Ohio Rural Health Transformation Plan Project Narrative

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Ohio Rural Health Transformation Program
PROJECT NARRATIVE

Rural Ohio - Background

Ohio is a largely rural state. Of its more than 11.8 million residents[1], 62 percent reside in the 15 most urban and populous counties[2], with better than 4.4 million Ohioans residing in the remaining 73 counties that are either designated as fully rural counties or who are counties with significant rural footprint.

Walking through rural Ohio, one sees wide-open fields of corn and soybeans in the northwest, where the land rolls gently and the horizon stretches uninterrupted; further east and south, in the foothills of the Appalachian Mountains, one finds wooded countryside where dairy farms, pastures, and small timber tracts sit alongside the legacy of coal or oil extraction. In many rural counties, population densities can be quite low — for example, Vinton County, Ohio has only about 12,800 people across approximately 412 square miles of land, and Monroe County, Ohio where the land area runs to around 456 square miles with just over 13,000 residents[3].

Agriculture remains one of the main economic lifelines in rural Ohio. According to the United States Department of Agriculture (USDA) data, Ohio had 74,000 farms in 2024, covering about 13.5 million acres (roughly 21,100 square miles) and the average farm size was about 182 acres[4]. The state grows more than 200 commodities, and its leading agricultural outputs include corn, soybeans, dairy, hogs and poultry[5]. Beyond the fields, many rural counties also support manufacturing, forestry, resource extraction (especially in the Appalachian-region counties), and increasingly, tourism or recreation tied to rivers, lakes, and outdoor pursuits. For many rural Ohioans, the land isn't just scenery, it is livelihood.

However, the rural footprint also carries certain challenges around healthcare access and infrastructure, income, housing, education, and ironically, access to healthy foods. Income levels

in many rural counties tend to lag urban centers. Education attainment (especially bachelor's degree or higher) is lower on average in rural regions, and health outcomes in many rural and Appalachian-Ohio counties aren't as strong as statewide or national averages. Access to care is more limited in rural communities where there are fewer physicians per capita, longer travel distances to seek care, and in some counties healthcare deserts where there is no hospital or clinic. Moreover, housing can be older and less dense, and broadband and infrastructure gaps persist in many rural areas. The story is consistent, rural Ohioans have strong ties to land and community but also pressing healthcare and socioeconomic needs.

Rural Ohio is small towns and farms, where land, economy, and community mix — where agriculture and forests meet manufacturing plants, where schools are smaller and neighbors more visible, where health care often requires a drive, and where the geography itself plays an outsized role in shaping how people live, work, and connect.

Rural Health Needs and Target Population

There are notable differences in health outcomes for Ohioans residing in non-urban settings. The gap between the Ohio overall age-adjusted premature mortality median number of deaths (among residents under age 75) and those in rural, Appalachian Ohio has grown steadily since 2008[6]. Premature mortality can be explained, in part to specific chronic conditions and behavioral health concerns. Rural communities experience heart disease mortality at a rate of 868 (to 100,000 residents) whereas the overall rate for Ohio is 753. The 2025 Ohio Chronic Disease Atlas found that, "The 32-county Appalachian region along the eastern and southern borders of Ohio has a higher prevalence of most of the chronic diseases and conditions examined: arthritis, CKD,

COPD, coronary heart disease, diabetes, disability, high cholesterol, hypertension, obesity, and stroke. Cancer and diabetes mortality rates were also high in southeastern Appalachia," and that "Rural, non-Appalachian counties were found to have a high prevalence of diabetes, high cholesterol, and obesity, and high mortality rates of CKD, heart disease, and Parkinson's Disease"[7]. For death attributable to drug over dose and suicide, Ohio's rate is 53, while it is 59 for rural Appalachian residents[8] Further, 14 of the 15 Ohio counties with the highest suicide rate were rural and Appalachian[9].

Ohio's rural healthcare infrastructure includes 57 rural hospitals, including 33 Critical Access Hospitals (CAHs) and 24 Prospective Payment System (PPS) hospitals. The state also has 70 Rural Health Clinics, 37 Federally Qualified Health Centers, and 48 rural free clinics. Despite these resources, many facilities are financially strained. Since 2010, three rural hospitals have closed, and ten more are currently at risk of closure. One hospital has already converted to CAH status, and others are exploring CAH or Rural Emergency Hospital models. As of 2023, one in four rural hospitals in Ohio operated at a financial loss, and 18 percent were considered vulnerable to closure. As of 2023, Ohio's Critical Access Hospitals had a median Medicaid patient mix higher than the national median, at 19 percent and 15 percent respectively.[10] While the majority of rural Ohio residents have healthcare coverage, access remains a challenge, partially attributable to a shortage of healthcare providers. Statewide, primary care is available at a rate of 75 providers to 100,000 residents while rural areas have a 42:100k rate. Behavioral health providers are in practice statewide at a rate of 326:100k residents, while rural communities have only 236:100k[11]. A shortage also exists for oral health workforce in rural counties. Maternal and infant health services add another dimension of access disparity in rural

Ohio. Thirteen Ohio counties are considered maternity care deserts, leaving approximately 97,000 women without local access to care since 2021 according to March of Dimes data.[12] Since June 2022, the Ohio Hospital Association recorded the closure or merger of ten maternity units across the state, citing workforce shortages, operational costs, and declining birth rates. Today, only eight of the state's 33 Critical Access Hospitals (24%) provide labor and delivery services, forcing many rural mothers to travel far longer distances than their urban peers to deliver safely.[13] Community benefits such as preventive screenings, community outreach, health fairs, research mental health services, and substance use treatment are also less commonly offered by CAHs compared to their urban counterparts according to the *2022 Community Impact and Benefit Activities of Critical Access, Other Rural, and Urban Hospitals Report*. These gaps leave rural residents with fewer local options for critical services.

Differences in factors that impact health also create challenges for rural Ohioans versus urban residents. Educational attainment, a predictive factor in health outcomes, lags behind as 10.3% of residents in non-metro areas do not hold a high school diploma, compared with 8.0% in metro counties and the thirteen counties with the highest rates of residents without a high school diploma are all rural.[14] This illustrates the need for health educators and community health workers (CHWs) to engage with rural residents, teaching them about healthy behaviors and chronic disease prevention, and supporting their navigation with health systems. A key differentiator for rural residents is household income: the average median income in non-metro counties is $64,000, as compared with $71,000 in metro areas.[15] Poverty remains a pressing concern. In 2023, 13.2 percent of residents in non-metro counties lived below the poverty line. The rural population is also older, with nearly one in three rural Ohioans aged 60 or older.[16]

Rural residents of Ohio's 73 least populous counties, as identified by The Ohio State University Rural Extension Program, need transformation of the healthcare systems that serve their regions. They need a transformation that prioritizes protecting their health across the lifespan, incorporating healthy behaviors that prevent disease, providing effective disease management for those impacted by chronic illness, and facilitating quality, easy-to-access care in the right place, at the right time. The newly created Ohio Rural Health Transformation team dedicated countless hours engaging with rural Ohioans and the organizations that serve them to develop this comprehensive plan to transform our healthcare delivery ecosystem to improve healthcare access, quality, and outcomes.

Ohio's Rural Health Transformation Plan

Ohio's Rural Health Transformation (RHT) Plan aligns with the federal strategic goals: Make Rural America Healthy Again, Sustainable Access, Workforce Development, Innovative Care, and Tech Innovation. Our approach in developing this plan began with intense engagement with rural Ohioans and the organizations that serve them, a publicly available input portal for Ohioans to share their ideas for transformation, and review of recently compiled data analysis from *Ohio's State Health Assessment*, including a supplemental deep dive into Appalachian health, *2025 Summary Assessment of Older Ohioans*, *Ohio Chronic Disease Atlas 2025*, and other publicly-available data. We then examined existing pilots or programs that have not been yet established in all of Ohio's non-urban communities but have demonstrated efficacy, such as school based health centers (SBHCs), and could be impactful in transforming rural health and are going to scale appropriate interventions into rural regions. We are also proposing new initiatives that have

not previously been implemented by the state, such as rural health regional centers of excellence. All initiatives proposed herein align with RHT federal guidance, are complementary to any existing initiatives – and not duplicative - and are designed to both transform care in rural areas and sustain beyond the lifespan of RHT funding.

Rural Health Transformation Goals and Strategies

Overview of Transformation Plan Alignment to RHT Framework

The initiatives section details the strategies, partnerships, stakeholder engagement, metrics, timelines, and estimated cost for each of our proposed projects. Each of Ohio's initiatives is designed to comprehensively transform rural health systems by addressing the needs of the community and the federal-defined RHT strategic goals. Additionally, many of our initiatives are interoperable, benefiting the system as a whole. For example, community health worker (CHW) training will be performed by one entity and serve the whole of the RHT Program which prepares CHWs to work in a variety of RHT settings and creates consistency across regional healthcare services.

Improving Access

Ohio's RHT plan addresses the most significant drivers of healthcare access challenges faced by rural residents. Our initiatives include:

- Creation of Ohio Rural Health Innovation Hubs in the form of clinically integrated networks, rural health regional centers of excellence, and pharmacy networks to improve access to high-quality, lower-cost care.
- A Rural Ohio Emergency Care Transformation project to improve response times by rural EMS and provide the right care, in the right place for rural residents. No longer will

transport to an emergency department be the only choice for patients who would be better served by an alternative care destination (e.g. urgent care, primary care, behavioral health provider, etc.) or on-site care by a highly skilled paramedic. This project reduces response times, delivers the right care to meet patients' needs, and reduces unnecessary and costly visits to emergency departments.

- Expanded scope of practice for pharmacists will improve access for individuals and support the rural health innovation hub concept as pharmacists will be able to work at an expanded level of practice, maximizing their credentials to build strong networks in rural communities.
- School Based Health Centers (SBHCs) will serve students in rural on-campus clinics (K-12 and higher education), while also providing primary care services to the community at large. These clinics reduce absenteeism for students, increase primary care engagement, offer specialty and telehealth services, and can be training grounds for clinical students, thus encouraging long lasting service in rural settings.
- High quality home visiting services which improve outcomes for pregnant women and their children will be made available in rural communities, providing babies with the healthiest start in life and preventing maternal and infant mortality.
- Addressing maternity deserts with legislative change and supports to rural hospitals who will have the opportunity to add quality, low-cost birthing centers operated by general practitioners and midwives for mothers with anticipated health deliveries. This initiative prevents unnecessary, sometimes long drives to hospitals away from the mother's home, while also leveraging the knowledge and skills of local practitioners and rural hospitals.

- The OH SEE program was initiated in 2025 with the purpose of providing ophthalmology care for Ohio's students, via mobile services that provide care on elementary school campuses in 13 counties. Ohio's RHT Program will expand OH SEE into rural communities and will expand services to include audiology and dental care. Bringing care that is delivered cyclically, such as eye exams and provision of eyeglasses to students via mobile services is an effective way of addressing the gap in the 25 percent of students who are not receiving follow up care after failed vision screenings.

Improving Outcomes

In addition to improving outcomes by increasing sustainable access to care in Ohio's rural communities, we will implement:

- Primary care prevention services provided through SBHCs and CIN and RHRCE clinics.
- Chronic disease self-management activities to include the use of remote monitoring and innovative tech devices integrated with patient navigation supported by CHWs and clinicians in rural Ohio Federally Qualified Health Centers (FQHCs) and other sites.
- Expansion of the Ohio Healthy Team Tressel Fitness Challenge to additional rural schools. The program actively involves students, school staff, and families in healthy eating and active living activities on an on-going basis. This program will complement re-introduction of the Presidential Fitness Challenge into Ohio's schools, as described in our proposed Policy Actions. These initiatives are introduced at a young age when lifelong healthy behaviors are most likely to take root.
- Implementation of Healthier Ohio initiatives population-based activities to engage rural residents in healthy behaviors and chronic disease prevention. The initiative will focus on

modifying behaviors to improve health, particularly with adults who would benefit from nutrition education and increased physical activity, and introducing health behaviors to Ohio's young residents (e.g., working in tandem with the Tressel Fitness Challenge and Presidential Fitness Challenge).

Technology Use

- Remote monitoring (e.g., telehealth, innovative health monitoring equipment) and personal tech devices will be embedded in RHT initiatives such as the Innovation Hubs and SBHCs. Additionally, innovative technology to screen for conditions such as autism spectrum disorder will be piloted in SBHCs and via OH SEE mobile units.
- Expanded use of electronic medical records (EMRs) for pharmacists will complement our work to expand their scope of practice, and support them in providing medication adherence, point-of-care test-to-treat, and overdose prevention work. Ohio is primed to expand the use of EMRs as we have a fully integrated health information exchange (HIE) in place.

Partnerships

Ohio's RHT plan was developed in partnership with state agencies and numerous stakeholders who live and serve in a variety of capacities in rural communities. Implementation of initiatives will be largely carried out by rural community organizations who are trusted by and knowledgeable about the communities and regions that the projects impact. State agencies and professional associations, with whom we have strong existing partnerships, will actively support the local organizations to provide guidance and ensure that initiatives are implemented to meet timelines and goals of the RHT. Each initiative is designed with engagement frameworks to

foster ongoing communication, feedback, and support for the projects. This approach has proven effective with previous large-scale cooperative agreements and grants, e.g., the Public Health Infrastructure Grant which is implemented in partnership with Ohio's 111 local health departments and five public health associations. Additional infrastructure is in place at the State level to facilitate efficient and effective implementation. Leadership at the Ohio Department of Health is actively engaged with the Office of Ohio Governor Mike DeWine and the newly created Ohio Legislative Rural Health Caucus. The Center of Public Health Excellence at the Ohio Department of Health has compiled Ohio's RHT submission and is also the home of the Ohio Office of Rural Health and the State Primary Care Office, providing natural alignment and important expertise and history of working with rural communities and health providers across the state.

In recognition that rural residents of border communities routinely receive healthcare in neighboring states, Ohio is committed to extending collaborative efforts beyond our borders. Ohio's Governor, Mike DeWine, and the Governor of West Virginia, Patrick Morrisey, have already committed to exploring collaborative models to improve health outcomes, provide workforce development opportunities, extend reciprocity for healthcare licensure, leverage innovative technology and remote care for rural residents, and to share lessons learned and best practices from our respective Centers of Excellence.

All proposed initiatives require partnerships for implementation. Examples include:

- The primary purpose of the Ohio Rural Health Innovation Hubs is to build formal, collaborative networks among health providers and community organizations in a region.
- SBHCs involve formal collaborative relationships between school districts, providers (e.g., FQHCs, independent clinicians, etc.), and the broader community.

- OH SEE brings together school districts, providers, and the program coordinators to deliver mobile services to students.
- The Rural Ohio Emergency Care Transformation project establishes new partnerships between local EMS and other healthcare providers to provide appropriate care for patients who do not require emergency room services.
- The Healthier Ohio initiatives require subrecipients to leverage partnerships to drive strategies to prevent chronic disease.

Ohio will continue the collaborative approach taken to develop our application as we implement the Rural Health Transformation plan. As part of Ohio's commitment to public health accreditation, we have demonstrated success with maintaining strong multi-sector partnerships with organizations and individuals who play a role in the factors that impact the health of Ohioans. As is our approach with the five-year cycle of planning and implementing the State Health Improvement Plan (SHIP), we will convene ongoing engagement with hospitals, academic institutions, local health departments, clinics and clinicians, community organizations, and rural residents to provide program updates and receive feedback to inform continuous quality improvement (CQI) of funded initiatives. Project implementation partners will be included in an annual RHT summit convened by the state to foster collaboration, and to share updates, lessons learned, and guidance for future project years.

Workforce

Ohio's RHT workforce initiatives are designed to quickly address current gaps in the rural healthcare workforce and to build a long-lasting pipeline that inspires young students to see themselves in rural healthcare careers, to provide them career pathways that begin in high school,

and to provide supports for individuals who pursue coursework with five-year commitments to serve as healthcare professionals and paraprofessionals in rural Ohio. We recognize the value of connections with rural students, and the opportunity to educate them close to home, provide them with experiential learning in rural communities, and to encourage them to serve rural patients. Ohio's proposed initiatives include:

- Programs to secure five-year commitments to rural services from a variety of healthcare practitioners (MD/DO, nurses, therapists, behavioral health, allied healthcare, nutritionists, etc.) for educational, relocation, and other incentives, particularly to staff RHT projects.
- Rural-specific training programs for community health workers (CHWs), patient navigators, and other para-professionals to provide upskilling in critical topics such as outreach to rural communities, meeting the unique needs of aging Ohioans, effective care coordination in SBHCs, patient education on use of remote monitoring tech devices and apps for chronic disease management, health promotion to educate rural residents about the importance of health behaviors and strategies to improve healthy eating and active living.
- Upskilling activities to support pharmacists, paramedics, and other providers to serve at the top of their credentials.

Data-driven Solutions

The Ohio RHT team selected the proposed initiatives based on input from rural stakeholders in conjunction with data about health status, gaps, and opportunities identified via comprehensive data collection and analysis. Ohio's State agencies and universities regularly perform this data

analysis as part of the State Health Assessment (SHA), State Health Improvement Plan (SHIP), and other specialized reports published by the Ohio Departments of Aging, Education and Workforce, Health, etc.

We identified an exciting opportunity for healthcare providers to utilize remote monitoring equipment and the data collected from it to capture and monitor health indicator data for patients with chronic illness. These data will equip providers with real-time data to more effectively diagnose and treat patients with a goal of improving their health status. Use of remote monitoring equipment and protocols will be encouraged for our Rural Health Innovation Hub networks and providers in Ohio SBHCs.

Rural Health Hospitals and Providers

Cause Identification

Rural hospitals in Ohio, like many across the U.S., face a mix of financial, demographic, and systemic challenges that make it hard to remain sustainable. The main reasons include:

- **Low Patient Volume**

  Rural areas have smaller and aging populations. With fewer patients overall—and many needing specialized or chronic care—hospitals bring in less revenue but still have to maintain expensive infrastructure and staffing. Rural hospitals frequently transfer patients to large, urban facilities for specialty care, transferring with them all associated revenue streams.

- **Dependence on Government Reimbursement**

  Many rural hospitals rely heavily on Medicare and Medicaid payments. Any delays or changes in federal or state reimbursement policies can quickly destabilize their finances.

- **Workforce Shortages**

  Recruiting and retaining physicians, nurses, and specialists is difficult in rural areas. Hospitals often must offer higher salaries or incentives, which increases operating costs.

- **High Operating Costs and Limited Economies of Scale**

  Even small hospitals must maintain 24/7 emergency services, advanced medical equipment, and regulatory compliance—all of which are costly. Without a large patient base, they can't spread those costs efficiently.

- **Competition and Patient Outmigration**

  Many rural residents travel to larger urban hospitals for specialized or perceived higher-quality care. This "outmigration" reduces patient revenue for local hospitals.

- **Limited Access to Capital and Technology**

  Financial constraints make it difficult for rural hospitals to invest in modern equipment, electronic health records, or telehealth systems that could improve efficiency and care delivery.

Financial Solvency Strategies

Our proposed RHT Program initiatives will address the hospital financial challenges identified above and critical needs for rural healthcare, including:

- One in four rural Ohio hospitals has a negative operating margin and almost one in five is vulnerable to closure.[17]
- Ohio has 57 rural hospitals that have a 6% median operating margin.[18]
- Eight of Ohio's 33 Critical Access Hospitals (24%) currently offer Labor and Delivery services, leaving rural Ohio moms with an increased travel time to a childbirth facility as compared to their urban peers.

Some healthcare regions have initiated work to establish integrated networks, and our RHT Rural Health Innovation Hubs will support scaling those networks while assisting other regions from start-up to scale. Clinically integrated networks (CINs) and rural healthcare regional centers of excellence (RHRCEs) prioritize providing quality patient care while reducing the cost of care by availing members of shared services, economies of scale savings, coordinating patient care and regional capacities so that there are quality, less costly services available closer to home, and leveraging technology such as telehealth to access specialty expertise without unnecessarily transferring patients. Also in the Ohio RHT plan, workforce initiatives will support training, upskilling, recruitment, and retention of a well-prepared healthcare workforce in rural communities. Ohio's plan will expand options for local EMS providers to provide care-in-place or to transfer to sites other than emergency departments (Eds) when a patient would be best served in doing so. This prevents unnecessary, costly care that often burdens both EMS and rural EDs. The State will also enact legislative changes needed to utilize existing space in rural hospitals to establish birthing suites where primary care physicians and midwives can provide labor and delivery services. This provides an opportunity for billable services that many rural hospitals would otherwise not have and gives rural families a close-to-home option for birthing services. RHT funds will support one time start-up costs for standard equipment, thus clearing a path for hospitals to sustain the initiative moving forward.

Program Key Performance Objectives

Our overarching goals for the five-year project period are: Improve access to quality, lower cost care for rural Ohioans by securing a clinically integrated network (CIN) or rural health regional center of excellence (RHRCE) covering all rural regions of the state.

- Reduce hemoglobin A1C for patients diagnosed with pre-diabetes and diabetes by 10%.

- Manage systolic blood pressure at clinically appropriate levels for patients diagnosed with hypertension.

- Increase number of school-based health centers (SBHCs) serving rural students and communities by a minimum of 30, with particular focus in the northwest and southeast rural communities that present the largest gaps in coverage.

Performance management metrics tracking outputs and outcomes are assigned to every initiative and articulated in the *Initiatives* section of this narrative.

Strategic Goals Alignment

Each of Ohio's proposed initiatives was carefully designed to align with the federal strategic goals, and accounts for evidence-based interventions that are allowable under the purpose of the RHT Program and Federal Cost Principles. The *Initiatives* section of this program narrative identifies the strategic goal alignment for each proposed project. The same can be found for each initiative outlined in the budget narrative document.

Policy and Legislative Actions

Tech Score #	Policy Item	Current State and/or Proposed Action
A.2.	CCBHC	Included in attachments
A.7.	DSH Payments	Please refer to latest DSH audit available to CMS
B.2.	Presidential Fitness Test (PFT)	Ohio commits to requiring schools to reestablish the PFT associated with federal Executive Order 14327 by 12/31/2028.
B.3.	SNAP Waivers	Ohio submitted a waiver to the USDA to exclude sugar-sweetened beverages from SNAP eligible foods, as recognized by the attached waiver and acknowledgement by USDA DUS Patrick Penn on 10/28/2025.
B.4.	Nutrition Continuing Medical Education (CME)	Ohio commits to requiring nutrition CME for physicians via regulation by 12/31/2028.
C.3.	Certificate of Need	Refer to Cicero Report

D.2.	Licensure Compacts	Per NOFO cited sources: Physician: Ohio is a IMLC state Nurse: Ohio is a NLC state Psychology: Ohio is a PSYPACT state PA: Ohio is a PA compact state Proposed Action: Ohio will pursue enactment of the Recognition of EMS Personnel Licensure Interstate Compact.
D.3.	Scope of Practice	Per NOFO cited sources: PA: Moderate scope of practice NP: Reduced scope of practice Dental Hygienist: Semi-restricted practice NOTE re: Pharmacist scope of practice: The Cicero Report does not reflect that Ohio does allow pharmacists to administer drugs, order and perform labs, and prescribe drugs in conjunction with a collaborative practice agreement with a physician. Proposed Action: Ohio commits to pursuing legislative change to permit point-of-care test-based prescribing to provide expanded, independent scope of practice for pharmacists by 12/31/2027.
E.1.	Medicaid Provider Payment Incentives	Described in narrative below this table
E.2.	Individuals Dually Eligible for Medicare and Medicaid	Described in narrative below this table
E.3.	Short-term, Limited-duration Insurance	Described in narrative below this table
F.1.	Remote care services	Described in narrative below this table
F.2.	Data infrastructure	Please refer to OBA data per the NOFO

E.1. Medicaid Provider Payments

The below describes Ohio's significant implementation of modernized payment models. Ohio commits to continued quality improvement and ongoing monitoring for opportunities. We

request that you consider the following successes when assessing all component of the score for section E.1. of the scoring rubric.

Since 2013, Ohio has led a statewide transformation from fee-for-service (FFS) to value-based payment (VBP), advancing the triple aim of better care, improved health, and lower cost growth. Through participation in the federal State Innovation Models (SIM) initiative, the Ohio Department of Medicaid (ODM) launched the Comprehensive Primary Care (CPC) program in partnership with managed care organizations. Now in its ninth year, CPC covers more than half of ODM's membership and spend, engaging primary care practices in tracking quality, patient experience, and total cost of care. CPC has demonstrably improved outcomes and generated over $200 million in shared savings, with practices earning up to 50% of verified savings when costs fall at least 1% below baseline.

Building on CPC's success, ODM implemented CPC for Kids (2020) and Comprehensive Maternal Care (CMC, 2023)—models that extend CPC's population health framework to pediatric and maternal care. These programs support team-based, data-driven care, connecting practices to community partners and leveraging technology to close care gaps and address cost drivers. Together, they create a consistent pathway from upside-only arrangements to two-sided risk, aligned with the Health Care Payment Learning and Action Network (HCP-LAN) framework (CPC at "3A"; CPC for Kids and CMC at "2C").

ODM designs its models for broad inclusion, with CPC practices now operating in 73 of 88 counties, expanding access in rural and underserved areas. Ohio has also piloted Integrated Care for Kids (InCK) to reduce out-of-home placements in two rural counties through community collaboration and proactive risk stratification. Promising results are informing plans for statewide sustainability and scale.

Most recently, ODM launched Outcomes Acceleration for Kids (OAK), a pediatric accountable care initiative meeting HCP-LAN Category 4 (population-based payment). OAK employs a sub-capitated model and targets four domains—behavioral health, asthma, sickle cell disease, and well-child visits—using evidence-based quality improvement methods to drive measurable, sustained improvements.

Finally, ODM reinforces its value-based strategy through a quality withhold program, reserving 3% of MCO capitation payments that are earned back through demonstrated improvement. Initiatives have included increasing well-child visit rates post-pandemic and reducing preterm births through enhanced maternal supports.

Together, these initiatives demonstrate Ohio's commitment to developing and sustaining feasible, evidence-based value programs that reward providers for improving outcomes, managing total cost of care, and transitioning to accountable, risk-based models.

E.2. Individuals Dually Eligible for Medicare and Medicaid

Initiative-Based Factor

Ohio currently operates several integrated care programs for dual-eligible members including Medicare-Medicaid Plans (MMPs) through the Financial Alignment Initiative (FAI) available in 29 counties, PACE sites in four counties with two more planned for 2026, and Coordinating-Only D-SNPs (CO-DSNPs) statewide. The MMPs and PACE sites are primarily located in metro counties, but Ohio is replacing the expiring demonstration MMPs with fully integrated dual special needs plans (FIDE-SNPs) and expanding the program statewide in CY 2026. While dual members in rural counties can currently utilize coordinating-only D-SNPs, Ohio is committed to expanding availability of a more integrated option to simplify dual-eligible members' combined Medicare and Medicaid benefit package. FIDE-SNPs are able to fully integrate member

materials, offer a single ID card for the entire medical and pharmacy benefit, streamline the appeals and grievance process, and fully cover all Medicare-covered services, Medicaid behavioral health, and Medicaid long-term services and supports under a single legal entity. Expansion of this fully integrated option to rural areas is a specific policy goal to improve care for individuals with complex needs to promote independence in the community. Beneficiaries in a FIDE-SNP or PACE are much less likely to be institutionalized, and FIDE-SNP members are more likely to utilize home and community-based services (HCBS).[19] These national findings are consistent with our own investigations in our MMP program where we incentivize the use of HCBS as an alternative to institutional settings of care by paying the managed care plans a blended rate for members who meet that level of care incentivizing them to make HCBS more available. An investigation into our MMP demonstration found that after implementation of MyCare, there was a 10.5% lower inpatient hospital use and an 8% lower utilization of Medicaid-funded nursing facility services relative to the non-demonstration counties where LTSS services are covered solely by fee-for-service.[20]

Ohio's FIDE-SNP program, called the Next Generation MyCare Ohio program, follows a lengthy stakeholder engagement process and competitive procurement. It will apply several innovations from stakeholders and foster an innovative collaboration between the managed care entities and local care coordinators in the 1915(c) waiver. The FIDE-SNP plans will contract with local area agencies on aging to provide local waiver service coordination in their community for waiver members at least age 60 and older. Ohio also leveraged its authority in the state Medicaid agency contract (SMAC) to require FIDE-SNP plans to cover certain Medicare supplemental benefits which will benefit dual benefit members in rural counties. These include expanded access to community palliative care not already covered under hospice and augmented

transportation benefits as well. The Ohio Department of Aging reported in its comprehensive state plan on aging that every single area agency on aging prioritized transportation access strategies as an area of community need.[21] The FIDE-SNP plans will be require to ensure members have transportation access to dialysis, chemotherapy, community behavioral health, preventive care, and prenatal and postpartum visits even if the transportation would otherwise be the responsibility of the county JFS office. The plan must also offer a minimum of 30 one-way trip rides annually for non-medical transportation to increase member access in the community even if they do not yet meet the level of care which would qualify them for waiver services. As the fully integrated option becomes available statewide and in all rural counties, we expect to see an increase in the number of dual-eligible Ohioans who have access to and select a fully integrated, coordinated plan to remove barriers to accessing their healthcare.

Data Driven Factor

ODM currently enrolls 809 PACE members and 55,401 MMP members. An additional 39,024 members are enrolled in Coordination-Only D-SNPs and are also enrolled in a MyCare managed care plan by the same company as the D-SNP for their Medicaid benefits. With 267,730 total full duals according to the most recent Medicare Monthly Enrollment data, that results in 35.6% of Ohio's total duals population in one of our three integrated care programs. Ohio does not track the enrollment of partial duals since there is no Medicaid benefit to integrate—only premiums and cost sharing. The state has multiple points of contact identified for the Medicare-Medicaid Coordination Office (MMCO) regarding issues related to individuals dually enrolled in Medicare-Medicaid. These points of contact include Steven Alexander and Tracy Hayes from the Integrated Care Policy section within the Bureau of Long-Term Services and Supports at the

Ohio Department of Medicaid. The state also has identified Jesse Wyatt, the Bureau Chief for Long-Term Services and Supports as another such point of contact for MMCO.

E.3. Short-term, Limited-duration Insurance

Short-Term Limited Duration (STLD) insurance plans are primarily regulated at the state level, with the federal government establishing overarching parameters such as maximum policy duration and disclosure requirements. Within this framework, the State of Ohio—through the Ohio Department of Insurance (ODI)—administers and enforces laws governing the regulation and approval of STLD policies. These state regulations are designed to operate fully within the boundaries defined by federal standards. Consequently, Ohio's approach is not more restrictive than federal requirements; rather, it reflects the state's responsibility to implement and uphold federal parameters through appropriate regulatory oversight.

F.1. Remote care services

Ohio's telehealth policy has evolved significantly since the Ohio Department of Medicaid (ODM) first implemented it in 2014. The initial framework mirrored Medicare's hub-and-spoke model, requiring patients to access telehealth services from clinical sites and limiting eligible providers and services to address rural and underserved needs. Since then, ODM has progressively expanded telehealth eligibility and flexibility. Policy updates in 2019 broadened the range of covered services and provider types and allowed greater flexibility in both patient and practitioner locations.

During the 2020 COVID-19 Public Health Emergency, ODM implemented additional expansions to meet surging demand, ensuring continued access to care—particularly in rural areas.

Telehealth utilization peaked at 15% of all Medicaid claims in April 2020 and has remained a stable, integral care modality even after the emergency ended.

Advances in secure, HIPAA-compliant technologies—ranging from smartphone applications to electronic health record integrations—have transformed care delivery and patient engagement across Ohio. Providers have incorporated telehealth into routine workflows, offering patients care options that fit their circumstances while maintaining continuity and quality. Telehealth also supports patient safety, reduces work and school absences, and enhances satisfaction and self-management.

ODM's current telehealth benefit is comprehensive and accessible across synchronous (audio-video and audio-only) and asynchronous (remote monitoring and store-and-forward) modalities. Telehealth services are reimbursed at parity with in-person care and must meet identical clinical and professional standards. Covered services span medical, dental, behavioral health, skilled therapy, dialysis monitoring, remote patient monitoring, and diabetes self-management. Behavioral health—including psychotherapy, substance use counseling, and case management—represents the largest area of utilization, followed by outpatient medical services.

Telehealth has improved access statewide, reaching both metropolitan and rural populations. In 2024, 15% of all Medicaid enrollees—more than 516,000 individuals—used telehealth services. Utilization rates were nearly identical between metro (15%) and non-metro (14%) counties, confirming that telehealth effectively bridges geographic barriers. Notably, several Appalachian counties with broadband limitations, such as Scioto, Athens, and Ross, rank among the highest for telehealth utilization. For instance, Scioto County—where 26% of households lack adequate broadband—has the second-highest telehealth use rate in the state, underscoring the impact of targeted outreach and investment.

Telehealth also expands access to maternal and infant health services, including nurse home visits, doula support, group prenatal care, lactation consultation, and pregnancy risk assessments. Women represent 60% of telehealth users, reflecting the program's importance in supporting behavioral and maternal health. Appalachian counties, despite infrastructure challenges, use telehealth slightly more than non-Appalachian areas, further demonstrating its potential to reduce disparities.

ODM's evolving telehealth policy continues to strengthen Ohio's health system by preventing care gaps, improving continuity, and expanding access—particularly in rural and underserved communities. Ongoing analysis and collaboration with stakeholders ensure that Ohio's telehealth framework remains one of the most robust and adaptive in the nation.

Proposed Initiatives and Use of Funds:

Use of Funds, Implementation Timelines, Stakeholder Engagement, Metrics, Sustainability

Initiative:	**Ohio Rural School Based Health Centers (SBHCs)**
Description	SBHCs improve access to healthcare for children and the community at large by adding to rural clinical infrastructure an accessible and sustainable way. Clinics operate on school grounds, are physically placed in a manner to provide access for community members while maintaining safe access for students and are commonly operated by a Federally Qualified Health Center (FQHC) or are integrated in a clinical network or rural health regional center of excellence. SBHCs provide primary prevention and sick care, screenings and exams (e.g., vision, hearing, etc.), dental care, behavioral health services, and can provide telehealth connections with specialty providers. In the RHT SBHCs, we plan to pilot the use of new, innovative technology that screens for autism spectrum disorder (ASD). This is an exciting opportunity because rural families often must travel to urban tertiary centers for ASD screening and this will provide that service close to home, improving the likelihood for children to be identified at a younger age which is known to improve outcomes for ASD. Ohio's existing SBHCs have demonstrated improvement in student seat time, as primary care can be provided on the school campus with minimal interruption to learning. In addition to operating SBHCs in K-12 schools, Ohio will seek opportunities to operate SBHCs on college

	campuses serving rural communities. College sites are also prime location to provide clinical rotations for medical students, creating a pipeline of clinicians to serve in rural communities upon graduation. Each site will staff a community health worker or similar navigator to provide care and resource coordination for patients, conduct community outreach to engage residents in primary care at the SBHC, and to provide patient education and support for utilization of consumer tech and remote monitoring equipment. ODH provides technical assistance support for school districts and their partners during a planning phase to ensure that best practices are utilized in site and equipment selection, service delivery models, staffing, school and community engagement, and sustainability strategies. SBHCs
Main Strategic Goal	Make Rural America Healthy Again, Sustainable Access, Innovative Care, Tech Innovation
Use of Funds	Prevention and chronic disease, Appropriate care availability, Innovative care, Fostering collaboration, Behavioral health
Technical Score Factor	B.1. Population health clinical infrastructure B.2. Health and lifestyle C.1. Rural provider strategic partnerships D.1. Talent recruitment F.1. Remote care services F.3. Consumer-facing technology
Key Stakeholders	Rural Ohioans/SBHC patients, rural school districts, rural community colleges/higher education and technical schools, rural clinicians, rural FQHCs, Ohio School-Based Health Alliance, state agencies (Ohio Departments of Health, Education and Workforce, Medicaid, Developmental Disabilities, Behavioral Health, Children and Youth), State Office of Rural Health.
Impacted Counties	School districts in Ohio's non-urban counties (73 total).
Estimated Required Funding	$20,000,000-25,000,000 annually

Implementation Plan & Timeline: Ohio Rural School Based Health Centers (SBHCs)		
Milestone	**Stage**	**Target Date**
PHASE ONE SITES		
Planning initiated, TA in progress	Stage 0	Quarter 1 2026
Equipping clinics, hiring and training, engaging community	Stage 1	Quarter 2 2026
Clinics open, TA continues	Stage 2	Quarter 3 2026
Clinics operational and continuous improvement processes in place	Stage 3	Quarter 4 2026
Services, engagement, and case load growth continue	Stage 4	Quarter 3 2027
Project completion, clinics operating independently	Stage 5	Quarter 3 2028
PHASE TWO SITES		

Planning initiated, TA in progress	Stage 0	Quarter 1 2027
Equipping clinics, hiring and training, engaging community	Stage 1	Quarter 2 2027
Clinics open, TA continues	Stage 2	Quarter 3 2027
Clinics operational and continuous improvement processes in place	Stage 3	Quarter 4 2027
Services, engagement, and case load growth continue	Stage 4	Quarter 3 2028
Project completion, clinics operating independently	Stage 5	Quarter 3 2029
PHASE THREE SITES		
Planning initiated, TA in progress	Stage 0	Quarter 1 2028
Equipping clinics, hiring and training, engaging community	Stage 1	Quarter 2 2028
Clinics open, TA continues	Stage 2	Quarter 3 2028
Clinics operational and continuous improvement processes in place	Stage 3	Quarter 4 2028
Services, engagement, and case load growth continue	Stage 4	Quarter 3 2029
Project completion, clinics operating independently	Stage 5	Quarter 3 2030
PHASE FOUR SITES		
Planning initiated, TA in progress	Stage 0	Quarter 1 2029
Equipping clinics, hiring and training, engaging community	Stage 1	Quarter 2 2029
Clinics open, TA continues	Stage 2	Quarter 3 2029
Clinics operational and continuous improvement processes in place	Stage 3	Quarter 4 2029
Services, engagement, and case load growth continue	Stage 4	Quarter 3 2030
Project completion, clinics operating independently	Stage 5	Quarter 3 2031

Stakeholder Engagement: Ohio Rural School Based Health Centers (SBHCs)	
Stakeholder Types/Names	SBHCs funded under the RHTP fundamentally require strong partnerships between school districts, state agencies (Ohio Departments of Health, Education and Workforce, Medicaid, Behavioral Health, State Office of Rural Health), clinical providers (often, Federally Qualified Health Centers (FQHCs) are service providers), affiliate organizations (e.g., Ohio School-Based Health Alliance), local community resource organizations, and importantly, community residents. SBHCs will also be included in the RHTP-created rural health innovation hub networks described later in the initiatives.
Engagement Framework	Ohio has established a community of practice that facilitates ongoing collaboration and learning opportunities with SBHCs, state agencies (Ohio Departments of Health, Education and Workforce, Medicaid, Behavioral Health, State Office of Rural Health) and their affiliate organizations (e.g., Ohio School-Based Health Alliance) to participate in ongoing cooperative learning, sharing of best practices, and to provide input on new initiatives. Ohio will leverage this existing network to inform RHT SBHC projects. Project implementation partners will be

	included in an annual RHTP summit convened by the state to share updates, lessons learned, and guidance for future project years.
Project Governance	Ohio will work with the existing SBHC community of practice to formalize a membership model that ensures inclusion of patient representation along with SBHC local teams and state agencies.

Metrics: Ohio Rural School Based Health Centers (SBHCs)			
Outcome Description	**Baseline**	**Goal**	**Data Source**
Percentage of student enrollment receiving care in RHT SBHCs	0	40%	SBHC reporting
Percentage of SBHC patients who are non-students	0	60%	SBHC reporting
Seat time savings for students	0		SBHC reporting
Reduce hemoglobin A1C for patients diagnosed with pre-diabetes and diabetes by 10%.	0	10%	SBHC data
Percent of patients with systolic blood pressure managed at clinically appropriate levels for patients diagnosed with hypertension.	79% (per FQHC statewide data)	89%	SBHC data

Sustainability: Ohio Rural School Based Health Centers (SBHCs)

- RHT SBHCs are provided technical assistance by a vendor with expertise with SBHC operations and sustainability strategies.
- SBHCs are required to serve both students and the broader community, providing a robust, sustainable case load.
- SBHC are equipped with electronic medical record (EMR) systems that support billable services to payors for patient services which create a sustainable model for clinics.
- SBHCs who enter into agreements with clinically integrated networks or rural health centers of excellence can benefit from shared services and enhanced payment models.

Initiative: OH SEE, vision, hearing, and dental services for rural students	
Description	Ohio will expand mobile optometric services to students in rural areas. OH SEE exists in 13 counties currently and will expand to statewide coverage using state general revenue funding to provide services in urban counties, and RHT funding for rural students. The program will add hearing and dental services. The OH SEE Program began in 2025, born out of recommendations from the Governor's Vision Strikeforce. Data shows that 74% of students who failed their school-based vision

	screening did not complete a follow-up exam and, therefore, were not equipped with prescription eyeglasses where needed.[22] Services are delivered either via mobile unit or via a roll-off/on approach with equipment brought into a school setting short-term. The program brings care where students are, for services that are needed cyclically and, therefore, are ideal for a mobile model. Appropriate vision, dental, and hearing care improve learning, promote good health, and prevent chronic conditions.
Main Strategic Goal	Make Rural America Healthy Again, Sustainable Access, Innovative Care, Tech Innovation
Use of Funds	Prevention, Appropriate care availability, Innovative care, Fostering collaboration
Technical Score Factor	B.1. Population health clinical infrastructure B.2. Health and lifestyle C.1. Rural provider strategic partnerships D.1. Talent recruitment F.1. Remote care services F.3. Consumer-facing technology
Key Stakeholders	Rural Ohioans, school districts, vision-hearing-oral health providers,
Impacted Counties	Ohio's 73 non-urban counties
Estimated Required Funding	$25,000,000-$30,000,000 annually

Implementation Plan & Timeline: OH SEE, vision, hearing, and dental services		
Milestone	**Stage**	**Target Date**
Vision implementation partners identified (Note: The three vendors currently providing services in 13 counties will support the expansion, and we will identify additional providers via competitive bid process beginning November 2025).	Stage 0	Quarter 1 2026
Engagement with school sites to schedule vision service visits.	Stage 1	Quarter 1 2026
Selection process for hearing providers	Stage 0	Quarter 1 2026
Initiate vision services at RHT school sites	Stage 2	Quarter 2 2026
Add hearing services to school scheduling	Stage 1	Quarter 2 2026
Hearing services initiated	Stage 2	Quarter 3 2026
Selection process for dental providers vendors	Stage 0	Quarter 2 2026
Vision and hearing services implemented and continuous quality improvement (CQI) processes in place	Stage 3	Quarter 3 2026
Engagement with school sites to schedule dental service visits	Stage 1	Quarter 4 2026
Dental services initiated at school sites and CQI in place.	Stage 2	Quarter 1 2027
Vision and hearing Vision and hearing services, engagement, case load growth, and CQI continue.	Stage 4	Quarter 3 2027
Dental services implemented and continuous quality improvement (CQI) processes in place	Stage 3	Quarter 1 2028
Dental services, engagement, case load growth, and CQI continue.	Stage 4	Quarter 3 2028

Project completion, services continue	Stage 5	Quarter 3 2030

Stakeholder Engagement: OH SEE, vision, hearing, and dental services	
Stakeholder Types/Names	As with SBHCs, partnerships with rural school districts are critical to the success of this program. Our early implementation of the OH SEE pilot was embraced by schools, and districts outside of the 13 pilot counties have already expressed interest in this expansion into additional rural communities. Current OH SEE vendors are Health Partners of Western Ohio, The Ohio Optometric Association (OOA), and iSee. These vendors will be offered the opportunity for expansion, and we will augment with additional providers as needed. Providers for hearing and dental services will be selected via competitive process per the above timeline. The state has established relationships with institutions of higher learning who offer audiology, optometry, and dental/dental hygiene degree programs and will continue to leverage these partnerships (Ohio State, Ohio University, Kent State, University of Akron, Cleveland State, University of Cincinnati, Youngstown State, and Columbus State and other community colleges). Our existing relationships with clinical associations and boards are also valuable for the success of the initiative.
Engagement Framework	OH SEE was born out of recommendations from the 2024 Ohio Children's Strike Force, appointed by Governor Mike DeWine, to identify solutions to the gap in Ohio students' vision care. We will continue to engage strike force members and similar specialists in the areas of audiology and oral health including representatives from state agencies, deans of respective clinical colleges, professional boards and organizations, individual practitioners, and non-profit organizations to provide progress updates and seek input. Each subrecipient will be required to conduct regular stakeholder engagement for their respective project, and to include state personnel in those meetings. Additionally, project updates are published for public access and public and patient feedback is collected via surveys and/or focus groups. Project implementation partners will be included in an annual RHTP summit convened by the state to share updates, lessons learned, and guidance for future project years.
Project Governance	Ohio will work with the existing SBHC community of practice to formalize a membership model that ensures inclusion of patient representation along with SBHC local teams and state agencies.

Metrics: OH SEE, vision, hearing, and dental services			
Outcome Description	**Baseline**	**Goal**	**Data Source**
Percent of school districts in the 73 non-urban counties who are participating	0	50%	Clinic reporting
Improvement in the number of students receiving follow-up eye exam after failed a screening	26%	60%	Clinic reporting
Percent of districts participating in dental and hearing services	0	25%	Clinic reporting
Parent satisfaction in meeting the healthcare gap	0	75%	

Sustainability: OH SEE, vision, hearing, and dental services
• Providers utilize a billable model for patient services which support sustainability for the program. • State general revenue funds which are currently utilized for start up of the 13 pilot projects can be transitioned in the future to support operational costs that are not reimbursed by healthcare coverage. (e.g. mobile unit upkeep)

Initiative: Ohio Rural Health Innovation Hubs	
Description	The mission of the rural hubs is to address rural residents' needs to close their healthcare gaps. Ohio is proposing to invest in establishing integrated networks by providing start-up funds for models that become self-sustaining, ensure that providers have the infrastructure they need to operate as part of a robust network, and to provide the supports needed for clinical professionals and paraprofessionals to operate at the highest level of their knowledge and credential. Clinically Integrated Networks (CINs) and Rural Health Regional Centers of Excellence (RHRCEs) are structured alliances or hub and spoke models among physicians, hospitals, clinics, emergency medical services (EMS), behavioral health, pharmacists, higher education, community resources, and other healthcare providers that collaborate to improve quality, efficiency, and coordination of patient care. The value of a CIN/RHRCE lies in its ability to align clinical, financial, and operational goals across the continuum of care, ultimately enhancing patient outcomes while controlling costs. Ohio will support planning, start-up costs, and expansion of CINs/RHRCEs to transform rural healthcare. Recognizing that there are a small number of networks in varying phases of development, while other rural areas do not yet have a network, we will provide funding in a tiered approach, providing incremental fiscal and technical supports with the goal of having every rural

	area of the state covered by a fully functioning, effective CIN or RHRCE by completion of the RHTP project period. Tier One – CINs/RHRCEs who are currently operating a small integrated alliance and can utilize funding to scale to a robust regional network. The goal is to fund these networks for a maximum of three years when they should be fully operational and financially independent. Tier Two – CINs/RHRCEs who have committed partners and a foundational plan or have operated a limited alliance for a short period of time. Funding will support additional start-up costs to prepare the network to scale regionally. The goal is to fund foundational start-up costs to support completion of planning for 2-3 years and for full implementation and scaling to take place in years 3-5. Projects will be awarded via competitive selection process. Projects are required to establish collaborative agreements that provide frameworks for shared services, implementation of practices to achieve value-based care for member practitioners, coordinated patient transfer models, telemedicine and remote patient monitoring, interoperability of data systems, and continuous improvement of care quality. Subrecipients must demonstrate ongoing integration efforts (e.g., establishing formal partner/member agreements, data collection and reporting of quality indicators, embedding technology in patient monitoring and care). Pharmacies are an important component of integrated networks, and funding can also be awarded to organizations with demonstrated experience or interest in coordinating the components needed to prepare rural pharmacies to integrate into the CINs/RHRCEs established as part of this initiative. To address maternity care deserts in rural areas, Ohio will propose a revision to current legislation which would allow rural hospitals who do not have birthing centers to provide labor and delivery care, provided by physicians or midwives, for low-risk births. This approach will create safe birthing options for families in rural areas so that they can deliver close to home without risk of delivery while enroute to a distant birthing center. This also adds to the sustainability of rural hospitals and discourages potentially unsafe home births. To protect the safety of mothers and babies, specific safety policies will be enforced. Midwives will be required to complete additional training in order to provide services in hospitals and participating hospitals must have specific transfer agreements in place to facilitate specialty care if a mother or baby would need it. We anticipate implementation of this process in year two and Ohio will plan to provide financial supports to hospitals who need to equip maternity rooms.
Main Strategic Goal	Sustainable Access, Make Rural America Healthy Again, Tech Innovation, Innovative Care, and Workforce Development

Use of Funds	Prevention and chronic disease, Consumer tech solutions, Training and technical assistance, IT advances, Behavioral health, Innovative care, Fostering collaboration
Technical Score Factor	B.1. Population health clinical infrastructure B.2. Health and lifestyle C.1. Rural provider strategic partnerships D.1. Talent recruitment E.1. Medicaid provider payment incentives F.1. Remote care services F.3. Consumer-facing technology
Key Stakeholders	Rural Ohioans and hospitals, clinics, emergency medical services (EMS), behavioral health, institutions of higher education, community resources, and other healthcare providers that serve them. Additionally, state agencies with impact on these organizations (e.g., Departments of Health, Medicaid, Education and Workforce, clinical regulatory boards, etc.) Existing CINs and RHRCEs, e.g. Ohio High Value Network, Kettering Health integrated network, Ohio State and Ohio Universities.
Impacted Counties	Residents of Ohio's 73 non-urban counties will be served by this initiative. Providers in those 73 counties are the main focus of this initiative; however, providers located in any of Ohio's 88 counties, and possibly contiguous counties in bordering states (West Virginia, Indiana, Kentucky, Pennsylvania, or Michigan) could be included in a network in order to best serve rural residents.
Estimated Required Funding	$90,000,000-$125,000,000 annually.

Implementation Plan & Timeline: Ohio Rural Health Innovation Hubs		
Milestone	**Stage**	**Target Date**
Subrecipients selected	Stage 0	Quarter 1 2026
Selected subrecipients initiate work, baseline data established	Stage 1	Quarter 1 2026
Tier 1 projects implement data collection of quality indicators and begin submitting quarterly progress reports	Stage 2	Quarter 2 2026
Tier 2 projects establish planned partners and begin submitting quarterly progress reports	Stage 1	Quarter 2 2026
Tier 1 projects begin patient quality indicator reporting	Stage 2	Quarter 3 2026
Tier 2 projects demonstrate progress on finalizing member agreements	Stage 2	Quarter 4 2026
Tier 1 projects demonstrate progress on regional scaling of the network through expanded member agreements	Stage 3	Quarter 1 2027
Tier 2 projects have initiated small-scale network operations	Stage 3	Quarter 4 2026
Introduce rural hospital labor and delivery legislative change.	Stage 1	Quarter 2 2027
Tier 1 projects have begun implementation of enhanced EMS integration	Stage 3	Quarter 1 2027

Tier 2 projects conducting continuous quality improvement (CQI) on small-scale network activities	Stage 3	Quarter 3 2027
Tier 1 projects have integrated remote monitoring, telemedicine, and other tech solutions	Stage 3	Quarter 3 2027
Continued efforts to establish rural hospital labor and delivery legislation change (if needed).	Stage 2	Quarter 4 2027
Tier 2 fully operational in small-scale network and transitioning into regional implementation	Stage 4	Quarter 1 2028
Provide technical assistance and training to rural hospitals regarding the new rural labor and delivery policies (once enacted) and provide financial supports to interested hospitals.	Stage 3	Quarter 1 2028
Tier 1 fully operational in regional model with capacity to add more members to the network	Stage 4	Quarter 3 2028
Monitoring, data collection, and CQI with rural hospitals providing alternative labor and delivery model	Stage 4	Quarter 3 2028
Tier 1 project completion, services continue beyond RHTP	Stage 5	Quarter 3 2029
Alternative rural labor and delivery model fully implemented and operating independently	Stage 5	Quarter 3 2029
Tier 2 project completion, services continue beyond RHTP	Stage 5	Quarter 3 2031

Stakeholder Engagement: Ohio Rural Health Innovation Hubs	
Stakeholder Types/Names	In addition to the 200 stakeholder recommendations provided through Ohio's RHTP planning portal, we conducted individual meetings with representatives from the Ohio Hospital Association and their members, Ohio Rural Health Association, State EMS, Ohio High Value Network (CIN), Ohio State University Medical Center, Ohio University College of Medicine, Kettering Health integrated network, Ohio Pharmacists Association, Ohio Board of Pharmacy, Ohio Department of Public Safety, Ohio Medicaid, Ohio Department of Behavioral Health, Cleveland Clinic, Ohio Department of Aging, and other interested parties to collect their input about how Ohio can best provide sustainable, quality healthcare access to improve the health of rural Ohioans.
Engagement Framework	Ohio will publish RHTP project updates for public access and feedback will collected via surveys and/or focus groups. Project implementation partners will be included in an annual RHTP summit convened by the state to share updates, lessons learned, and guidance for future project years. Each subrecipient will be required to conduct regular stakeholder engagement for their respective project, and to include state personnel in those meetings.
Project Governance	Subrecipients will identify key stakeholders in their funding applications and will be required to demonstrate ongoing engagement with those stakeholders, including end users (e.g., patients, patient families). The state team will provide monitoring of this process.

Metrics: Ohio Rural Health Innovation Hubs			
Outcome Description	**Baseline**	**Goal**	**Data Source**
Number of participating members, by category, in each CIN or RHRCE	0	100	Subrecipient reporting
Rate of providers in the region who are members of the CIN/RHRCE	0	60%	Subrecipient reporting
Reduce hemoglobin A1C for patients diagnosed with pre-diabetes and diabetes by 10%.	0	10%	HIE data
Percent of patients with systolic blood pressure managed at clinically appropriate levels for patients diagnosed with hypertension.	79% (per FQHC statewide data)	89%	HIE data
# of EMS diversions to a non-ED site	0	14% (Based on EMRA.org handbook	EMS data

Sustainability: Ohio Rural Health Innovation Hubs
• Providers utilize a billable model for patient services which support sustainability for the program. • Integrated systems create back-of-the-house and other shared service efficiencies, reduce costs to providers and patients because patients receive the right care, in the right place, at the right time, and reduce duplicative healthcare services, thus enhancing sustainability. • The greatest costs associated with a CIN/RHRCE are in start-up investments, so integrated models with initial financial support inherently become self-sustainable when they are planned and implemented appropriately.

Initiative: Rural Ohio Emergency Care Transformation	
Description	In early 2025, Ohio initiated a pilot project in one rural county to support alternate destination transport (ADT) or treat-in-place (TIP). This initiative will build upon that pilot, scaling to rural communities across the state. A vendor will provide 911 system upgrades that allow for dispatcher-initiated triage of patients while the medic unit is enroute responding to a scene. Protocols for each EMS provider are established by the respective local EMS medical director and include considerations for ensuring that patients receive the right care, in the right place, at the right time. This can include TIP by appropriately trained paramedics (with an option to utilize telehealth) or a behavioral health crisis mobile unit, or ADT to sites like urgent care, primary care/FQHC, behavioral health provider, or transport to an emergency department. These options also best serve the patient by connecting them

	with appropriate resources for long-term, rather than only acute care,, and this can include paramedicine in addition to primary care and behavioral health services. In recognition of the financial strain that implementation places on rural EMS, we will provide one-time funding to the providers to support development of protocols to include ADT and TIP, and training of dispatchers, medics, and ADT sites. Data collection will identify utilization of ADT and TIP. Tech upgrades to provide enhanced connectively between providers across jurisdictions have been recommended by EMS providers and we are exploring options to address the need for potential year two implementation.
Main Strategic Goal	Sustainable Access, Tech Innovation, Innovative Care, Make Rural America Healthy Again
Use of Funds	Workforce, IT advances, Appropriate care availability, Behavioral health, Innovative care, Fostering collaboration
Technical Score Factor	B.1. Population health clinical infrastructure B.2. Health and lifestyle C.1. Rural provider strategic partnerships D.1. Talent recruitment D.2. Licensure compacts F.1. Remote care services
Key Stakeholders	Rural Ohioans and emergency medical services (EMS) – both publicly and privately operated, regional trauma organizations, hospitals, clinics, behavioral health, pharmacists, community resources, and other healthcare providers that serve them. Additionally, state agencies with impact on these organizations (e.g., Departments of Health, Medicaid, Education and Workforce, Public Safety, etc.)
Impacted Counties	Residents of Ohio's 73 non-urban counties will be served by this initiative. Providers in those 73 counties are the main focus of this initiative; however, providers located in any of Ohio's 88 counties, and possibly contiguous counties in bordering states (West Virginia, Indiana, Kentucky, Pennsylvania, or Michigan) could be included if they provide an appropriate alternative care facility to best serve rural residents. Ohio's existing licensure compacts and our commitment to pursue licensure compacts for EMS further expands destination options (refer to *Policy Actions* section).
Estimated Required Funding	$12,000,000-18,000,000 annually.

Stakeholder Engagement: Rural Ohio Emergency Care Transformation	
Stakeholder Types/Names	Rural Ohioans and emergency medical services (EMS) – both publicly and privately operated, regional trauma organizations, hospitals, clinics, behavioral health, pharmacists, community resources, dental health, and other healthcare providers that serve them. Additionally, state agencies with impact

	on these organizations (e.g., Departments of Health, Medicaid, Education and Workforce, Public Safety, etc.)
Engagement Framework	State of Ohio Emergency Medical Services and Ohio Department of Public Safety have existing collaboratives that bring together stakeholders that have involvement in EMS. We will leverage their existing partnerships to facilitate enrollment in the project and ongoing stakeholder engagement. Additionally, the state will have regular monitoring and assistance calls with EMS agencies and providers who participate in this initiative. Project updates are published for public access and public and patient feedback is collected via surveys and/or focus groups. Project implementation partners will be included in an annual RHTP summit convened by the state to share updates, lessons learned, and guidance for future project years.
Project Governance	Awarded EMS and participating healthcare providers will be responsible for communicating with impacted stakeholders about project updates and receiving feedback on services. State personnel will conduct monitoring and assistance activities to ensure appropriate engagement.

Implementation Plan & Timeline: Rural Ohio Emergency Care Transformation		
Milestone	**Stage**	**Target Date**
EMS provider outreach and recruitment activities conducted	Stage 0	Quarter 1 2026
EMS providers selected for year one implementation	Stage 1	Quarter 1 2026
Vendor initiates work with local 911 centers • Technology upgrades • Development of protocols to include ADT and TIP • Training of local EMS, dispatchers, and ADT sites	Stage 2	Quarter 2 2026
Year one EMS providers begin operating under new ADT and TIP protocols. Monitoring and continuous quality improvement (CQI) are in place.	Stage 3	Quarter 3 2026
Requirements collection for tech upgrades to enhance connectivity of EMS providers across jurisdictions.	Stage 0	Quarter 3 2026
EMS providers selected for year two implementation	Stage 1	Quarter 4 2026
Vendor initiates work with year two local 911 centers • Technology upgrades • Development of protocols to include ADT and TIP • Training of local EMS, dispatchers, and ADT sites	Stage 2	Quarter 2 2027
E-system upgrades to provide enhanced connectivity between jurisdictions initiated	Stage 1	Quarter 1 2027
E-system upgrades to provide enhanced connectivity between jurisdictions in progress with regular vendor-project manager-end user engagement ongoing	Stage 2	Quarter 2 2027
Year one EMS providers begin operating under new ADT and TIP protocols. Monitoring and continuous quality improvement (CQI) are in place.	Stage 4	Quarter 3 2027

Year two EMS providers begin operating under new ADT and TIP protocols. Monitoring and continuous quality improvement (CQI) are in place.	Stage 3	Quarter 3 2027
EMS providers selected for year three implementation	Stage 1	Quarter 4 2027
E-system upgrades to provide enhanced connectivity between jurisdictions in test phase – minor fixes ongoing	Stage 3	Quarter 1 2028
Year one EMS provider transformation complete, services continue beyond RHTP	Stage 5	Quarter 2 2028
Vendor initiates work with year three local 911 centers • Technology upgrades • Development of protocols to include ADT and TIP Training of local EMS, dispatchers, and ADT sites	Stage 2	Quarter 2 2028
Year two EMS providers begin operating under new ADT and TIP protocols. Monitoring and continuous quality improvement (CQI) are in place.	Stage 4	Quarter 3 2028
Year three EMS providers begin operating under new ADT and TIP protocols. Monitoring and continuous quality improvement (CQI) are in place.	Stage 3	Quarter 3 2028
E-system upgrades to provide enhanced connectivity between jurisdictions deployed, user training complete, CQI ongoing	Stage 4	Quarter 1 2029
Year two EMS provider transformation complete, services continue beyond RHTP	Stage 5	Quarter 2 2029
Year three EMS providers begin operating under new ADT and TIP protocols. Monitoring and continuous quality improvement (CQI) are in place.	Stage 4	Quarter 3 2029
Year three EMS provider transformation complete, services continue beyond RHTP	Stage 5	Quarter 2 2030
E-system upgrades to provide enhanced connectivity between jurisdictions full implementation complete, deliverables met	Stage 5	Quarter 1 2030

Stakeholder Engagement: Rural Ohio Emergency Care Transformation	
Stakeholder Types/Names	In addition to the 200 stakeholder recommendations provided through Ohio's RHTP planning portal, we conducted individual meetings with representatives from the Ohio Hospital Association and their members, Ohio Rural Health Association, State EMS, Ohio High Value Network (CIN), Ohio State University Medical Center, Ohio University College of Medicine, Kettering Health integrated network, Ohio Pharmacists Association, Ohio Board of Pharmacy, Ohio Department of Public Safety, Ohio Medicaid, Ohio Department of Behavioral Health, Cleveland Clinic, Ohio Department of Aging, and other interested parties to collect their input about how Ohio can best provide sustainable, quality healthcare access to improve the health of rural Ohioans.
Engagement Framework	Ohio will publish RHTP project updates for public access and feedback will collected via surveys and/or focus groups. Project implementation partners will be included in an annual RHT summit convened by the state to share

	updates, lessons learned, and guidance for future project years. Ongoing engagement with EMS and ADT sites will continue throughout all phases of implementation and for the year following each jurisdiction's roll out to identify technical assistance and training needs.
Project Governance	Agreements with the vendor, EMS providers, and ADT sites will provide for engagement and ongoing technical assistance support. Partners will be required to deploy patient satisfaction surveys and the state will engage with system users to identify strengths and opportunities for improvement.

Metrics: Rural Ohio Emergency Care Transformation			
Outcome Description	**Baseline**	**Goal**	**Data Source**
Number of alternative destination providers in participating communities	0	200	Subrecipient reporting
Reduce hemoglobin A1C for patients diagnosed with pre-diabetes and diabetes by 10%.	0	10%	HIE data
Percent of patients with systolic blood pressure managed at clinically appropriate levels for patients diagnosed with hypertension.	79% (per FQHC statewide data)	89%	HIE data
# of EMS diversions to a non-ED site	0	14% (Based on EMRA.org handbook	EMS data

Sustainability: Rural Ohio Emergency Care Transformation
• EMS and ADT providers utilize a billable model for patient services which support sustainability. • The state has initiated efforts with Ohio Medicaid to provide reimbursement for EMS who transport to ADT sites this replaces traditional payment models that only reimburse for transport to emergency departments.

Initiative: Rural Health Workforce Pipeline and Development Projects	
Description	Ohio recognizes the need for developing long-lasting pipelines that engage students at the earliest stages of career planning to educate them about the numerous opportunities that exist in healthcare. This is vitally important in rural areas where the need for workforce is great and we have the opportunity to create pathways for high school students to explore rural health careers, initiate learning in high school, continue training close to home (in technical/trade schools, community colleges, or universities with significant rural engagement), and secure careers in health provider settings in the rural communities that are most familiar to them. Our activities in this initiative will

	place high priority on integrating pipelines, recruitment and retention activities for 5-year work commitments, and upskilling and workforce development in RHTP sites. Projects will be implemented in partnership with academic institutions and other training facilities, professional and paraprofessional associations to: (1) Coordinate workforce pipeline activities between high schools, universities, community colleges, career technical schools, and healthcare employers. Activities include career awareness/exploration, pathways education programs starting in high school, secondary education programs, rural work-based learning/apprenticeships, and career placement agreements with employers. A focus is placed on placements in RHTP facilities. (2) Provide upskilling to community health workers (CHWs) to address rural-specific needs and to support RHTP projects including training on utilization of consumer facing technology and remote monitoring devices to support healthy lifestyle and chronic disease management. (3) Provide upskilling to pharmacists to operate at the top of their license, complementing Ohio's policy initiative to increase pharmacists' ability for point-of-care test-to-treat models. (4) Provide rural recruitment and retention incentives and 6-month housing stipends for those who relocate to serve in rural communities for 5-year commitments (minimum). This project will support filling workforce needs for a variety of healthcare capacities, e.g. MD/DO, nurses, pharmacists, therapy providers, dietitians, behavioral health, oral health, optometry, audiology, CHWs/navigators, etc. (5) Provide CME resources for physicians on nutrition (to support the Policy Action to adopt a CME requirement).
Main Strategic Goal	Workforce
Use of Funds	Workforce, Training and technical assistance, Fostering collaboration
Technical Score Factor	B.1. Population health clinical infrastructure B.2. Health and lifestyle B.4. Nutrition CME C.1. Rural provider strategic partnerships D.1. Talent recruitment D.3. Scope of practice F.1. Remote care services F.3. Consumer facing technology
Key Stakeholders	Education partners at every level, healthcare employers, particularly those engaged with RHTP initiatives, (e.g. hospitals, FQHCs, SBHCs, clinics, EMS, pharmacies, behavioral health, specialty care, nursing facilities), state agencies (Departments of Health, Education and Workforce, Aging, Behavioral Health, Medicaid, EMS, Public Safety, Job and Family Services), Ohio Means Jobs (Ohio-specific public-private collaborative for workforce)

Impacted Counties	Ohio's 73 non-urban counties
Estimated Required Funding	$10,000,000-15,000,000 annually

Implementation Plan & Timeline: Rural Health Workforce Pipeline and Development		
Milestone	**Stage**	**Target Date**
WORKFORCE PIPELINE		
Coordination meeting between identified partners for the pipeline project to clarify plans and prevent duplication of work	Stage 1	Quarter 1 2026
Information sessions with education partners and employers initiated	Stage1	Quarter 1 2026
Engagement with clinical students initiated. Special focus on those graduating in 2026 for placement in experiential learning and employment commitments.	Stage 2	Quarter 1 2026
Continued education partner and employer engagement to increase participation in the program, place students in experiential learning, and employment commitments. (ongoing)	Stage 3	Quarter 2 2026
Students placed in summer clinical experiences	Stage 3	Quarter 2 2026
Repeat these steps each semester, addressing variety of professional and paraprofessional needs.	Stage 4	Quarter 3 2026
By year 4, secure private investment to support longevity of the program, addressing variety of professional and paraprofessional needs. Examples of sustainable support: scholarships, employer-supported training programs	Stage 4	Quarter 3 2030
RHTP deliverables complete, pipeline activities continue	Stage 5	Quarter 3 2030
CHW UPSKILLING		
Mapping/scheduling of CHW RHTP workshops in coordination with partners who employ/are seeking to employ CHWs (topics must include RHTP essentials: understanding the RHTP, engaging with rural residents, unique needs of Ohio's aging population, SBHC operations, uniquely rural populations in Ohio and the things that impact their health (e.g. Amish, farmers), navigating rural resources.	Stage 0	Quarter 1 2026
Initiate CHW upskilling sessions. Include pre- and post-assessments to gauge efficacy. This is ongoing.	Stage 1	Quarter 1 2026
Perform ongoing CQI to assess efficacy of workshops and modify curriculum where needed. This is ongoing.	Stage 2	Quarter 2 2026
Add CHW supervisor training to provide leadership development on the same topics as offered to CHW.	Stage 2	Quarter 2 2026

Assess how the RHTP curriculum could be integrated in foundational CHW training programs and as part of the CHW certification regulated by the Ohio Board of Nursing.	Stage 3	Quarter 3 2026
Repeat this process to provide ongoing upskilling to CHWs and to support RHTP partners as they scale to new sites. Ongoing	Stage 4	Quarter 4 2026
Project completion, training has been delivered widely, is incorporated in foundational training for CHWs, and is available in a recorded format.	Stage 5	Quarter 3 2030
PHARMACIST UPSKILLING		
Mapping for pharmacist engagement in coordination with Ohio Pharmacists Association (OPA) and key partners	Stage 0	Quarter 1 2026
Engagement with pharmacists, hospitals, and other healthcare providers re: pharmacy policy action (see policy section) begins	Stage 1	Quarter 2 2026
Policy action initiated through the Board of Pharmacy	Stage 2	Quarter 2 2026
Continued engagement with key stakeholders through policy process to garner their support through the legislative process	Stage 2	Quarter 3 2026
Work initiated with OPA on training rural pharmacists about best practices for utilizing electronic medical records (EMRs) to provide medication counseling to patients. This is ongoing.	Stage 2	Quarter 3 2026
Upskilling curriculum designed in anticipation of successful policy implementation	Stage 2	Quarter 3 2026
Legislative action to adopt point-of-care test-to-treat scope of practice for pharmacists. If this action is secured earlier, future stages (outlined below) could be implemented sooner.	Stage 3	Quarter 4 2027
Initiate communication and upskilling sessions with pharmacists and other impacted providers about the specifics of expanded scope of practice for pharmacists, including billing procedures for pharmacists.	Stage 3	Quarter 1 2028
Data collection to identify how change in scope of practice is impacting patient care is in place. Continued engagement with pharmacists and other healthcare providers to support CQI.	Stage 4	Quarter 2 2028
Project completion, benefits of expanded scope of practice continue	Stage 5	Quarter 3 2030
5-YEAR COMMITMENT INCENTIVES		
Mapping of workforce needs for local RHTP projects	Stage 1	Quarter 1 2026
Identify students currently participating in clinical experiential learning (non-RHTP) that are ending in 2026 to conduct outreach for potential recruitment into RHTP projects.	Stage 2	Quarter 1 2026
Conduct student engagement sessions on rural campuses or with students from rural communities (e.g., Appalachian scholarship cohorts at large campuses such as Ohio State) to raise awareness about the 5-year commitment program in rural communities. Ongoing, beginning in Q1 2026)	Stage 2	Quarter 1 2026

Provide learning sessions with RHTP sites about recruitment and retention options to help with their staffing needs.	Stage 2	Quarter 2 2026
Develop a seamless way of plugging recruitment incentives into the workforce pipeline project (described above).	Stage 2	Quarter 2 2026
Conduct assessment of early results and perform CQI activities	Stage 2	Quarter 2 2026
Ongoing engagement on campuses (universities, tech schools, community colleges (in conjunction with the workforce project)	Stage 3	Quarter 3 2026
In coordination with the workforce project, establish a support system for healthcare workers in recruitment/5-year placement project to provide networking and peer connection for those who may need support in adjusting to their new community.	Stage 3	Quarter 4 2026
Conduct quarterly evaluation of the project and conduct CQI activities where improvement opportunities exist. Ongoing	Stage 4	Quarter 1 2027
Continue engagement with 5-year placement recruits to support continued service in rural communities. Ongoing.	Stage 4	Quarter 1 2027
Project completion. Conduct final evaluation of RHTP outcomes. Establish connections for Ohio to continue to track service time of placements in rural community which could inform future state-led activities.	Stage 5	Quarter 3 2030

Stakeholder Engagement: Rural Health Workforce Pipeline and Development Projects	
Stakeholder Types/Names	In planning for the RHTP, Ohio engaged with the Ohio University-led Health Collaborative which brings together institutions of higher learning, health systems, other health providers, and community partners to implement strategies to improve health for Ohioans. Additionally, The Ohio Department of Health participates in the Ohio CHW Center of Excellence which helps to identify needs and opportunities for CHWs. We also received written input from 200 health sector partners and met with a broad spectrum of health-related associations and their members, including the Ohio Hospital Association and the Ohio Rural Health Association. Workforce was identified as a key need for meaningful rural health transformation. The feedback of partners is reflected strongly in this plan.
Engagement Framework	Ohio is proposing to select a vendor, through competitive process, who will establish a strong collaboration with rural healthcare providers, educational institutions at all levels, and health-related associations to take an approach to workforce that has proven successful in meeting needs in the manufacturing sector in Ohio; creating awareness about healthcare career opportunities for students before they begin planning, expanding on Ohio's high school career pathways to offer more health-related programs, and establishing commitments from employers to provide experience-based learning in their facilities, and to employ students upon graduation from these programs.

Project Governance	Subrecipients will be responsible for engaging with stakeholders impacted by their work and for collecting feedback to inform CQI. State personnel will conduct monitoring and assistance activities to ensure appropriate engagement. The state will post regular RHTP updates for public review and will provide feedback loops for stakeholders to inform projects and opportunities for improvement. Subrecipients and partners will participate in annual summit to learn about project updates, expectations, and best practices/outcomes from their peer rsubecipients.

Metrics: Rural Health Workforce Pipeline and Development Projects			
Outcome Description	**Baseline**	**Goal**	**Data Source**
Number of members of the workforce pipeline collaborative, by sector type	0	100	Subrecipient reporting
Number of students in RHTP experiential placements	0	1000	Subrecipient reporting
Number of students from RHTP pipeline employed by collaborative partners	0	500	Subrecipient reporting
Percentage of Ohio-trained physicians practicing in rural Ohio, by university	To be identified upon project start	20%	Subrecipient reporting

Sustainability: Rural Health Workforce Pipeline and Development Projects
• 5-year rural workforce commitments are a good strategy to encourage healthcare workers to establish roots in rural areas. Ohio will also implement social supports (e.g. networking and regular engagement with placements) to further the likelihood that program participants develop strong bonds that establish them as long-term rural residents.
• Garnering private partnerships that provide long-term activities will benefit employers and strengthen the workforce pipeline beyond the life of the RHTP. Our subrecipients are charged with establishing commitments from private partner to offer scholarships and continued on-the-job learning beyond 2030.

Initiative: Maternal and Infant Wellness Home Visiting in Rural Ohio	
Description	Start-up investments in nurse-led home visiting will provide program availability to all rural and partially rural counties. The RHT funds will support training and upskilling for nurses to provide evidence-based home visiting models, a program that has driven significant shift in infant mortality where it has been implemented. These funds will complement State general revenue funds that are available to pay for services once the nurse workforce is in place. Home visiting curriculum provides families with education on a variety of topics, including safe sleep demonstrations

	(using the family's actual crib/bedroom), lactation support, and infant early childhood mental health. Mothers participating in the program can also receive peer recovery and behavioral health supports and other resources to promote wellbeing of the mother and child(ren).
Main Strategic Goal	Sustainable Access, Make Rural America Healthy Again, Innovative Care, Workforce Development
Use of Funds	Prevention and chronic disease, Appropriate care availability, Behavioral health, Training and technical assistance, Workforce
Technical Score Factor	B.1. Population health clinical infrastructure B.2. Health and lifestyle D.1. Talent recruitment F.1. Remote care services
Key Stakeholders	Ohio Department of Children and Youth, nurses, colleges of nursing, home visiting organizations, and other organizations and providers with regular engagement with pregnant and new moms and their children.
Impacted Counties	All 73 non-urban counties of focus. 32 of these currently do not have nurse-led home visiting services at all.
Estimated Required Funding	$6,000,000-$8,000,000

Implementation Plan & Timeline:Maternal & Infant Wellness Home Visiting – Rural OH		
Milestone	**Stage**	**Target Date**
Identify current home visiting organizations who have the capacity to expand with addition of more nurses. Determine the need to accept bids from other organizations.	Stage 0	Quarter 4 2025
Map hiring and training needs with home visiting organizations who will expand services to currently unserved communities.	Stage 1	Quarter 1 2026
Initiate training of nurses – schedule ongoing rotation of training to accommodate nurses are they are onboarded.	Stage 2	Quarter 2 2026
Ongoing training of new nurses continues.	Stage 2	Quarter 3 2026
Early training cohorts begin providing home visiting services.	Stage 3	Quarter 1 2027
Nurse cohorts continue training as they are hired, while others initiate home visiting services upon training completion. This work is ongoing.	Stage 3	Quarter 2 2027
Rural home visiting is staffed with training conducted as program growth requires.	Stage 4	Quarter 1 2029
Rural home visiting continues, self-sustaining and independent of RHT funding	Stage 5	Quarter 3 2030

Stakeholder Engagement: Maternal and Infant Wellness Home Visiting in Rural Ohio

Stakeholder Types/Names	Ohio Department of Children and Youth (DCY) is the primary partner with the Ohio Department of Health (ODH) for this initiative. DCY works with home visiting organizations across the state.
Engagement Framework	DCY currently facilitates ongoing engagement with home visitors and the organizations who employ them. DCY coordinates workforce development and upskilling for home visitors. They will continue to do so for the RHT-funded home visiting initiative.
Project Governance	DCY will facilitate continued governance for home visiting projects and engagement with stakeholders. ODH will participate in these activities as the RHT-implementing agency. Additionally, DCY and representatives from local home visiting projects will participate in the annual RHT Summit to report progress and best practices, and to learn about expectations for the upcoming year.

Metrics: Maternal and Infant Wellness Home Visiting in Rural Ohio			
Outcome Description	**Baseline**	**Goal**	**Data Source**
Number of nurses trained on delivery of evidence-based curriculum for rural health services through the RHT	0	200	Program reporting (DCY)
Reduction in wait lists for the 73 non-urban counties, by county	0	50%	Program reporting (DCY)
Percentage of home visiting babies completing 6 or more well visits in the first 15 months of life	57%	70%	Medicaid
Percentage of participating mothers who received at least one post-partum check 7-84 days from delivery	76%	90%	Medicaid HEDIS

Sustainability:

- Ohio has funds available to support home visiting services after a network is established and staff are trained to deliver appropriate, evidence-based models. RHTP funds will support start-up needs, including upskilling staff to deliver these models. Once services are initiated in currently unserved rural communities, those services become self-sustainable.

Initiative: Rural Hospital Training and Technical Assistance Center (RHTAC)	
Description	Recognizing that rural hospitals operate with limited budgets and face challenges with solvency and sustainability, this initiative will provide a resource for hospitals to receive no-cost technical assistance, training, and guidance for developing sustainability plans. The RHTAC will conduct

	workshops for healthcare administration professionals to equip them with best practices in addressing hospital solvency, which can include joining an integrated network to achieve value-based payment structures and other efficiencies (described in an earlier initiative) and the RHTAC can assist with that transition. The RHTAC will also be available to help with ad hoc hospital needs such as addressing emergent issues or upskilling for new administration leaders. Finally, a requirement of the vendor selected for this initiative is to work with Ohio's critical access hospitals (CAHs) to develop formal sustainability plans for them. These funds will also support the previously referenced RHTP annual summit, bringing together all recipients/vendors of RHTP funds to share outcomes, best practices, lessons learned, and to clarify ongoing expectations of program participants.
Main Strategic Goal	Workforce, Sustainable Access
Use of Funds	Training and technical assistance
Technical Score Factor	B.1. Population health clinical infrastructure C.1. Rural provider strategic partnerships E.1. Provider payment incentives
Key Stakeholders	Rural healthcare providers and systems, Ohio Rural Health Association and other health associations serving rural stakeholders, rural residents
Impacted Counties	Ohio's 73 non-urban counties
Estimated Required Funding	$800,000-1,500,000

Implementation Plan & Timeline: Rural Hospital Training and Technical Assistance Center (RHTAC)		
Milestone	**Stage**	**Target Date**
Training center activities initiated. Ad hoc requests accepted.	Stage 1	Quarter 1 2026
Annual training schedule announced to healthcare providers across the state.	Stage 1	Quarter 2 2026
Clinics open, TA continues	Stage 2	Quarter 3 2026
Clinics operational and continuous improvement processes in place	Stage 3	Quarter 4 2026
Services, engagement, and case load growth continue	Stage 4	Quarter 3 2027
Project completion, clinics operating independently	Stage 5	Quarter 3 2028
ANNUAL SUMMIT		
Establish and announce location and dates for 2026 summit	Stage 0	Quarter 1 2026
Establish agenda and identify keynotes	Stage 0	Quarter 1 2026
Monitor program data for early successes to include in summit	Stage 1	Quarter 2 2026

Summit preparation ongoing (logistics with site, refining agenda, etc.). Registration open.	Stage 2	Quarter 2 2026
Finalize speaker presentations, complete registration process.	Stage 3	Quarter 3 2026
Conduct summit, collect participant feedback.	Stage 3	Quarter 4 2026
Repeat Stage 0-3 annually, incorporating participant feedback and program outcomes/best practices in each year. Ongoing.	Stage 4	Quarter 1 2027
Conduct final summit and report on project outcomes.	Stage 5	Quarter 2 2031

Stakeholder Engagement: Rural Hospital Training & Technical Assistance Center	
Stakeholder Types/Names	Rural Health Association and other health associations serving rural stakeholders, rural healthcare providers, rural residents, universities – particularly those training the healthcare workforce, other RHT programs (e.g., Rural Health Innovation Hubs)
Engagement Framework	The vendor for this initiative will be required to regularly convene training sessions and workshops that are informed by requests from stakeholders. Therefore, they will be required to engage with stakeholders in the mapping phase. Additionally, ongoing engagement and methods for collecting feedback on training sessions and workshops will be a requirement for funding. Finally, the vendor will engage with all RHT projects at the annual Ohio RHT Summit to learn about project progress, lessons learned, best practices, and expectations for the coming year.
Project Governance	ODH will conduct monitoring of this project to ensure that appropriate stakeholder engagement is conducted.

Metrics: Rural Hospital Training and Technical Assistance Center (RHTAC)			
Outcome Description	**Baseline**	**Goal**	**Data Source**
Number of attendees at each workshop (Note: goal may be adjusted during the scheduling process, depending on the audience of focus as some topics will have broader audiences than others)	0	100	Subrecipient reporting
Percentage of workshop participants who indicate increased knowledge, by topic, through a pre- and post-evaluation	0	80%	Subrecipient data collection
Percentage of CAHs with robust, formal sustainability plans	0	100%	Subrecipient reporting
Percentage of rural hospitals reporting improvement in financial solvency as a result of TA provided through the training center	0	70%	Subrecipient data collection

Sustainability: Rural Hospital Training and Technical Assistance Center (RHTAC)
• The training center contract will be awarded to an organization who demonstrates experience working with Ohio's rural hospitals, such as an association or a collaborative. In doing so, we are establishing a capacity and knowledge base that will live beyond the RHTP cycle. • The nature of the workshops and supports for development of sustainability plans for CAHs and other rural providers extends the knowledge base from the selected vendor to the healthcare systems that need it. This approach can be likened to the adage of 'teaching people to fish' rather that 'giving them fish'. • The RHTAC will also act as a resource for referring hospitals and providers to CINs and rural health regional centers of excellence who exist to coordinate high quality care for rural residents and to reduce costs for network members, thus furthering sustainability of Ohio's rural health system.

Initiative: Electronic Medical Record Access for Pharmacies	
Description	This initiative provides fundamental tools and training for pharmacists to operate under the expanded scope of practice that we are proposing as part of our policy actions. Pharmacists will utilize EMRs to become an integrated part of patient care, providing point-of-care testing and prescribing, and utilizing Ohio's Automated Rx Reporting System (OARRS) to prevent misuse and diversion of prescription drugs and to promote improved patient care in rural communities. Consumer-facing technology and remote monitoring devices are available strategies for pharmacists to utilize in monitoring patient health indicators. The Ohio Board of Pharmacy and Ohio Pharmacists Association will conduct outreach to pharmacies and integration readiness assessments, provide training to pharmacists and oversee the implementation of the prescription drug monitoring program (PDMP). Building this function into a State agency provides sustainable oversight to ensure rural provider compliance to licensure standards/law.
Main Strategic Goal	Sustainable Access, Innovative Care, Make Rural America Healthy Again
Use of Funds	Appropriate care availability, Fostering collaboration, Innovative care, Behavioral health, Training and technical assistance
Technical Score Factor	B.1. Population health clinical infrastructure B.2. Health and lifestyle D.3. Scope of practice (pharmacists) F.2. Data infrastructure F.3. Consumer facing technology
Key Stakeholders	Pharmacists practicing in rural Ohio, Ohio Board of Pharmacy, Ohio Pharmacists Association, pharmacies (including those embedded in

	hospitals and clinics) providing services to rural Ohioans, and rural residents.
Impacted Counties	73 non-urban counties of focus
Estimated Required Funding	$3,000,000-$4,500,000 annually

Implementation Plan & Timeline: EMR Access for Pharmacies		
Milestone	**Stage**	**Target Date**
Board of Pharmacy (BOP) conducts outreach and readiness assessment with rural pharmacy sites.	Stage 1	Quarter 1 2026
NOTE: some supportive activities that will be conducted by the Ohio Pharmacists Association (OPA) are described in the Workforce initiative timeline.		
BOP begins deployment of OARRS to pharmacies - ongoing	Stage 2	Quarter 3 2026
EMR access to pharmacies begins rollout in partnerships with Clinisync (HIE vendor) and the OPA - ongoing	Stage 2	Quarter 3 2026
Completion of EMR rollout	Stage 3	Quarter 3 2027
Completion of OARRS integration	Stage 3	Quarter 4 2027
Monitoring and CQI with pharmacies - ongoing	Stage 4	Quarter 1 2028
Project completion, BOP continues to provide TA when needed	Stage 5	Quarter 3 2031

Stakeholder Engagement: EMR Access for Pharmacies	
Stakeholder Types/Names	In developing this RHTP initiative, we engaged with the Ohio Pharmacists Association (OPA), Ohio Hospital Association (OHA), Community Pharmacy, independent pharmacists and chain pharmacies, and the Ohio Board of Pharmacy.
Engagement Framework	We will continue to engage with the stakeholders above along with the vendor for Ohio's health information exchange (HIE), CliniSync, as we implement this initiative. This includes requirements gathering from state and end users, testing by those stakeholders, and CQI post-roll out. The Ohio Board of Pharmacy will perform the work related to OARRS enhanced integration and utilization by rural providers and they will ensure that the various stakeholders are engaged using the same approach that was successful with earlier OARRS integration in urban centers and lessons learned from that experience.
Project Governance	The Ohio Department of Health has established framework for ongoing work on the HIE, as does Ohio Board of Pharmacy for OARRS projects. Both follow a project governance structure for stakeholder engagement, prioritization, and sound project management.

Metrics: EMR Access for Pharmacies			
Outcome Description	**Baseline**	**Goal**	**Data Source**
OARRS integration in rural pharmacies	Collected through readiness assessment in Q1	90%	OH Board of Pharmacy data
Percentage of pharmacies in the 73 non-urban counties providing PDMP	Collected through readiness assessment in Q1	90%	OH Board of Pharmacy data
Reduce death due to overdose through improved monitoring of controlled substance dispensing. 29% of decedents were dispensed a prescribed controlled substance in the 30 days prior to death.	29%	24%	OARRS data
Percentage of rural pharmacies with EMR access	10%	70%	Subrecipient data

Sustainability: EMR Access for Pharmacies
• All investments in this initiative are one-time start-up costs to equip pharmacists with the infrastructure needed to operate at an expanded scope of practice. Ohio's Health Integrated Network (HIE) will continue to provide data integration needed for pharmacists to access records beyond the lifespan of the RHTP. • Pharmacists operating at expanded scope of practice do so under a billable model making them eligible for reimbursement from healthcare coverage for the services provided to patients. This adds sustainability for rural pharmacies that often face challenges with solvency when they are limited in scope.

Initiative:	**Healthier Ohio Initiatives**
Description	Ohio aims to implement an innovative movement to engage rural communities that bridges medicine and preventive behaviors into a holistic and collective impact approach for improved health outcomes. Clinical settings, schools, and community-serving agencies will implement systemic, sustainable, and evidence-based initiatives that focus on Lifestyle Medicine's six pillars for reducing risk and mortality of chronic disease throughout the age continuum of the resident population. • Optimal Nutrition - Eating Well • Being Active • Restorative Sleep • Positive Outlook – Stress Management

	• Belonging – Social Connectedness • Avoiding risky behaviors Clinical settings will adopt integrated care models and focus on behavior improvements for any or all of the six pillars. Schools will serve as a hub for the whole community that invite students, staff, families, and community members to participate in initiatives that support physical, mental and social health. This includes access to school-based health care, where accessible. Community-serving agencies will implement evidence-based programs and initiatives that support individual behavior change and improve access to services. The Ohio Department of Health will create a competitive bid process for the three system types to apply. Selection of more than one strategy as well as proof of cross-system collaboration will be encouraged. Clinical settings will be asked to standardize and scale high-value preventive medicine interventions within practices. Systems can select from the following infrastructure enhancement examples: • Training and certification of rural clinicians in Lifestyle Medicine. • Standardize guidance about the six pillars into well-visits and medical home services. • Establish coordinated care teams that are multidisciplinary, patient-centered, exercise regular and clear communication, and have clearly defined roles and responsibilities. • Utilize remote patient monitoring through technological devices, including remote care services that build interoperable data and analytics that integrate with electronic health records and deploy consumer-facing engagement tools that drive adherence and self-management. Wearable devices must be FDA approved. • Hire community health workers to assist with accessing resources related to social determinants of health and supporting use of technological devices. • Add new services such as culinary classes, grocery shopping planning, exercise classes, support groups, biofeedback coaching, and healthy food access support. Schools will be asked to reinforce the benefits of healthy eating and physical activity while providing access to nutritious food and beverages and opportunities to be physically active. This initiative will enhance clinical care provided through school-based health care models and align to the Whole Schools, Whole Community, Whole Child model. In September 2025, Ohio launched the Governor's Healthy Ohio *Team Tressel Fitness Challenge,* to encourage students and families to be active together. The Team Tressel Fitness Challenge is a 90-day journey to help students build healthy habits in physical activity, sleep, and nutrition through personalized goal setting. This initiative is foundational to the reestablishment of President's Physical Fitness Test and aligns with research found within the Journal of School Health. Schools may choose from the following:

	• Implement Governor's Healthy Ohio Team Tressel Fitness Challenge and associated activities to support behavior modification. • Provide professional development to teachers which supports Ohio's prescribed curriculum law (ORC 3311.52) that aligns with MAHA: schools must include education on nutritive value of foods, including natural and organically produced foods, the relation of nutrition to health, and the use and effects of food additives. • Establish pathways to support students and families in accessing clinical health services and adopting behaviors related to the six pillars. Examples can include use of community health workers and policy adoption for sustainability. Community-Serving Agencies play an important role in reducing the burden of chronic disease by advancing access to care and creating opportunities to improve the underlying factors that increase disparity. While increasing access to strategies related to the six pillars, agencies will utilize evidence-based models from *Principles of Community Engagement* to amplify individual behavior participation and foster culture of wellness with the communities being served. Ohio law requires coordination of Community Health Needs Assessments, Hospital-Based Implementation Strategies, and Community Health Improvement Plans. These should drive identification of need and advance collaborative opportunity. Agencies may apply to: • Establish infrastructure coordination to improve and increase preventive services to facilitate collective impact, leverage resources utilization across agencies in their geographic area. • Increase access to specialists like dietitians, fitness experts, and community health workers to provide skills-based health education and improve outcomes of the six pillars. • Coordinate outreach to residents to increase participation in clinical and community-based strategies. • Increase access to healthy food that is sustainable and physical activity opportunities. • Create skills-based marketing strategies to improve the behaviors related to the six pillars. Topics and messages must be selected using evidence and feedback from residents. An evaluation of impact must be utilized.
Main Strategic Goal	Make Rural America Healthy Again, Sustainable Access, Innovative Care, Tech Innovation
Use of Funds	Prevention and chronic disease, Consumer tech solutions, Appropriate care availability, Innovative care, Fostering collaboration
Technical Score Factor	B.1. Population health clinical infrastructure B.2. Health and lifestyle B.4. Nutrition Continuing Medical Education F.1. Remote care services F.3. Consumer-facing technology

Key Stakeholders	Hospitals, local health departments, school districts, federally qualified health centers, rural health clinics, universities and colleges, community centers, faith-based organizations, recreation entities, behavioral health centers, medical schools, education associations, nonprofit organizations, state agencies, and state associations.
Impacted Counties	Rural counties with the highest chronic disease burden. (Ohio Chronic Disease Atlas 2025: Maps of Chronic Disease Prevalence, Mortality, Risk Factors, and Non-Medical Health Factors by County)
Estimated Required Funding	$15,000,000-$25,000,000 annually

Implementation Plan & Timeline: Healthier Ohio Initiatives		
Milestone	**Stage**	**Target Date**
Selected subrecipients adjust workplans and begin initiatives.	Stage 1	Quarter 2 2026
Community health workers hired and receiving training on chronic disease prevention and management.	Stage 2	Quarter 3 2026
Rural school physical activity challenge participation increased.	Stage 2	Quarter 4 2026
Charters enacted to improve infrastructures and coordination.	Stage 2	Quarter 1 2027
Infrastructure enhancements are initiated to increase access to healthy food.	Stage 3	Quarter 4 2027
Access to behavior support specialists increased across 50% of counties.	Stage 3	Quarter 1 2028
Remote monitoring is available in 50% of counties.	Stage 3	Quarter 3 2028
Skills-based marketing related to six pillars integrated into 60% of counties.	Stage 3	Quarter 4 2028
Five rural health systems commit to increasing Lifestyle Medicine certifications.	Stage 4	Quarter 3 2029
Professional development for teaching skills related to chronic disease prevention released.	Stage 4	Quarter 3 2029
Access to remote monitoring increased by 50%.	Stage 3	Quarter 1 2030
Utilization of community health workers expanded in all counties.	Stage 4	Quarter 4 2030
One health system in each county fully integrates guidance for well-visits that focus on the six pillars.	Stage 4	Quarter 2 2031
Remote monitoring available in all RHT counties.	Stage 5	Quarter 3 2031
RHT systems report sustainable infrastructure enhancements related to chronic disease achieved.	Stage 5	Quarter 4 2031

Stakeholder Engagement: Healthier Ohio Initiatives	
Stakeholder Types/Names	State agencies, Ohio Hospital Association, State Office of Rural Health, Ohio Association of Health Commissioners, and universities, The Ohio State University Extension, Ohio Produce Perks, Ohio Farmers Market Network, Ohio Association of Food Banks, Ohio Alliance of YMCA, Ohio

	Parks and Recreation Association, managed care plans, education associations, rural planning associations and other affiliates.
Engagement Framework	An action team for chronic disease prevention and management will be associated with the Advisory Committee for the State Health Improvement Plan. Specific support will be provided to funded entities to advance the allocation resources, participate in cooperative learning, and share best practices for engaging rural communities and residents. Stakeholders listed above will be engaged along with funded subrecipients. Entities will utilize Clear Impact scorecards and Results Based Accountability to reflect performance measures. Project implementation partners will be included in an annual RHT summit convened by the state to share updates, lessons learned, and guidance for future project years.
Project Governance	Ohio will utilize charters and agreements to define a project management model that focuses on accountability and responsibilities, engagement of stakeholders, and enhance communication for realizing successful performance measures and outcomes.

Metrics: Healthier Ohio Initiatives			
Outcome Description	**Baseline**	**Goal**	**Data Source**
Number of community health workers, with training on chronic disease management and prevention guidance, serving schools, faith-based entities, and hospitals or clinics in RHT counties.	0	70	Program reports
Percent of rural counties with improvement in prevalence in hypertension.	0	20%	CDC. PLACES: Local Data for Better Health
Percent of patients receiving remote monitoring devices achieving improved outcomes in hemoglobin A1C, blood pressure and body weight.	0	80%	Clinic reporting
Percent of schools in rural counties implementing the Healthy Ohio Team Tressel Fitness Challenge or similar challenge within each school calendar year. *The Presidential Fitness Challenge will be added when program parameters are available. **We will convert this metric to a percentage of schools participating when we add the Presidential Challenge, to provide a better means of measurement. Ultimately, Ohio will require all schools to participate in the Presidential Challenge.	261	To be set as a percentage post-award.	Ohio Department of Education & Workforce
Percent of rural counties with an increase in healthy food access interventions.	0	100%	Program reports

Sustainability: Healthier Ohio Initiatives
• RHT Community health workers are trained in chronic disease prevention and management and are integrated into rural systems to support access to health improvement interventions and drive culture change toward health behaviors. • RHT healthcare systems (CIN and RHRCE) are expected to integrate chronic disease prevention and self-management activities into patient care to improve patient outcomes, building a sustainable culture that increases overall health. • RHT MAHA communities increased self-efficacy of residents to engage with technological devices to monitor health indicators and improve individual health behavior. • RHT MAHA school districts are hubs for promoting and accessing health interventions in their respective communities. Building a culture of healthy behaviors creates sustainability.

End Notes

[1] https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html

[2] https://urban-extension.cfaes.ohio-state.edu/about/ohio-urban-county-directory

[3] https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html

[4] https://www.nass.usda.gov/Statistics_by_State/Ohio/

[5] https://farmflavor.com/ohio/ohio-crops-livestock/top-ohio-agriculture-facts-from-the-2024-census-of-agriculture/

[6] https://www.healthpolicyohio.org/files/publications/datasnapshotruralhealth.pdf

[7] https://odh.ohio.gov/know-our-programs/chronic-disease/data-publications/Ohio%20Chronic%20Disease%20Atlas%202025

[8] https://www.healthpolicyohio.org/files/publications/datasnapshotruralhealth.pdf

[9] https://www.healthpolicyohio.org/files/publications/datasnapshotruralhealth.pdf

[10] https://www.census.gov/programs-surveys/sahie.html
[11] https://www.communitysolutions.com/resources/behavioral-health-disparities-in-appalachia-and-rural-ohio#

[12] https://www.marchofdimes.org/peristats/data
[13] https://www.healthpolicyohio.org/health-policy-news/2023/05/12/ohio-hit-hardest-by-shrinking-access-to-maternity-care-study-finds

[14] https://hdpulse.nimhd.nih.gov

[15] https://www.census.gov/programs-surveys/saipe.html

[16] https://aging.ohio.gov/about-us/reports-and-data/summary-assessment-of-older-ohioans-2020

[17] Instability Continues to Threaten the Rural Health Safety Net, Chartis Center for Rural Health, August 7, 2025

[18] Instability Continues to Threaten the Rural Health Safety Net, Chartis Center for Rural Health, August 7, 2025
[19] https://aspe.hhs.gov/sites/default/files/documents/9739cab65ad0221a66ebe45463d10d37/dual-eligible-beneficiaries-integrated-care.pdf

[20]
https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Families%2C%20Individuals/Programs/MyCar MyCar/Evaluation_of_Ohio_s_MyCare_demonstration.pdf

[21] https://dam.assets.ohio.gov/image/upload/aging.ohio.gov/State-Plan-2023-2026-Full-Document.pdf, (pp 21-22).

[22] https://odh.ohio.gov/know-our-programs/cvsf/childrens-vision-strike-force