fiscal Year, beginning in October and ending in September.

Initiative 1: Transforming for a Sustainable Health System in Rural Georgia	
AHEAD Hospital and AHEAD Primary Care (assessments; Technical Assistance (TA); risk mitigation)	**Stage 0:** Establish contracts to perform assessments (Q2, FY26); identify rural hospitals to be assessed (Q2, FY26); SORH and MAP hire additional staff (Q2, FY26);
	Stage 1: Hospital assessments begin (Q3, FY26); instructions for hospital transformation plans sent to AHEAD ready identified hospitals (Q2, FY27); provider discussions begun (Q2, FY27); new staff begin development of TA and knowledge sharing program (Q2, FY27)
	Stage 2: Hospital assessments completed (Q3, FY27); information session held with identified hospitals (Q3, FY27); FQHC and CCBHC discussions begin (Q3, FY27); recruitment of hospitals and providers begins (Q4, FY27); TA and knowledge sharing program goes live (Q4, FY27)
	Stage 3: TA provided to hospitals as needed (ongoing); payers recruited (Q3, FY29); TA provided to prepare hospitals for end to mitigation payments (FY29/30)
	Stage 4: Hospital transformation plans completed (Q4, FY27); risk mitigation payments begun (Q4, FY29); risk mitigation payments updated (Q1, FY30)
	Stage 5: AHEAD model ready (Q4, FY28); risk mitigation payments end (Q4, FY30); ongoing global budget formula finalized (Q4, FY30)
Initiative 2: Strengthening the Continuum of Care in Rural Georgia	
Public Health Investments: Georgia Newborn Screening Program	**Stage 0:** This funding is proposed for year two so no activities will take place during the first 12 months. (FY26); purchase and installation of new equipment for newborn screening testing at the Ware County laboratory (Q1, FY27); test onboarding and ensure staff are trained to perform laboratory tests using the new screening equipment (Q2, FY27); create and distribute protocols to determine how newborn screening program specimens will arrive at the Waycross laboratory (Q4, FY27)
	Stage 1: Maintain new equipment for newborn screening testing at the Ware County laboratory and begin use in phases (Q1, FY28); collaborate to create an emergency preparedness plan in which the Ware County laboratory serves as a backup for the entire state of Georgia (Q4, FY28)
	Stage 2: Full capacity newborn screening at the Waycross laboratory for rural parts of the state (Q1, FY29); provide additional training and TA to project staff (Q1, FY29); begin evaluation on the impact of the Waycross State Public Health Laboratory as a new Georgia Newborn Screening Program test sit (Q1, FY30)
	Stage 3: Provide additional training and TA to project staff (Q1, FY30)
	Stage 4: Prepare in year four to transition to newborn screening fees to cover expenses (Q1, FY30)
	Stage 5: Transition to newborn screening fees to cover expenses in year five and after, ensuring sustainability (Q2, FY31)
Public Health Investments: Inter-hospital Transportation	**Stage 0:** Hire project manager to work with the hospitals and assist with program roll out (Q2, FY26); develop process and criteria to determine rural hospitals with the greatest need, that will receive inter-hospital Type 2 ambulances (Q2, FY26)
	Stage 1: Purchase first six inter-hospital ambulances and transfer ownership to the selected hospitals (Q1, FY27); provide all hospitals receiving ambulances with training and technical assistance to ensure ambulances are maintained, established protocols and procedures are communicated, and ambulances are utilized to their maximum capacity (Q1, FY27); assist hospitals with the billing structure to cover maintenance and staffing costs and ensure sustainability (Q2, FY27); begin evaluation on the impact of the inter-hospital Type 2 ambulance transfer program (Q4, FY27)
	Stage 2: Purchase six inter-hospital ambulances and transfer ownership to selected hospitals (Q1, FY28); continue provision of training and technical assistance (Q1, FY28); share ongoing evaluation results with stakeholders (Q4, FY28); review evaluation data and implement strategy to learn from evaluation feedback and make improvements (Q4, FY28)

	Stage 3: Purchase six inter-hospital ambulances and transfer ownership to selected hospitals (Q1, FY29); continue provision of training and technical assistance (Q1, FY29); share ongoing evaluation results with stakeholders (Q4, FY29); review evaluation data and implement strategy to learn from evaluation feedback and make improvements (Q4, FY29)
	Stage 4: Purchase six inter-hospital ambulances and transfer ownership to selected hospitals (Q1, FY30); continue provision of training and technical assistance (Q1, FY30); share on-going evaluation results with stakeholders (Q4, FY30); review evaluation data and implement strategy to learn from evaluation feedback and make improvements (Q4, FY30)
	Stage 5: Purchase six inter-hospital ambulances and transfer ownership to selected hospitals (Q1, FY31); continue provision of training and technical assistance (Q1, FY31); share on-going evaluation results with stakeholders (Q4, FY31); review evaluation data and implement strategy to learn from evaluation feedback and make improvements (Q4, FY31)
Support for Acquired Brain Injury (ABI) Survivors	**Stage 0:** Begin needs assessment to determine new Clubhouse placement (Q1, FY 2026); introduce concept of ABI Clubhouse model in targeted communities, relationship building with rural hospitals (Q2, FY26); work with DCH to determine specific rural location for each ABI Clubhouse (Q2, FY26); hire COO to lead rural expansion and build community support (Q2, FY26); information system capacity building investment to transform SBS into hub and spoke modeled organization (Q2 - Q4, FY26); host community meetings in all new clubhouse communities (Q3, FY26 and ongoing); host community and virtual meetings in first community to recruit clients/members (Q4, FY26); begin interviews for Clubhouse staff to support opening ABI Clubhouse 1 (Q4, FY26)
	Stage 1: ABI Clubhouse 1 opens (Q1, FY27); host community and virtual meetings in second new ABI Clubhouse community to recruit clients/members (Q3, FY27); establish agreement for second clubhouse with hospital partner (Q4, FY27); continued community engagement in each distinct region (Ongoing)
	Stage 2: ABI Clubhouse 2 opens (Q2, FY28); host community and virtual meetings in third new ABI Clubhouse community to recruit clients/ members (Q3, FY28); establish agreement for third clubhouse with hospital partner (Q4, FY28); continued community engagement in each distinct region (Ongoing); ABI Clubhouse 1 at capacity (Q4, FY28)
	Stage 3: ABI Clubhouse 3 opens (Q1, FY29); ABI Clubhouse 1 operating sustainably and supported by community (Q4, FY29); continued community engagement in each distinct region (Ongoing); ABI Clubhouse 2 at capacity (Q4, FY29)
	Stage 4: ABI Clubhouses 1 and 2 operating sustainably and supported by communities (Q4, FY30); continued community engagement in each distinct region (Ongoing); assessment of hub and spoke organization and community impact results of each clubhouse prepared for DCH (Q4, FY30); ABI Clubhouse 3 at capacity (Q4, FY30)
	Stage 5: ABI Clubhouses 1, 2 and 3 operating sustainably and supported by communities (Q4, FY31); each clubhouse is full and meeting all goals for service to ABI survivors and their community (Q4, FY31); serving over 200 ABI survivors annually - over 500 ABI survivors/family members/caregivers served in rural communities (Q4, FY31); evaluation (Q1 – Q4, FY31)
Transportation to Treatment for Mental Health Crisis	**Stage 0:** Expand the pilot project as a fully-fledged program in SW Georgia. Develop a sustainable funding model (Q3, FY26); evaluate other rural regions to select expansion partners (Q4, FY26)
	Stage 1: Expand program into an additional rural region (Q1 – Q4, FY27); secure vehicles for transport (Q1, FY27); secure transport vehicles (Q1, FY27)
	Stage 2: Expand program into an additional rural region (Q1–Q4, FY28); secure vehicles for transport (Q1, FY28); secure transport vehicles (Q1, FY28)
	Stage 3: Expand program into an additional rural region. (Q1–Q4, FY29); secure vehicles for transport (Q1, FY29); secure transport vehicles (Q1, FY29)
	Stage 4: Expand program into an additional rural region. (Q1–Q4, FY29); secure vehicles for transport (Q1, FY30); secure transport vehicles (Q1, FY30)
	Stage 5: Program implementation and document success keys (Q4, FY31)
Building Bridges (School-Based	**Stage 0:** Multistakeholder council (MSC) formation (Q2, 2026); MSC governance structure development (Q3, 2026); community coordinating group recruitment (Q4, 2026)

Health Care Services Infrastructure)	**Stage 1:** Implementation framework finalized (Q4, 2026); environmental scan and needs assessment (Q4, 2026); site eligibility criteria and readiness assessment development (Q4, 2026); HIE infrastructure development (End of year 2026); training resource development (Q4, 2026)
	Stage 2: Early implementation sites identification and onboarding (End of Q3, 2027); statewide scaling strategy development (Q1, 2028)
	Stage 3: Site implementation continuous improvement (2028-2029); scaling strategy implementation and refinement (2028-2029); phase 2 site implementation (2028); online training platform development (Q3 & Q4, 2028)
	Stage 4: Online training platform implementation (2029-2030); phase 3 sites implementation (2029-2030)
	Stage 5: Maintenance and sustainability activities (2030); evaluation (2028-2030)
Emergency Preparedness – Shelter in Place	**Stage 0:** Key stakeholders convene and an advisory committee established (Q2, FY26); assessment tool and methodology developed (Q3, FY26); existing data about rural healthcare facility infrastructure evaluated (Q3, FY26); marketing and communications plan generated and implemented (Q3, FY26)
	Stage 1: Baseline assessments at all rural hospitals, SNFs, and in-patient hospice facilities completed (Q2, FY26 – Q1, FY27);
	Stage 2: Prioritization matrix for infrastructure enhancement designed (Q3, FY27); recommended infrastructure enhancements finalized (Q3, FY27); competitive grant program developed (Q3, FY27)
	Stage 3: Applications to grant program submitted by each facility (Q4, FY27); initial awards administered (Q4, FY27); technical assistance in grant writing and contractor identification provided (Q4, FY27)
	Stage 4: Applications to grant program submitted by each facility (Q4, FY27); initial awards administered (Q4, FY27); technical assistance in grant writing and contractor identification provided (Q4, FY27)
	Stage 5: Repeat facility assessments conducted to verify completion of improvements and realization of goals (Q1–Q4, FY31); program results and data incorporated into Georgia's response and recovery plans (Q4, FY31)
Regional Nursing Home Transportation Enhancement	**Stage 0:** Feasibility study, policy and contract review, program design (Q2–Q4, FY26); Establish partnership with established entity with community connections (Q2 FY26)
	Stage 1: Education, training and regional pilot implementation in at least 2 regions with partner. (Q1–Q4, FY27)
	Stage 2: Program expansion into additional regions (Q1–Q4, FY28)
	Stage 3: Program expansion into additional regions (Q1–Q4, FY29)
	Stage 4: Program expansion into additional regions (Q1–Q4, FY30)
	Stage 5: Maintenance and sustainability (Q3, FY30–Q3, FY31); evaluation (FY31)
Rural Provider Nutrition Training for Autism Spectrum Disorder (ASD)	**Stage 0:** Planning and assessment of current ASD nutrition programs (Q3, FY26)
	Stage 1: Develop ASD feeding curriculum (Q4, FY26)
	Stage 2: Deliver accredited continuing medical education modules on ASD feeding protocol (Q1–Q4, FY28)
	Stage 3: Deliver accredited continuing medical education modules on ASD feeding protocol (Q1-Q4, FY29); expand referral networks into more rural counties (Q1-Q4, FY29)
	Stage 4: Deliver accredited continuing medical education modules on ASD feeding protocol (Q1 – Q4, FY30)
	Stage 5: Maintenance & sustainability (Q3, FY30– Q3, FY31); evaluation (FY31)
Planning for Healthy Babies: Nutrition & Weight Management Eligibility Category	**Stage 0:** Planning and assessment of current population eligible for coverage; work with providers to determine threshold for BMI/weight eligibility (Q3, FY26)
	Stage 1: Develop waiver materials, including contracting for actuarial development of 1115 cost impact (Q4, FY26); create marketing for interpregnancy (Q1, FY27)
	Stage 2: Develop outcome process (Q1, FY27)
	Stage 3: Begin enrollment of patients in eligibility category (Q2, FY28, pending CMS approval)
	Stage 4: Complete all outcome tracking and monitoring, per 1115 STCs (Q1, FY29)

	Stage 5: Maintenance and sustainability (Q3, FY30– Q3, FY31); evaluation (FY31)
Initiative 3: Connecting to Care to Improve Healthcare Access in Rural Georgia	
Care to Consumer: Point of Care Telepods & Mobile Clinics	**Stage 0:** Host kick-off meeting to determine components of assessment (Q2, 2026); vendor selection process for assessment and for point-of-care telehealth pods (Q3, 2026); work with DBHDD regarding IDD dental mobile unit (Q3, 2026)
	Stage 1: Complete assessment of care needs, geographic area, sustainability feasibility (Q3/4, 2026); develop Request for Grant Application (RFGA) and send to rural candidates for mobile and point-of-care telehealth units (Q3, 2026); RFGA submitted for both mobile unit and point-of-care telehealth pods (Q3/Q4, 2026); procure and outfit DBHDD dental unit (Q4, 2026); begin developing work plan for health student rotations with mobile units (2026-2031)
	Stage 2: Begin training staff and coordinate TA assistance for service lines needed in each area (Q4, 2026); acquire vans built to specifications of services offered (Q3/Q4, 2026); host local stakeholder meetings for operational logistics of launching pods (Q3/4, 2026; Q1 2027)
	Stage 3: Begin marketing plans in rural communities (Q4, 2026); launch service in initial 5 mobile units and initial 5 point-of-care telehealth pods (Q1-3 2027); launch DBHDD dental van (Q1, 2027)
	Stage 4: Assess current successes/lesson learned; adjust future implementation for years 2-5 accordingly; collect data from mobile units and point-of-care telehealth pods (ongoing) for evaluation; release additional RFGA and repeat processes for implementation (2027-2031)
	Stage 5: Project fully implemented with 26 mobile units offering services and 25 point-of-care telehealth pod placements (2031); cost benefit, health outcomes, and evaluation data demonstrate fiscal sustainability (2031); all units are billing for services and integrated into workforce clinical rotations as needed (2031)
Telehealth Enhancements	**Stage 0:** Establish governance and collaborative structures (Q2, 2026); recruit initial cohort and complete baseline assessments aligned with statewide needs (Q3-4, 2026)
	Stage 1: Begin workforce preparation and deploy standardized technology and operational processes (Q3-4, 2026); initiate remote specialty access for acute care needs (Q4, 2026)
	Stage 2: Implement core technology functions and integrate people, processes, and equipment at rural sites (Q1-3, 2027); upgrade and expand local capacity for preventive and screening services (Q1-3, 2027); expand workforce training and begin enrollment of additional hospitals (Q3-4, 2027)
	Stage 3: Onboard additional cohorts through phased implementation (Q1, 2028 and ongoing); broaden preventive, specialty, and care coordination services (2028-2029); use program data to assess progress and guide refinements (2028-2030); introduce predictive analytics and strengthen workforce capacity (2028-2030)
	Stage 4: Achieve broad adoption of digital infrastructure and processes (2029-2030); scale advanced care models and enhance feedback loops for workforce engagement (2029-2030); conduct program evaluation and develop business models tied to sustainability (2029-2030)
	Stage 5: Complete a statewide multi-hub network with coordinated care pathways (2030); refine sustainability strategies and local business planning (2030); demonstrate measurable improvements in access, outcomes, and workforce stability, and publish roadmap for replication (2030)
Rural Stabilization Grants (RSG)	**Stage 0:** Revise Request for Grant Application (RFGA) to include second track focused on aligning with AHEAD and the state's RHTP priorities (Q2, FY26); develop and refine program criteria to include metrics and reporting requirements (Q2, FY26)
	Stage 1: Disseminate RFGA to qualifying rural hospitals in designated rural counties (Q3, FY26); award funding to 20 hospitals for $1 million based on metrics and program alignment with AHEAD (Q4, FY26); develop TA program for grantees as needed
	Stage 2: Grantees submit annual reports (Q4, FY27); GREAT Health program leadership reviews reports and reflects on lessons learned, challenges, and opportunities (Q1, FY28); release revised RFGA to qualifying rural hospitals and expand to include primary care, such

	as rural health clinics and FQHCs that align with the AHEAD model (Q3, FY27); award grants to 20 new grantees (Q4, FY27)
	Stage 3: Grantees submit annual reports (Q4, FY28); RHTP leadership review reports and reflect on lessons learned, challenges, and opportunities (Q1, FY29); release revised RFGA to qualifying rural hospitals, primary care, such as rural health clinics and FQHCs that align with the AHEAD model (Q3, FY28); award grants to 20 new grantees (Q4, FY28)
	Stage 4: Grantees submit annual reports (Q4, FY29); GREAT Health program leadership review reports and reflect on lessons learned, challenges, and opportunities (Q1, FY29); release revised RFGA to qualifying rural hospitals, primary care, such as rural health clinics and FQHCs that align with the AHEAD model (Q3, FY29); award grants to 20 new grantees (Q4, FY29)
	Stage 5: Grantees submit annual reports (Q4, FY30); GREAT Health program leadership review reports and reflect on lessons learned, challenges, and opportunities (Q1, FY30); release revised RFGA to qualifying rural hospitals, primary care, such as rural health clinics and FQHCs that align with the AHEAD model (Q3, FY29); award grants to 20 final grantees (Q4, FY30).Evaluation and reporting of program outcomes (Q1 – Q4, FY31)
Strengthening Perinatal Systems of Care	**Stage 0:** Develop assessment of perinatal quality assurance and improvement of non-delivering and birthing hospitals (Q2, 2026)
	Stage 1: Procure and prepare fully stocked, mobile, color-coded obstetrical emergency carts (Q2–Q3, 2026); develop standard operating procedures for maternal emergencies (Q3, 2026)
	Stage 2: Deploy 57 obstetrical emergency carts (Q3–Q4, 2026); train staff on cart use, maintenance, and neonatal resuscitation (Q4, 2026); implement standardized, evidence-based patient safety bundles (Q1-Q4, 2027)
	Stage 3: Expand patient safety bundle implementation to additional rural birthing hospitals (2028–2030); ongoing training and simulation drills for maternal and neonatal emergencies (2026–2030)
	Stage 4: Conduct continuous quality improvement monitoring, data collection, and program evaluation (2027–2030)
	Stage 5: Integrate program into ongoing DPH perinatal quality initiatives (2030)
Public Health Telehealth Infrastructure	**Stage 0:** Launch Telehealth Infrastructure Fund and establish application process (Q2, 2026); complete baseline assessments of technical capacity, staffing readiness, and community need (Q2–Q3, 2026)
	Stage 1: Initiate space outfitting for pilot sites (Q3–Q4, 2026); procure telehealth equipment and deploy to funded sites (Q1-Q2, 2027); complete provider and staff training on telehealth platforms, billing, and compliance (Q2–Q3, 2027)
	Stage 2: Implement telemedicine, teledentistry, and telepsychiatry at initial sites (Q3–Q4, 2027); expand infrastructure upgrades to additional rural health departments (2028)
	Stage 3: Launch community awareness campaigns (2028)
	Stage 4: Implement evaluation of access, utilization, and health outcomes (2030)
	Stage 5: Transition fund to a sustainability model supported by reimbursements and multi-sector partnerships (end of 2030)
Rural Telepsychiatry: Consultations and Primary Care Provider Training	**Stage 0:** Assess the readiness of DBHDD Project ECHO (Q2, FY26); assess the readiness of PEACE (Q2, FY26); identify rural pediatrician and OB partners (Q3, FY26)
	Stage 1: Create and distribute marketing material for both programs (Q4, FY26); outreach to rural pediatricians and OBs to increase adoption (Q1 – Q4 FY27); implement Project ECHO model with DBHDD and pediatric psychiatrists (Q4, FY26); scale PEACE for Moms with DPH (Q4, FY26)
	Stage 2: Continue outreach to rural peds and OBs to increase adoption (Q1 – Q4 FY28); expand Project ECHO model to reach more pediatric psychiatrists (FY27); expand PEACE for Moms to reach more OBs (FY27); collect outcome data & refine programs (Q4, FY27)
	Stage 3: Continue outreach to rural peds and OBs to increase adoption (Q1 – Q4 FY29); expand Project ECHO model to reach more pediatric psychiatrists (FY28); expand PEACE for Moms to reach more OBs (FY28); collect outcome data & refine programs (Q4, FY28)

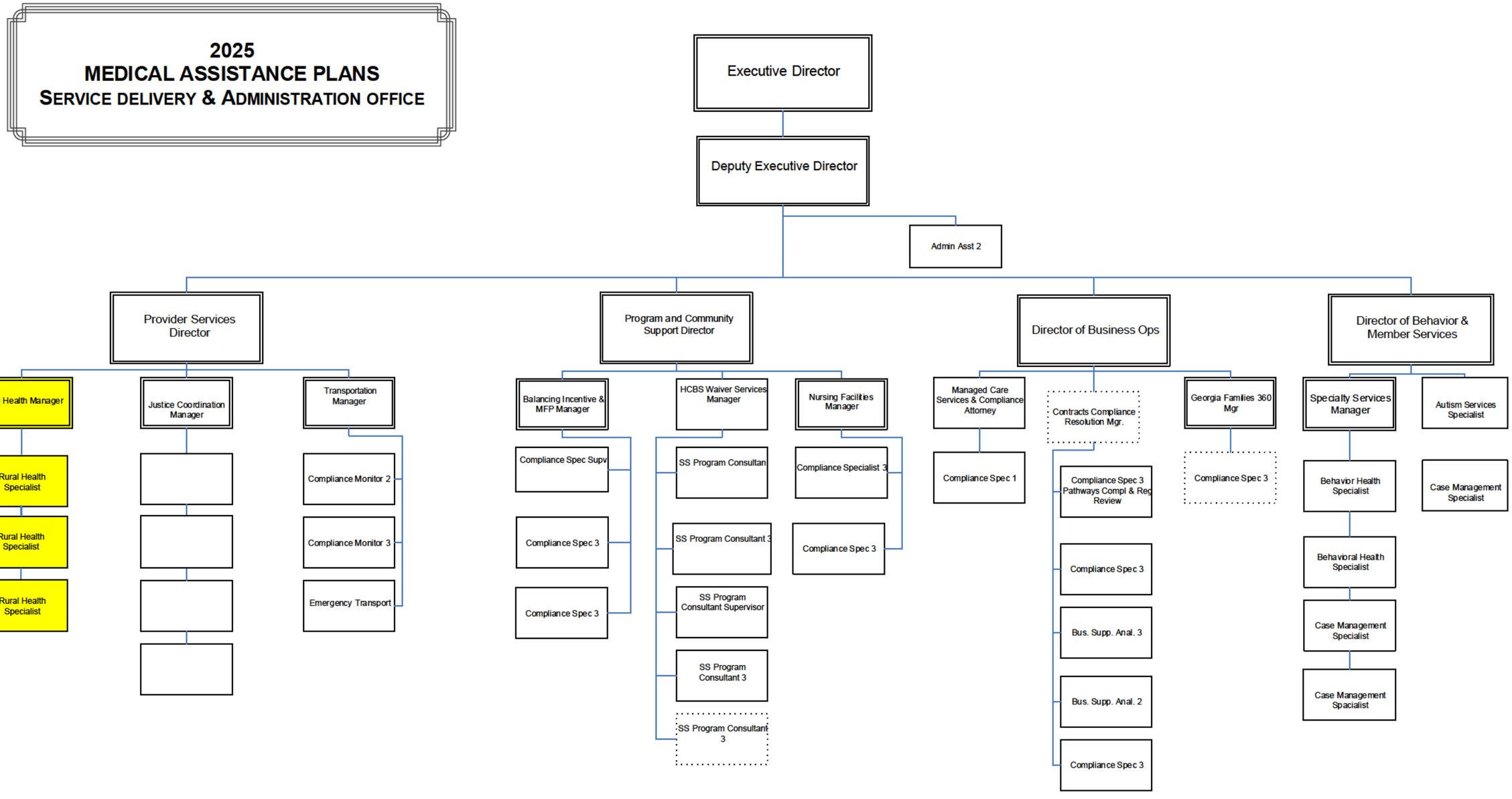
	Stage 4: Continue outreach to rural pediatricians and OBs to increase adoption (Q1 – Q4 FY30); expand PROJECT ECHO model to reach more pediatric psychiatrists (FY29); expand PEACE for Moms to reach more OBs (FY29); collect outcome data and refine programs (Q4, FY29)
	Stage 5: Continue outreach to rural pediatricians and OBs to increase adoption (Q1 – Q4 FY31); expand Project ECHO model to reach more pediatric psychiatrists (FY30-FY31); expand PEACE for Moms to reach more OBs (FY30 – FY31); collect outcome data and evaluate program (Q4, FY31)
Initiative 4: Growing a Highly Skilled Healthcare Workforce in Rural Georgia	
Rural Provider Workforce & GME Enhancements	**Stage 0:** Establish statewide consortium to serve as the advisory board, led by the Georgia Board of Health Care Workforce, ensuring representation of rural stakeholders. (Q2, FY26)
	Stage 1: Expand GME residency slots by 25 statewide (Q1, FY27); fund 12 additional fellows across multiple specialties (Q1, FY27); create rural recruitment incentive grant program for doctoral level providers (Q2, FY27); create incentives to increase the percentage of residents and fellows trained at rural sites (Q2, FY27)
	Stage 2: Expand GME residency slots by 25 statewide (Q1, FY28); fund 12 additional fellows across multiple specialties (Q1, FY28)
	Stage 3: Expand GME residency slots by 25 statewide (Q1, FY29); fund 12 additional fellows across multiple specialties (Q1, FY29)
	Stage 4: Expand GME residency slots by 25 statewide (Q1, FY30); fund 12 additional fellows across multiple specialties (Q1, FY30)
	Stage 5: Measure and report final outcomes of workforce strategies; demonstrate impact of program on residency opportunities, fellows, incentive program, physician retention (2031)
Telehealth Mentoring for Dementia	**Stage 0:** Curating a statewide dementia training catalog (Q3, FY26)
	Stage 1: Facilitate Project ECHO learning collaboratives; deliver the Dementia Care Navigation Training Series; equip health professionals to deliver evidence-based care via a series of tools, trainings & resources; complete training (Q4, FY26)
	Stage 2: Scale program and trainings to additional rural providers (Q4, FY27)
	Stage 3: Scale program and trainings to additional rural providers (Q4, FY28)
	Stage 4: Scale program and trainings to additional rural providers (Q4, FY29)
	Stage 5: Evaluate and report outcomes (Q1 – Q4, FY31); complete training for over 13,000 professionals (Q4, FY31)
Area Health Education Centers (AHEC) Training & Housing	**Stage 0:** Assign staff to work on projects (Q2, FY26)
	Stage 1: Provide stipends for 20 additional students for shadowing/experiential learning (Q2, FY26); Begin training medical students as Digital Health Navigators and start hosting up to 20 community-based training events (Q2, FY26); Expand provider participation in state Preceptor Tax Incentive Program (Q3, FY26); Conduct student focus groups (Q4, FY 26);
	Stage 2: Provide stipends for 20 additional students for shadowing/experiential learning (Q2, FY27); Begin digitizing and modernizing training manuals and videos (Q3, FY27); Continue Digital Health Navigator trainings and host 30+ community events (Q1-Q4, FY27); Begin hosting workforce transformation regional meetings with provider partners (Q4, FY27)
	Stage 3: Provide stipends for 20 additional students for shadowing/experiential learning (Q2, FY28); Continue hosting regional workforce transformation meetings to identify gaps and solutions (Q1-Q4, FY28); Continue digitizing and modernizing training manuals and videos (Q1-4, FY28)
	Stage 4: Publish training manuals and videos (Q1, FY29) Provide stipends for 20 additional students for shadowing/experiential learning (Q2, FY29); Offer TA and outreach to rural providers who volunteer as preceptors for shadowing programs (Q4, FY 29)
	Stage 5: Continue provider continuing education opportunities for preceptors (Q1-2, FY 30); Provide stipends for 20 additional students for shadowing/experiential learning

	(Q2, FY30); Conduct workforce needs assessment and identify areas for additional training (Q2-Q4, FY30)
Emergency Services Scholarships	**Stage 0:** GEMSA/GAPA assign staff as project manager (Q2, 2026)
	Stage 1: Develop Grant Process/Requirements and application for students (Q2, 2026); identify qualified training agencies with pass rates of 80% or higher from state regulatory program data (Q2, 2026)
	Stage 2: Finalize implementation framework (Q3 2026); develop Oversight and Accountability Committee (Q3 2026)
	Stage 3: Launch implementation framework (Q4 2026); Launch Oversight and Accountability Committee (Q4 2026); open Grant Process statewide (Q4, 2026)
	Stage 4: Complete approval process (Q1 2027); award scholarships (Q1 2027)
	Stage 5: Implement EMT and Paramedic Scholarships (Q2, 2027 and continue through end 2030)
Nursing Care Improvements	**Stage 0:** Launch planning stage for each project area (Q2, FY26)
	Stage 1: Establish process for advance degree applications and approvals (Q2, FY26); establish work group for clinical faculty training (Q2, FY26); assign staff to manage process (Q2, FY26); establish summer camp workgroup (Q2, FY26); hire and onboard staff for simulation efforts (Q3, FY26)
	Stage 2: Open applications for advance degree (Q4, FY26); establish reimbursement process (Q3, FY26); create template, format, and curriculum (Q2, FY26); manage simulation enrollment (Q3, FY26); create training modules for clinical faculty training (Q3, FY26)
	Stage 3: Train summer camp staff (late Q2, 2026); host first summer camp (Q3/4, FY26); open applications (Q3, FY26);
	Stage 4: train clinical faculty (Q4, FY26); track data (Q4, FY26)
	Stage 5: Run continuously all programs on the same schedule (Q1, FY27 –Q4, FY31); track data to ensure programs are meeting outcomes annually (Q4, FY26 – FY31)
Initiative 5: Leveraging Technology for Healthcare Innovations in Rural Georgia	
Cybersecurity Enhancements	**Stage 0:** Initial engagement and coordination with implementing partners (Q2, FY26); develop and finalize vendor and university contracts (Q2, FY26)
	Stage 1: Assemble and finalize implementation team and partners (Q2, FY26); begin assessment of cybersecurity risks (Q3, FY26); finalize implementation plan (Q3, FY26); begin recruitment/outreach to rural hospitals (Q3, FY26); communications and coordination with cybersecurity internship programs in preparation for project launch (Q3-4, FY26); development of resources and other materials (Q3-4, FY26); onboard and train student interns (starting Q4, FY26 and ongoing)
	Stage 2: Initial site visits, technical assessments, and document review for select number of pilot sites (Q1, FY27 and ongoing); policy and playbook development (Q1, FY27); deploy EDR platform to select number of pilot sites (Q2, FY27); scale cybersecurity assessments to additional rural hospitals (Q3-4, FY27); training and support for hospital staff (Q1, FY27 and ongoing); provide continuous monitoring services (FY27 and ongoing)
	Stage 3: Continued scaling of efforts to additional hospitals (FY28); sustain and optimize cybersecurity operations all participating facilities (FY28-FY30); refine and update policies and procedures based on feedback from field (FY28-FY30); maintain student intern pipeline (FY28-FY30)
	Stage 4: Continued scaling of efforts to additional hospitals (FY29-FY30
	Stage 5: Maintenance and sustainability (FY29-FY30); Evaluation (FY28-FY31)
Advancing Access to Robust Care and Health in Rural Georgia (ARCHER) Tech Catalyst Fund	**Stage 0:** Establish contractual agreement with GTRI to manage fund and construct vision and purpose of fund (Q2, FY26)
	Stage 1: GTRI identifies early and mid-stage companies for first year of investment (Q3, FY26)
	Stage 2: Begin at least quarterly check-ins with GTRI to ensure projected goals are being met (Q4, FY26); Promote ARCHER fund across state and nation to encourage applicants and innovative ideas (Q4. FY26)

	Stage 3: First incubator ideas projected to hit market for use (Q1, FY28)
	Stage 4: Fund is evaluated for portfolio impact and ROI (Q1, FY29)
	Stage 5: Fund is self-sustaining based on structure of investments
EMR Enhancements	**Stage 0:** Evaluate hospital needs and develop a Request for Grant Applications (RFGA) to support EMR enhancements for population health metrics (Q3, FY26)
	Stage 1: Release RFGA for EMR enhancements to hospitals (Q4, FY26); hospital EMR grants awarded (Q2, FY27)
	Stage 2: Release RFGA for EMR enhancements to further facilities (Q4, FY27); EMR grants awarded to second round (Q1, FY28)
	Stage 3: Funded entities develop population health strategic plans aligned with AHEAD reporting and quality metrics (FY27–FY28)
	Stage 4: Align upgraded EMRs, develop data-driven outcomes (FY28)
	Stage 5: All rural facilities using enhanced EMR and ready for AHEAD (Q1, FY31); Program evaluation completed (Q4, FY31);
Workforce Retention Technology	**Stage 0:** Determine rural hospital candidates (Q2, FY26); develop grant process (Q3, FY26)
	Stage 1: Disseminate grant opportunity candidate hospitals (Q4, FY26); review grant proposals and make selection decisions (Q1, FY27)
	Stage 2: Purchase and distribute surgical robots (Q1, FY27); train staff and providers at awarded hospitals (Q2–Q4, FY27)
	Stage 3: Provide TA (Q1–Q4, FY28); maintain systems (Q1–Q4, FY28)
	Stage 4: Provide TA (Q1–Q4, FY29); maintain systems (Q1 –Q4, FY29)
	Stage 5: Provide TA (Q1–Q4, FY30); maintain systems (Q1 –Q4, FY30); conduct evaluation (Q1–Q4, FY31)
Eligibility System Enhancements	**Stage 0:** Identify DCH and DOI staff to oversee project (Q2, FY 26)
	Stage 1: Determine enhancements needed to Gateway, GetInsured, and other systems to meet deliverables (Q4, FY26)
	Stage 2: Begin making needed enhancements (Q1, FY27)
	Stage 3: Test updates to systems (Q3, FY27)
	Stage 4: Make necessary tweaks to systems (Q1, FY28); implement updated systems (Q3, FY28)
	Stage 5: Automate eligibility determination for MAGI applicants with new system (Q1, FY29); integrate Gateway system with GetInsured/Georgia Access, ensure two-way referrals for qualifying applicants (Q1, FY29)
Consumer Engagement Enhancements	**Stage 0:** Identify DCH and SHBP staff to work on project (Q2, FY26)
	Stage 1: Assess the SHBP's Sharecare system for compatibility with Medicaid/Medicare (Q4, FY26)
	Stage 2: Create plan for implementation (Q2, FY27)
	Stage 3: Begin implementation (Q3, FY27)
	Stage 4: Publicize Sharecare during open enrollment/Medicaid renewal (Q1, FY28)
	Stage 5: Integrate Sharecare as benefit to members (Q2, FY28); adjust Sharecare system as needed (Q3, FY28-Q4, FY30)
Behavioral Health State Assessment of Technology (BHSAT)	**Stage 0:** Create strategic project plan and oversight committee including key stakeholder groups (Q3, FY26); MOUs developed and signed amongst key stakeholders (Q4, FY26)
	Stage 1: Develop inventory and mapping of the key data elements (Q2, FY27
	Stage 2: Develop and test assessment architecture (Q3, FY28)
	Stage 3: Conduct Beta test assessment architecture (Q2, FY 29)
	Stage 4: Go live and monitor with assessment architecture (Q1, FY 30)
	Stage 5: Inform population-level behavioral health interventions to include workforce development using finalized assessment architecture (Q4, FY31)
EMS Treat-versus-Transport (TvT)	**Stage 0:** Host regional meetings with EMS leaders to discuss and plan for implementation process to include process to purchase equipment (Q2-Q3, FY26)

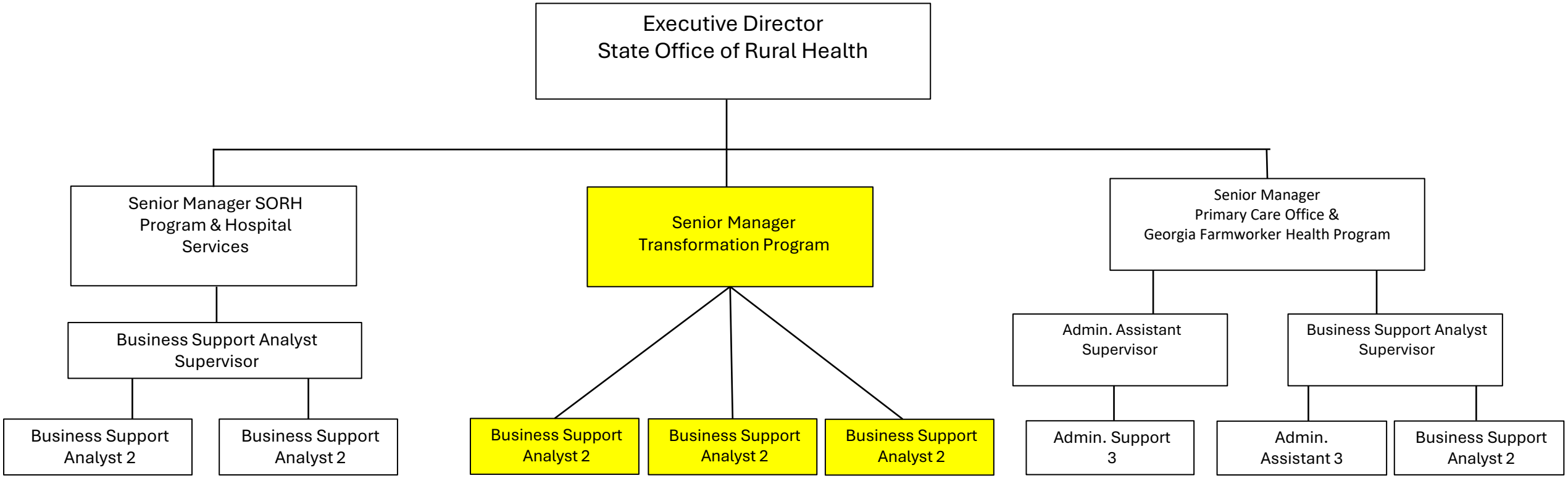
	Stage 1: Procure and install Starlink connectivity kits and telehealth equipment in rural ambulances (Q4, FY26); develop EMS telehealth training curriculum and statewide staff training (Q2–Q4, FY26)
	Stage 2: Launch ambulance-based telehealth services for non-emergency and low-acuity 911calls (Q4, FY26); integrate telehealth workflows with local hospitals, urgent care centers, and behavioral health providers (FY27/28)
	Stage 3: Participate in regional EMS learning collaboratives to share best practices and refine teleconsultation protocols (Q1, FY27– Q4, FY29)
	Stage 4: Transition connectivity costs to billable revenue generated through telehealth services (FY 26 – FY30)
	Stage 5: Evaluate to strengthen and scale the Treat versus Transport model statewide (FY29- 30)
Management for Hiring	
	Stage 0: Review, revise, and approve job descriptions for 15 proposed positions (Q1, FY26); complete approval process via human resources (Q1, FY26; post positions and form hiring committees (Q1-Q2, FY26); GREAT Health leadership team releases information regarding selection process for awarding subcontracts for implementation (Q1, FY26)
	Stage 1: Review applications, conduct interview process (Q2, FY26); make offers to final candidates (Q2, FY26); subcontracts proposals reviewed and selections finalized, and subcontract work begins (Q2, FY26)
	Stage 2: On-board candidates per state process and orient new team members to GREAT Health program (Q2, FY26); subcontracts continue with annual report reviews (Q2, FY26)
	Stage 3: New hires in place (Q3, FY26); probationary reviews conducted (Q3, FY26); subcontract work continues with annual report reviews (Q3, FY26)
	Stage 4: Annual reviews conducted as part of retention strategy (Q4, yearly)
	Stage 5: Positions sustained as needed to maintain the work (Q4, FY30); subcontracts end per end of funding period (Q4, FY31)

Attachment F: Department of Community Health, Medical Assistance Plans Division Organization Chart

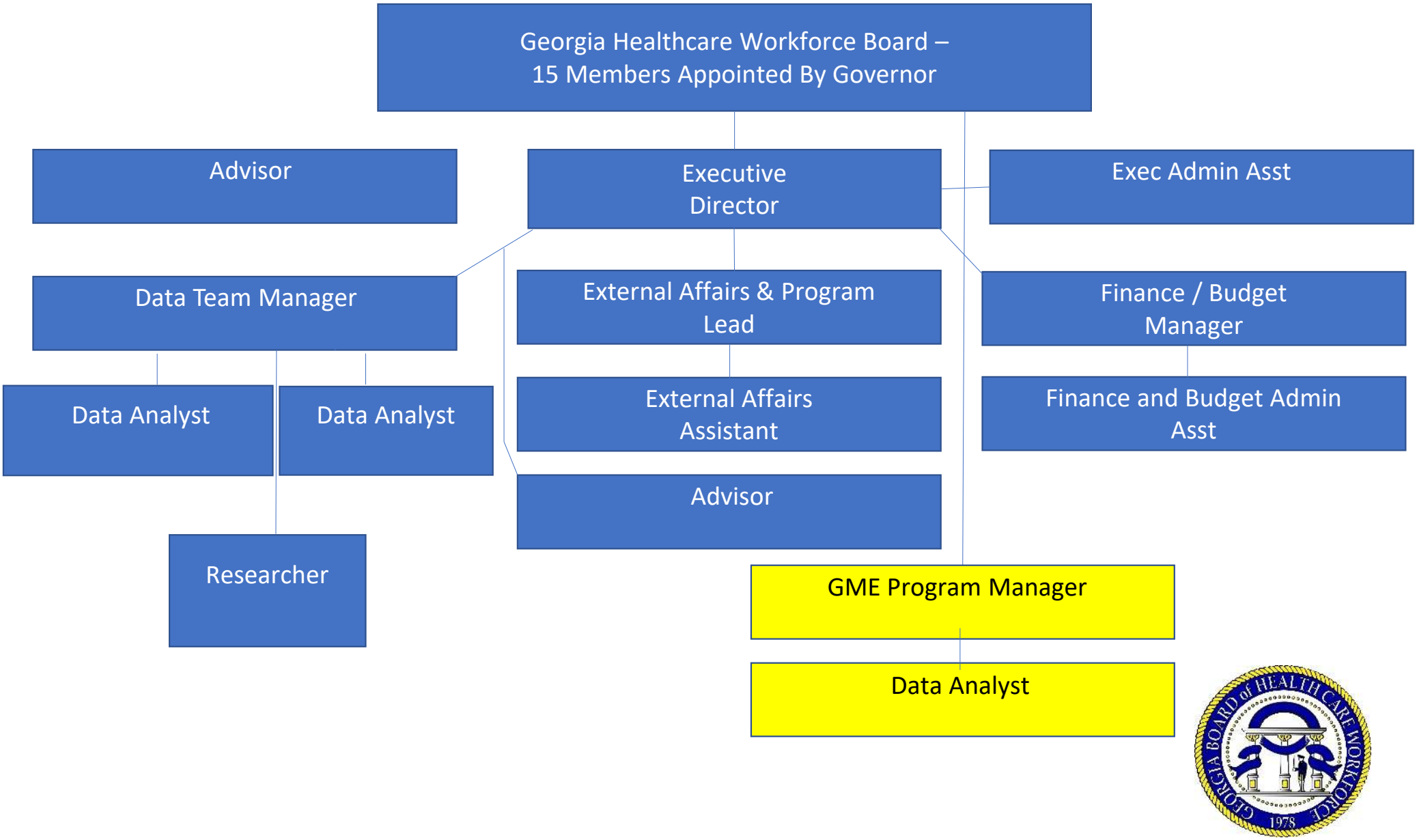


Attachment G: State Office of Rural Health Organization Chart

SORH
State Office of Rural Health
A Division of the Georgia Department of Community Health



Attachment H: Georgia Board of Health Care Workforce Organization Chart



Attachment I: Evaluation Plan Initiative Metrics

Initiative 1: Transforming for a Sustainable Health System	
Metric 1.1: Increase rural hospital participation in the AHEAD program. **Target:** 10 **Baseline**: 0 Hospitals **Element:** Financial Solvency	**Data Collection:** Data will be collected quarterly from DCH who will be charged with the rollout of the program. Data will be reported on a community level.
Metric 1.2: Increase primary care provider participation in the AHEAD. **Target:** 100 **Baseline:** 0 rural primary care providers **Element**: Financial Solvency	**Data Collection:** Data will be collected quarterly from DCH who will be charged with the rollout of the program. Data will be reported on a community level.
Metric 1.3: Increase private payers, not affiliated with Medicare or Medicaid, participation in the AHEAD. **Target:** 2 **Baseline:** 0 Private Payers **Element**: Partnerships	**Data Collection:** Data will be collected quarterly from DCH who will be charged with the rollout of the program. Data will be reported on a community level.
Metric 1.4: Increase in the number of rural patients participating in annual physical each year. **Target:** 10% **Baseline:** Baseline determined at year 0 **Element:** Improving Access	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data annually. Data will be reported on a community level.
Metric 1.5: Improved physical health outcomes measurement each year for populations receiving care in participating hospitals compared to prior years. **Target:** Determined at year 0 **Baseline**: Baseline determined at year 0 **Element:** Improving Outcomes	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data annually. Data will be reported on a community level.
Metric 1.6: Baseline assessments of physical infrastructure outcomes of the facilities post-assessment. **Target:** Determined at year 0 **Baseline**: Baseline determined at year 0 **Element:** Data Driven Decisions	**Data Collection:** Data will be collected through hospital reports, evaluation team create survey for assessment. Utilize the All Payers Claim Database to understand utilization and outcomes data annually. Data reported on a community level.

Initiative 2: Strengthening the Continuum of Care	
Metric 2.1: Improved physical infrastructure reported for hospital systems. **Target:** 100% **Baseline:** Baseline determined at year 0 **Element**: Improving Outcomes	**Data Collection:** Hospitals will report annually. Data will be reported on a community level.
Metric 2.2: Increase of referrals to behavioral health services. **Target:** 20% **Baseline:** Baseline determined at year 0 **Element**: Improving Access	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data.
Metric 2.3: Increase screenings for individuals served under this initiative. (screenings include behavioral health & newborn) **Target:** 20%	**Data Collection:** Utilize the All Payers Claim Database to understand utilization

Baseline: Baseline determined at year 0 **Element:** Improving Outcomes	and outcomes data. Data will be reported on a community level.
Metric 2.4: Number of baseline assessments for emergency preparedness completed. **Target:** 249 **Baseline:** 0 hospitals **Element**: Data Driven Decisions	**Data Collection:** Baseline assessments will be completed in year 0. Hospital will report annually on their baseline assessments. Data will be reported on a community level.
Metric 2.5: Baseline assessments of physical infrastructure outcomes of facilities post-emergency preparedness assessment. **Target:** Determined post-assessment **Baseline:** Baseline assessments completed in year 0 **Element**: Data Driven Decisions	**Data Collection:** The evaluation team will create the survey for the assessment and facilities will complete annual reporting. Data will be reported on a community level.
Metric 2.6: Improved physical health outcomes each year for populations receiving care in participating hospitals compared to prior years **Target:** Determined at year 0 **Baseline:** Baseline determined at year 0 **Element:** Improving Outcomes	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data. Data will be reported on a community level.
Metric 2.7: Increase in number of methods of technological coordination between primary care, behavioral health, and community organizations for individuals engaged in the initiative. **Target:** Determined at year 0 **Baseline:** Baseline determined at year 0 **Element**: Improving Access	**Data Collection:** The kinds of technological coordination will be mapped after collecting the information through surveys. Data will be reported on community level.
Metric 2.8: Increase in patient satisfaction in hospitals engaged in initiatives. **Target:** Determined at year 0 **Baseline:** Baseline determined at year 0 **Element:** Improving Outcomes	**Data Collection:** Hospitals will report annually. Data will be reported on a community level.

Initiative 3: Connecting to Care to Improve Healthcare Access	
Metric 3.1: Increase adequate care for prenatal and postpartum visits. **Target:** 25% **Baseline:** Baseline determined at year 0 **Element**: Improving Access	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data. Data will be reported on a community level.
Metric 3.2: Reduce 30-day readmission rates for Inpatient visits. **Target:** 10% **Baseline**: Baseline determined at year 0 **Element:** Improving Outcomes	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data. Data will be reported on a community level.
Metric 3.3: Decrease ED visit related to non-emergent physical health, chronic disease, and mental/behavioral health in rural counties. **Target:** 995,000	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data. ED visits by hospital is also collected in the Department of

Baseline: 1,312,638 rural ED visits **Element:** Improving Outcomes	Community Health's "Annual Hospital Questionnaire." Data will be reported on a community level.
Metric 3.4: Increased use of primary care/preventative care services related to management of chronic disease, and mental/behavioral health. **Target:** 30% **Baseline**: Baseline determined at year 0 **Element:** Improving Outcomes	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data. Data will be reported on a community level.
Metric 3.5: Increase in number of methods of technological coordination between primary care, behavioral health, and community organizations for individuals engaged in the initiative. **Target:** Determined at year 0 **Baseline:** Baseline determined at year 0 **Element**: Improving Access	**Data Collection:** The kinds of technological coordination will be mapped after collecting the information through surveys. Data will be reported on community level.
Metric 3.6: Increase screenings for individuals served in initiatives (screenings include behavioral health, newborn screenings, social service screeners) **Target:** 10% **Baseline**: Baseline determined at year 0 **Element:** Improving Outcomes	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data. Data will be reported on a community level.
Metric 3.7: Percent of rural practitioners trained. **Target:** 50% **Baseline:** 171 providers used project ECHO in DBHDD Pediatric Psychiatry program **Element:** Improving Access	**Data Collection:** Data collected from sub-grantees through strategies annually.

Initiative 4: Growing a Highly Skilled Healthcare Workforce	
Metric 4.1: Improve retention of graduated GME students as rural providers. **Target:** 10% **Baseline:** Baseline determined in year 0 **Element:** Workforce	**Data Collection:** Data will be collected annually from the Georgia Board of Health Care Workforce. Data will be reported on a community level.
Metric 4.2: Increase in rural students trained in rural areas. **Target:** 30% **Baseline**: Baseline determined in year 0 **Element:** Workforce	**Data Collection:** Data will be collected annually from the Georgia Board of Health Care Workforce. Data will be reported on a community level.
Metric 4.3: Decrease ED visit related to non-emergent physical health, chronic disease, and mental/behavioral health in rural counties **Target:** 995,000 **Baseline:** 1,312,638 rural ED visits **Element:** Improving Outcomes	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data. ED visits by hospital is also collected in the Department of Community Health's "Annual Hospital Questionnaire." Data will be reported on a community level.
Metric 4.4: Reduce EMT turnover rates **Target:** 15% **Baseline:** Baseline determined at year 0	**Data Collection:** Data will be reported by strategies annually. Data reported at county level.

Element: Workforce	
Metric 4.5: Reduction in preventable hospitalizations for chronic diseases. **Target:** Determined at year 0 **Baseline:** Baseline determined at year 0 **Element:** Improving Outcomes	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data. Data will be reported on a community level.
Metric 4.6: Increased use of primary care/preventative care services related to management of chronic disease and mental health **Target:** 30% **Baseline:** Baseline determined at year 0 **Element:** Improving Outcomes	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data. Data will be reported on a community level.

Initiative 5: Leveraging Technology for Healthcare Innovations	
Metric 5.1: Increase number of hospitals with population health reporting capacity. **Target:** Determined at year 0 **Baseline:** Baseline determined at year 0 **Element**: Technology Use	**Data Collection:** Data reported by hospitals and grant award reports; collected at hospital level
Metric 5.2: Reductions in health IT staff positions vacancies. **Target:** 20% **Baseline:** Baseline determined at year 0 **Element**: Workforce	**Data Collection:** Hospitals engaged in the enhancements project will report through surveys. Data will be reported on community level.
Metric 5.3: Increase in number of consumers directly engaged in new health technology. **Target:** Determined at year 0 **Baseline**: Baseline determined at year 0 **Element:** Technology Use	**Data Collection:** New technology user numbers as reported by sub-grantee organizations.
Metric 5.4: Enhance cybersecurity practices and systems in rural health care organizations. **Target:** Determined at year 0 **Baseline**: Baseline determined at year 0 **Element:** Technology Use	**Data Collection:** Cybersecurity breach reportable data; reported at hospital/organization level.
Metric 5.5: Decrease ED visit related to physical health, chronic disease, and mental/behavioral health in rural counties. **Target:** 995,000 **Baseline**: 1,312,638 rural ED visits **Element:** Improving Outcomes	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data. ED visits by hospital is also collected in the Department of Community Health's "Annual Hospital Questionnaire." Data will be reported on a community level.
Metric 5.6: Increased use of primary care/preventative care services related to management of chronic disease and mental/behavioral health. **Target:** 30% **Baseline**: Baseline determined at year 0 **Element:** Improving Outcomes	**Data Collection:** Utilize the All Payers Claim Database to understand utilization and outcomes data. Data will be reported on a community level.

Attachment L

Jon Burns
Speaker

eorgia eneral Assembly
State Capitol
Atlanta, Georgia 30334

urt ones
Lieutenant
overnor

October 31, 2025

Dr. Oz,

As legislative leaders in the state of Georgia, we are writing to express our support for Georgia's application to the Rural Health Transformation Program as part of HR 1, the One Big Beautiful Bill Act, passed by Congress. We are proud to work with the office of Governor Brian Kemp and the Department of Community Health to advance this plan to transform healthcare for rural Georgians.

We have placed rural health concerns at the forefront of our legislative agendas. The House of Representatives has appointed members to work out-of-session on the Rural Development Council, and the Senate has appointed various study committees to focus on rural health. Both the Senate and the House consistently support legislation to improve and enhance the health outcomes of Georgians on issues, such as certificate of need and workforce recruitment initiatives. Our bodies also ensure health issues receive the appropriations needed to do important work.

As legislators that live, work, and raise our families in rural Georgia, we innately understand the healthcare access concerns facing rural Georgians because we experience them every day. Our constituents require access to innovative, high-quality, and effective healthcare, and we will work with the Department to ensure the proposed strategies are effectively communicated to our communities and provide the resources we all need.

The General Assembly is committed to continuing our support of rural health throughout all five years of Rural Health Transformation, and we pledge our assistance to the state to ensure these projects have the tools to be successful and impactful. We appreciate the opportunity for this investment and look forward to the changes to come.

Burt Jones
13th Lieutenant Governor of Georgia,
President of the Senate

Jon Burns
75th Speaker of the House of Georgia

Attachment M

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Dean Burke, MD, Commissioner**

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | 404-656-4507 | www.dch.georgia.gov

October 8, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Dr. Oz,

The State Office of Rural Health (SORH) submits this letter to fully support the visionary Rural Health Transformation Program (RHTP) application submitted by the State of Georgia. It is the mission of SORH to help our rural communities develop long-term solutions to rural health problems with the ultimate goals of increasing access to health care in these areas and improving health outcomes.

The health care challenges in Georgia's rural communities are well-known:

- Rural Georgians are less healthy than those living in urban areas.
- Rural Georgians have a higher incident of obesity, diabetes, heart disease, and cancer.
- Rural Georgians are more likely to be under-insured or uninsured.

For over ten years, SORH has administered the Rural Hospital Stabilization Program, providing much-needed funding to rural hospitals to improve financial and operational stability and reduce hospital closures.

The varied projects proposed in Georgia's RHTP application will provide vital support to develop a highly skilled healthcare workforce, to leverage technology in support of health care innovation and to strengthen rural providers in the continuum of care for improved access to services.

Of particular interest to our office is the Achieving Healthcare Efficiency through Accountable Design (AHEAD) model which will provide greater financial stability for rural providers by aligning priorities to reduce cost and improve quality, with an emphasis on primary care, community resources, chronic disease prevention and promotion of healthier living.

The State Office of Rural Health stands ready to partner with other offices, agencies and stakeholders as we work together to bring impactful and lasting change to the communities we serve. We are Dedicated to a Healthy Georgia!

Respectfully,

Nita Ham
Executive Director
Georgia State Office of Rural Health

Attachment N

GEORGIA DEPARTMENT OF PUBLIC HEALTH

D·B·H·D·D
Georgia Department of Behavioral Health & Developmental Disabilities

Georgia Department of Human Services

October 29, 2025

Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Subject: Joint Letter of Support for Georgia's Rural Health Transformation Program Application

Dear Dr. Oz:

The Departments of Public Health (DPH), Behavioral Health and Developmental Disabilities (DBHDD), and Human Services (DHS) write collectively to express our full support for Georgia's application for the Rural Health Transformation Program, to be known as the **GREAT Health Program,** as submitted by the Department of Community Health (DCH). We appreciate DCH's leadership in this initiative, which offers a pivotal opportunity to boldly innovate our state's rural health system.

The health challenges facing rural Georgia are complex and require a coordinated, multi-faceted approach. Our departments are uniquely positioned to partner with DCH by providing our distinct expertise and resources to ensure the GREAT Health Program is comprehensive and impactful. We are committed to continued collaboration with DCH to ensure the success of the program initiatives by integrating physical, behavioral, and mental health.

Rural communities experience a shortage of healthcare providers, resulting in gaps in access to care and in health outcomes. The proposed initiatives will strengthen the continuum of care; connect to care for improved healthcare access; grow a highly skilled healthcare workforce; transform a sustainable health system; and leverage technology for healthcare innovations.

The Rural Health Transformation Program presents a unique opportunity to drive system-wide change and build a sustainable rural health system for future generations. Our agencies are united in our support and commitment to this effort. We look forward to continuing our partnership to deliver a transformative plan for the health and well-being of all rural Georgians.

Sincerely,

Kathleen E. Toomey, M.D., M.P.H.
Commissioner and State Health Officer, DPH

Kevin Tanner, M.P.A.
Commissioner, DBHDD

Candice L. Broce, J.D.
Commissioner, DHS

Attachment O

BOARD OF REGENTS OF
THE UNIVERSITY SYSTEM OF GEORGIA

CHANCELLOR SONNY PERDUE
270 WASHINGTON STREET, S.W.
ATLANTA, GEORGIA 30334

PHONE: (404) 962-3000
FAX: (404) 962-3013
EMAIL: CHANCELLOR@USG.EDU

October 29, 2025

Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Subject: Letter of Support for Georgia's Rural Health Transformation Grant Application

Dear Administrator Oz,

The University System of Georgia (USG) writes to wholeheartedly support the state's application to the Rural Health Transformation (RHT) Program grant. With students and future health professionals entering our university system from across the state, USG directly understands how impactful and transformative this funding will be for rural health.

USG has worked closely with the Department of Community Health (DCH) in the creation of this plan. Four universities (the University of Georgia, Georgia Institute of Technology, Georgia State University, and Augusta University) will be working with DCH to evaluate and implement strategies described in the application. We are proud to partner with the state as we pursue deeper knowledge and better health outcomes for Georgians.

As trainers of future healthcare professionals, we have worked with DCH to increase the number of nurses in our state. Georgia is set to face a 21% shortage of nurses by 2030, and our greatest limitation to training more is a shortage of qualified faculty to teach. Strategies proposed by Georgia's GREAT Health Program will assist us in doing just that and will allow us to work collaboratively with DCH and all twenty-one university nursing schools to increase capacity well beyond our current impact.

Finally, with over 98,000 full- and part-time employees and a majority of our 26 colleges and universities having at least one campus in a rurally designated area, healthcare in rural Georgia is of great importance to USG as an employer. When recruiting talent to our universities, one of the top indicators of professional and personal concern is medical care. By increasing access and improving the services families can receive in rural Georgia, the RHT Program grant will ensure the state remains an excellent place for educators to bring their experience and expertise.

Thank you for the opportunity to pursue this funding. We are excited to see the transformation this plan brings to Georgia.

Sincerely,

Sonny Perdue

Dr. Sonny Perdue

Attachment P

GEORGIA ALLIANCE OF COMMUNITY HOSPITALS

P.O. Box 1572 · Tifton, GA 31793 · (229) 386-8660 · Fax (229) 386-8662 · marcy@gach.org · www.gach.org

October 7, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

RE: Support of the Rural Health Transformation Program Proposal Submitted by the Georgia Department of Community Health

Dear Administrator Oz:

The Georgia Alliance of Community Hospitals (the "*Alliance*") is a statewide association of approximately ninety (90) community nonprofit hospitals and health systems, rural and urban, large and small, located throughout the State of Georgia which seeks to promote sound health care policy, laws, and regulations affecting Georgia's community hospitals.

The Alliance has worked closely with the Georgia Department of Community Health (the "*Department*") in the development of the State of Georgia's proposal pursuant to the Rural Hospital Transformation Program and fully supports the application filed by the Department. The proposal is the result of multiple meetings between non-profit hospital CEOs comprising the Alliance membership as well as multiple meetings with the Department. The proposal is carefully designed to benefit the rural health care system in Georgia generally rather than any single provider, provider type, or specific region. The proposal, as presented by the Department, is reflective of the input of numerous stakeholders across the state and aligns with the multiple stated goals and objectives of the Rural Health Transformation Program.

The Alliance respectfully encourages the Secretary to consider the Georgia application and looks forward to building upon our historic collaboration with the Department to implement the plan proposed in accordance with the grant of the Secretary of the U.S. Department of Health and Human Services.

Sincerely,

Monty Veazy
President/CEO

Attachment Q

October 8, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: State of Georgia's Application for the Rural Health Transformation Program (Opportunity No. CMS-RHT-26-001)

Dear Administrator Oz:

On behalf of our 150 hospital and health system members, the Georgia Hospital Association (GHA) is pleased to support the Georgia Department of Community Health (DCH) and the state of Georgia's application for grant funding through the Rural Health Transformation Program (RHTP), in response to the Centers for Medicare and Medicaid Services (CMS) Notice of Funding Opportunity number CMS-RHT-26-001.

Prior to drafting its application, DCH sought input from GHA and other stakeholders through written comments and town hall meetings. We appreciate the opportunity to provide both initial and ongoing feedback to the department. DCH's approach to the funding opportunity demonstrates a commitment to sustaining our critical rural hospital infrastructure to support health care access for Georgians. It also supports and prepares rural hospitals for future opportunities and transformation related to new care delivery models, focused on improving both population health outcomes and value.

We look forward to our continued partnership with the state and DCH to expand sustainable access to high quality rural healthcare services and truly transform the health of rural Georgians, and we stand ready to assist at every juncture.

Sincerely,

Caylee Noggle
President and CEO

Georgia Hospital Association
380 Interstate North Parkway SE, Suite 150, Atlanta, Georgia 30339 I Phone: 770-249-4500 I Fax: 770-955-5801|
www.gha.org

Attachment R

October 8, 2025

Dear Dr. Oz,

On behalf of HomeTown Health, LLC, we are pleased to express our strong support for the Georgia Department of Community Health's Rural Health Transformation Program. As a long-standing partner and advocate for rural healthcare providers across Georgia for over 25 years, we commend the DCH's leadership in advancing innovative, community-driven strategies to strengthen rural health systems and improve outcomes for underserved populations.

HomeTown Health, LLC serves as a collaborative partner to the Georgia Department of Community Health. Our organizations have a long history of working side-by-side to support rural providers firsthand in the challenges of workforce shortages, limited access to specialty care, aging infrastructure, and financial instability. This close partnership shows how Georgia is well-positioned to rapidly implement the RHT Program initiatives with strong stakeholder buy-in. We commend DCH for its inclusive approach in gathering public input and hosting town hall meetings across the state. This collaborative process ensures the application reflects the real needs of Georgia's rural communities and aligns with the program's strategic goals. We stand ready to assist in executing DCH's plan by offering our organizational support and ensuring innovations are translated into practice effectively at the local level. Our shared goals and trusted partnership with DCH will be invaluable assets in achieving the RHT Program's objectives in Georgia.

HomeTown Health, LLC enthusiastically endorses the Georgia Department of Community Health's RHT Program application. We are confident the DCH's proposed initiatives – aimed at bolstering rural healthcare infrastructure, expanding access, and improving outcomes – will be transformational for Georgia's rural communities.

Jimmy Lewis
Chief Executive Officer
jimmy.lewis@hometownhealthonline.com

Kristy Thomson, MS
Chief Operating Officer
kristy.thomson@hometownhealthonline.com