Rural Health Transformation Application Project Narrative

I. Rural health needs and target population

Minnesota's rural communities, from the northern pine forests to the prairies of the Driftless Region, are vibrant and unique. But like many rural areas, they face challenges accessing appropriate health care, loss of key local health care services, family financial pressures, difficulty in recruiting and retaining workers, and health outcomes that are worse than their urban counterparts, particularly for chronic conditions and behavioral health. This section of Minnesota's Rural Health Transformation Program (RHTP) application describes those challenges in more detail, leading to Minnesota's plan to address these issues through strategic technology, partnerships and training investments that are responsive to local needs.

Rural criteria

To define rurality, Minnesota (MN) uses the US Department of Agriculture's Rural-Urban Commuting Areas (RUCA) classification, which scores census tracts based on population density, urbanization and commuting patterns to the closest urban core. Census tracts with RUCA codes 4-10 are considered rural, and encompass micropolitan areas, small-town areas, and isolated rural areas, reflecting weaker population commuting ties to urban cores. The use of RUCAs is consistent with the Health Resources and Services Administration (HRSA) definition of rural. Minnesota will use this definition to define facility eligibility for RHTP efforts and to define rural entities. Given the unique role that Critical Access Hospitals (CAHs) and Federally Qualified Health Centers (FQHCs) play in ensuring access points for essential health services in underserved communities, Minnesota will also consider all CAHs eligible for program participation regardless of geographic location, as well as all FQHCs outside the Twin Cities metropolitan area.

Rural demographics

Minnesota is the 14th largest US state, covering 79,631.6 land miles^2 and 7,311.7 miles^2 of water.[i] Rural Minnesotans make up 29.7% of the population. The state's population is projected to grow from 5.78 million in 2024 to 6.11 million in 2075.[ii] Minnesota is home to 11 sovereign Tribal Nations, including seven Anishinaabe (Chippewa, Ojibwe) reservations and four Dakota (Sioux) communities, with ten located in rural areas of the state.

Rural Minnesotans are more likely to work in resource extraction (farming, forestry, mining) or government jobs or to be self-employed than their urban counterparts, and less likely to be in professional or business services roles (legal, accounting, management).[iii]

Financial challenges are often more severe in rural Minnesota than in urban areas, impacting both access to care and outcomes:

- Most rural Minnesota counties have child poverty rates at or above the statewide average, limiting residents' ability to travel for care when it is not available locally.[iv]
- Rural Minnesotans are more likely to have household incomes below the statewide median, have a higher uninsurance rate (4.1% vs 3.5%) than urban areas and are more likely to access health care using public insurance programs (Medicare, Medicaid or MinnesotaCare, a state low-income program) than employer-sponsored or commercial plans.
- Rural Minnesotans experience high monthly cost-sharing for commercial and Medicare plans, and overall monthly health care costs are higher for adults in rural areas.[v]

Rural health outcomes

People living in rural Minnesota are at elevated risk for chronic disease as a result of having less access to healthy foods and health care services, higher rates of smoking, and lower levels of physical activity, as well as, on the whole, being an older population:

- Roughly 51% (553,000) of adults in rural Minnesota have at least one chronic condition (coronary heart disease, heart attack, stroke, diabetes, cancer, COPD, asthma, chronic kidney disease, or hypertension) (Table 4). This increases to 64% (667,000) of adults when including obesity.[vi]
- Hypertension, diabetes and high cholesterol prevalence, hospitalizations, and deaths are higher in both rural and small towns than in metropolitan areas (Table 5, 6).[vii]

In 2024 the suicide rate in entirely rural counties was about twice that of the Twin Cities metro area counties.[viii,ix,x] Even though opioid deaths decreased in Minnesota for the second year in a row, there were still 678 opioid-involved deaths in 2024.[xi] Regions in Greater Minnesota bear equal or higher opioid use burden compared to the metro area but lack equivalent resources for prevention and treatment. Adult residents of Northeast and Northwest Minnesota have comparable opioid use rates to metro area residents, and 2-4 times greater prevalence of Neonatal Abstinence Syndrome, but are less likely than metro area residents to live near a treatment facility.[xiixiii]

Access to consistent, high-quality prenatal care is critical to healthy pregnancies, but this access has been decreasing with hospitals in 18 Minnesota counties reducing or eliminating labor and delivery services over the last decade.[xiv] Declines in hospital-based obstetrics have been linked to increases in preterm births, unplanned out-of-hospital births or births in hospitals without full obstetric support, and long travel distances can worsen pregnancy-related complications. [xv] Although Minnesota's maternal and infant mortality rates are lower than national averages, Black and American Indian populations experience significantly higher mortality rates than white populations. [xvi xvii]

Rural health care access

Proximity to health care is essential for ensuring timely response to time-critical diagnoses[xviii] and regularly accessing routine screenings and follow-ups, but rural residents face steep challenges accessing care close to home. Gaps in health care access contribute to worse health outcomes for rural residents as longer wait times or travel times may lead to foregone care. Rural health access challenges in Minnesota show up across multiple service lines and provider types. Travel times to inpatient services (maternity, neonatal, medical/surgical) are longer in rural settings. Rural patients seeking inpatient mental health and chemical dependency treatment travel more than three times longer than urban patients (84 minutes vs. 25 minutes).[xix] Children with behavioral health needs face severe limitations in accessing services, with one behavioral health provider available for every 14,000 residents in isolated rural areas.[xx] Compared to urban areas, rural Minnesota reports more trouble getting primary care and dental appointments, and lower telehealth use.[xxi]

Minnesota has 125 non-federal, acute care, and community hospitals and two Indian Health Services Hospitals, with a total of 95 hospitals considered rural for the purposes of this application; 76 Minnesota hospitals are critical access hospitals (CAHs), and there is one rural emergency hospital. There are 108 rural health clinics in the state, and 40% of all primary care clinics (241 of 599) are in rural areas (just 22% of all specialty care clinics are rural). But access to care has been shrinking across rural Minnesota. Between 2013 and 2023, rural Minnesota lost 80 mental health beds, and 18 counties saw labor and delivery services reduced or eliminated. Hospitals must notify the Minnesota Department of Health (MDH) of service curtailments or cessations; since 2023, five hospitals have implemented reductions in mental health or chemical dependency treatment services.[xxii]

Access to pharmacy services is also often lacking in rural Minnesota. In 2024, more than 86,000 Minnesotans outside of Metropolitan Statistical Areas lived more than 15 miles from the nearest pharmacy, and more than 336,000 lived in an at-risk community, with access to only one pharmacy. This reduces access to medication refills, vaccinations, medication management, and other services that are key to reducing the impact of chronic and communicable diseases.[xxiii] Minnesota has 120 designated stroke hospitals, but only 84% of rural Minnesotans live within 30 minutes of one.[xxiv] While 99.6% of Minnesotans live within 60 minutes of a trauma hospital and 77% of Minnesota children live within 60 minutes of a pediatric trauma hospital, ambulance services are stretched thin in rural Minnesota due to a lack of EMS providers. Over half of Minnesota's 230 rural ambulances cover a service area of more than 200 square miles and 37% cover more than 300 square miles, increasing the risk that an individual will not receive timely hospital care.[xxv] Further challenging access to care, rural Minnesota has a disconnected public transit system (bus, taxi, rideshare) with fewer options than larger towns and cities.[xxvixxvii] Availability and reliability of transportation, lengthy travel times, reliance on volunteer drivers, or barriers to owning a personal vehicle often contribute to missed appointments or delayed care. Workforce shortages are a significant contributor to all of these service gaps. Minnesota has a maldistribution of health care professionals across the state (Table 7); 80% of Minnesota providers work in urban areas, compared to 74% of the population living in those areas.[xxviii] Provider-to-population ratios in urban and rural areas make the shortages starkly clear: rural Minnesota has just 2.5 primary care physicians/100,000 population compared to 32.7 in urban areas; for internal medicine, the ratios are 0.8 and 31.3/100,000.[xxix] Federal shortage designations also highlight these challenges: 69 of 87 Minnesota counties include a primary care physician Health Professional Shortage Area (HPSA), and 57 of 87 counties include a dental HPSA.[xxx]

Rural facility financial health

Forty-one Minnesota hospitals, including 34 rural hospitals, are considered financially distressed, with four or more years of negative operating margins in the past eight years. Five rural hospitals[xxxi] have closed since 2005, and hospital-based services have declined due to financial distress or regional consolidation; for rural hospitals, these include loss of obstetrics, inpatient psychiatric services, surgical services, and multiple types of radiological services.[xxxii]

In 2023, 14% of hospital admissions were at rural hospitals, and average length of stay was 3.6 days, compared to 5.6 days at urban hospitals. However, rural hospitals accounted for 39.8% of outpatient visits and 31.0% of emergency department registrations, and a higher percentage of inpatient days were for general medical and surgical care, mental health, orthopedic and obstetric care than their urban counterparts. This reflects rural hospitals' role in providing critical services, including primary care, to their communities.[xxxiii]

Target Population

Approximately 29.7% of the state's population (1.69 million residents) lives in rural areas using the definition above. Minnesota's plan is focused on making strategic investments across all rural areas in Minnesota, including Tribal Nations, with a particular emphasis on higher-need or more vulnerable communities (those with higher uninsurance rates and fewer available health care providers) and populations (those with or at risk of chronic conditions). In terms of the population focus, this application includes strategies designed to benefit all rural Minnesotans.

II. Rural health transformation plan; goals and strategies

Minnesota's plan for rural health transformation adopts a comprehensive, data-driven and coordinated approach that builds on strong partnerships and local determinations of need and uses emerging technology and practices to improve provider financial sustainability and expand

access to health care deeper into trusted rural and Tribal community settings. We envision a vibrant, collaborative, technology-enabled rural health care system that ensures all rural Minnesotans have access to the care they need, when they need it, as close to home as possible. To achieve this, we have developed five Minnesota goals that align with CMS strategic goals:

Minnesota Goal		CMS Strategic Goal
1	Improve health outcomes for rural Minnesotans with or at risk of developing cardiovascular disease, diabetes, and chronic kidney disease (cardiometabolic disease).	Make Rural America Healthy Again
2	Build education pathways and promote training opportunities in rural communities to sustainably expand the health care workforce in rural MN.	Workforce Development
3	Expand health care access in rural communities by creating new access points for community-based screenings, preventive care, and chronic disease management through technology-enabled care delivery, mobile care, and increased use of community-based frontline workers.	Sustainable Access, Make Rural America Healthy Again, Tech Innovation
4	Strengthen partnerships between providers to enable delivery of expanded services in rural areas through shared learning, collaborative approaches, and advanced technology interventions.	Tech Innovation, Sustainable Access
5	Strengthen and stabilize rural provider financial health through strategic investments in technology, data infrastructure, and collaborative mechanisms needed to address unique needs of rural providers.	Innovative Care, Sustainable Access, Tech Innovation

Improving access and improving outcomes

As noted above, access to primary care and behavioral health services as well as specialty care is a challenge for many rural Minnesotans. Minnesota will use a range of approaches to improve access to services, with an ultimate goal of improving health care outcomes, particularly for chronic conditions and behavioral health. Specific actions include:

- Bringing screenings and patient care closer to the community; rural providers and Tribal health programs will receive funding to make chronic disease, behavioral health and preventive care screenings available in schools, pharmacies, Tribal clinics, and trusted community settings through direct outreach, establishment of telehealth hubs, and mobile care. This will allow for earlier identification of health issues, increased availability of appropriate services, and connection to upstream supports such as healthy food, improved chronic condition management and mental health outcomes. (Initiatives 1 and 3)

- Providing tools to rural residents to make healthy lifestyle choices and improve their health outcomes by supporting access to nutritious foods, promoting physical activity, providing education in accessible formats by community-based frontline health workers and Tribal Community Health Representatives (CHRs), and leveraging technology that makes it easier for people to track their decisions and progress. (Initiative 1)
- Increasing the number and scope of rotations in rural hospitals and clinics during medical school, medical residencies, and Advanced Practice Provider (APP) training programs to increase the number of rural-trained providers to build the rural health care workforce. (Initiative 2)
- Funding treatment-in-place programs to allow ambulance services and Tribal EMS programs to provide appropriate treatment to patients in their homes through assessment, assisted by telehealth when needed, treatment and referral to expand access to care and improve EMS financial stability. (Initiative 4)
- Developing sustainable systems for treating urgent and emergency behavioral health care services by linking EMS, emergency departments, Tribal and rural health providers and telehealth partners capable of initiating medications for opioid use disorder (MOUD) and coordinating follow-up care with primary care and community organizations to increase the likelihood of sustained recovery. (Initiative 4)
- Building rural provider expertise and improving health outcomes by creating networks of physicians and other practitioners who learn from each other and expert specialists through ECHO (Extension for Community Healthcare Outcomes) programs in obstetrics and behavioral health. (Initiatives 1 and 4)

For more detailed information on specific access and outcome metrics that Minnesota will be tracking as part of its RHT Program, see the Metrics and Evaluation section.

Technology and data-driven solutions

Rapidly evolving technologies such as artificial intelligence (AI), telehealth platforms, and remote patient monitoring have the potential to transform rural health by improving efficiency, coordination, and access to care. Access to advanced data analytics platforms can enable earlier identification of patient health trends and targeting of interventions. But many rural providers lack expertise in these technologies or funding to make initial investments that will improve financial solvency over time. Minnesota will invest in the following high-impact strategies:

- Expanding use of telehealth to enable specialist consultations, chronic disease screenings and management, and obstetric care in community settings and to connect rural physicians and other providers to partners who can consult with, train and advise them in addressing complex patient needs to improve access and health outcomes. (Initiatives 1, 3, 4)
- Supporting adoption and use of remote patient monitoring tools to increase access to care closer to home. (Initiative 1)
- Building and maintaining rural clinician skills through the use of high-fidelity simulation training programs and the networking and remote peer engagement opportunities available through ECHO programs. (Initiative 4)
- Increasing rural providers' operational efficiencies by investing in the use of AI-enabled patient care coordination systems. (Initiative 5)
- Making meaningful investments in health data analytics platforms, capabilities, and infrastructure for rural providers to work independently or through collaborative structures to improve patient care and increase efficiencies. (Initiative 5)

Partnerships

Rural providers, especially those that are more geographically isolated, often need access to a range of clinical and community partners to offer health care services and maintain financial sustainability. Our plan recognizes this need and focuses on new ways to bring rural providers together with partners who can help them achieve their goals related to improved access to timely and appropriate health care and financial sustainability. Specific activities include:

- Fostering provider-to-provider learning and support networks using simulation training and ECHO programs to improve clinical knowledge, reduce professional isolation, and strengthen the quality and scope of primary care, mental health care and prenatal/obstetric care delivered in underserved regions. (Initiatives 1, 4)
- Creating a rural telehealth center and developing telehealth linkages to provide access to professional services not available in the local community and to give primary care providers access to specialist expertise when needed for higher-risk patients. (Initiatives 1, 4)
- Providing funding to rural providers interested in joining in existing or new clinically integrated networks or other collaborative mechanisms, which will provide flexibility in offering needed services and investing in technologies that lay a foundation for improving the financial health of rural providers. (Initiative 5)

Workforce

A strong and sustainable health care workforce is foundational to the success of Minnesota's transformation efforts. Rural communities face persistent, and well-documented workforce shortages that jeopardize access and health care outcomes for rural residents. Addressing these challenges requires coordinated investments in our people—supporting students who want to serve their hometowns, bringing training and education to rural areas to build the number of

health care workers and allow professionals to practice at the top of their license, grounding more clinical training in rural practice environments, and creating supportive systems that encourage health care professionals to serve rural residents long-term. To these ends, Minnesota will:

- Expand efforts to introduce high school students across rural Minnesota to health care careers through health care career camps. (Initiative 2)
- Expand clinical training programs by increasing the number of clinical training sites and scope of rotations in rural hospitals and clinics during medical school, medical residencies, fellowships and APP training programs to increase the number of rural-trained providers to build the rural health care workforce. (Initiative 2)
- Provide opportunities for community members to grow into health care careers through apprenticeships. (Initiative 2)
- Help rural health care professionals maintain their skills and practice at the top of their license though simulation training and technology-enabled connections to care partners across the state. (Initiative 4)

Financial solvency strategies, including addressing causes of service closures

As in other states with significant rural populations, some Minnesota hospitals and clinics have reduced services in recent years. Minnesota-specific and national data show that service reductions and closures are linked to several factors: low patient volumes create financial pressures on small facilities and make it difficult for physicians to maintain their skill sets related to complex cases (particularly for labor and delivery); competitive pressures from larger systems and continued health care consolidation mean that smaller rural providers lack sufficient negotiating power with payors while health care costs continue to rise, and demographic changes

have led to population loss in many rural areas. To address these challenges, Minnesota's plan provides technical assistance and resources to rural hospitals and other providers to chart a path toward financial sustainability. Specifically, Minnesota will:

- Support rural providers to become more efficient and financially sustainable through investments in the use of revenue cycle management. (Initiative 5)
- Provide funding and technical assistance to support rural provider readiness to participate in clinically integrated networks and/or other types of partnerships across separate health care providers. Participation in clinically integrated networks facilitates shared investment in data infrastructure and allows for scalability as members participate in value-based purchasing arrangements. (Initiative 5)
- Support low-birth-volume rural hospitals in sustaining obstetric services through simulation training, learning networks, advanced training for physicians through obstetrics fellowships, and planning grants to identify sustainable practices, to allow this important revenue stream – and critical community asset for rural families – to continue. (Initiative 4)
- Expand the ability of EMS programs to provide treatment in place, and the use of remote patient monitoring technologies, to avoid unnecessary emergency department visits and hospitalizations for conditions that can be effectively managed in the home. (Initiative 4)

Program key performance objectives

Together, the initiatives and activities outlined in this application will move Minnesota's rural communities toward the RHTP strategic goals. Detailed metrics for each initiative are provided in the metrics and evaluation section of the program narrative. The metrics in the table below describe overall program objectives that will demonstrate the value of the activities and investment, and what successful implementation will do for improving rural health in Minnesota.

RHTP key performance objectives

Metric	Initiative	CMS Strategic Goals	Data Source[xxxiv]	Baseline	5 Year Target
Increased telehealth utilization in rural areas	3, 4	Sustainable Access; Tech Innovation; Make Rural America Healthy Again	MN APCD, Medicaid Management Information System 2023	Rural commercial: 17% Rural Medicare Advantage: 15% Medicaid: baseline to be calculated in 2025	Rural commercial: 27% Rural Medicare Advantage: 20% Medicaid: 10% increase from baseline
Increased intent to continue working in rural areas (retention)	2	Workforce Development	RHTP custom provider survey	New survey. Baseline to be collected in 2026	50% increase in providers reporting intent to continue working in a rural area
Reduced avoidable hospital utilization in rural areas	3	Make Rural America Healthy Again; Sustainable Access	Provider EHR data	Pending new CMS hybrid hospitalization measure	10% reduction in readmission (pending new measure)
Improved rate of cardiometabolic disease management in rural areas	1	Make Rural America Healthy Again	Provider EHR data	Baseline data not available at time of application	4 percentage point increase from baseline
Number of participating rural providers that increase capacity to implement Value-based Care (VBC)*	5	Innovative Care; Tech Innovation	Grantee reporting	Baseline data not available at time of application	15% improvement over baseline

The RHTP investments will drive Minnesota toward improvement on five key performance objectives. By increasing telehealth utilization in rural areas for rural commercial, Medicare Advantage and Medicaid enrollees, care can be provided closer to home for rural residents, ensuring access to specialists and subspecialists to provide needed consultations and treatment--and minimizing disruptions felt when it is necessary to travel far from family and community support to attend to health needs. In recognition of research that shows providers tend to practice near where they train, we believe we can have a great impact on access to rural health by using RHTP resources to develop more clinical training sites and rural residency programs for primary care providers.[xxxv] Rotations and residencies will give trainees the ability to get to know the community and build relationships with fellow clinicians—and more teaching opportunities will lead to greater job satisfaction for those providers who love teaching and have new opportunities

for precepting. Understanding the value of maintaining health, especially for those with chronic conditions, we propose using RHTP funds to expand frontline staff who can make personal connections and expand the use of technology in helping people make healthier choices, improve their ability to manage existing cardiometabolic conditions and attain a better quality of life. We believe these interactions will result in fewer acute complications, a reduction in rural hospital readmissions and save scarce resources. All metrics closely align with CMS strategic priorities.

Legislative or regulatory action

Minnesota does not need to pursue any legislative or regulatory action to implement the initiatives included in this plan. If needed, Minnesota commits to pursuing such action.

Other required information

State Policies

Section	Status	Source
B2 – Health and lifestyle	MN does not require schools to reestablish the Presidential Fitness Test	MN has required K12 Academic Standards in Physical Education that mandate all students in grades K-12 receive instruction in physical education as required by statute.
B3 – SNAP waivers	MN does not have SNAP waivers to ban access to "junk" foods	https://www.fns.usda.gov/snap/waivers/foodrestriction
B4 – Nutrition Continuing Medical Education (CME)	MN does not have a requirement for nutrition to be included in CME for physicians	None. Reference here: 5605.0300 - MN Rules Part
C3 – Certificate of Need	MN does not have a certificate of need program but does have a hospital bed moratorium and public interest review process	50-State-CON-Rankings-Report-12-5-2024.pdf Sec. 144.551 MN Statutes Sec. 144.552 MN Statutes
D2 – Licensure compacts	MN is a member of the Interstate Medical Licensure Compact	Physician License | Interstate Medical Licensure Compact
	MN is not a member of the Nurse Licensure compact	Home | NURSECOMPACT. Note: Legislators have introduced legislation in previous years for MN to join.
	MN is not a member of the EMS compact	Home | EMS Compact
	MN is a member of PSYPACT	PSYPACTMap - Psychology Interjurisdictional Compact (PSYPACT)
	MN is a member of the PA Compact	pacompact.org | Home

D3 – Scope of Practice	State scope of practice environment for PAs is "Advanced"	PA State Practice Environment - AAPA
	State scope of practice environment for NP licensure is "Full Practice"	State Practice Environment
	State scope of practice for pharmacists scores a 6	2025 Policy Strategies for Full Practice Authority | Cicero Institute
	MN has 6 allowable tasks for Dental Hygienists	"Dental Hygiene Practice Variations by State - OHWRC"
E3 – Short-term, limited duration insurance (STLDI)	MN restricts STLDI plans beyond the latest federal guidance	MN Statutes Sec. 62A.65 MN Statutes
F1 – Remote care services	MN Medicaid pays for at least one form of live video	MN Statutes 256B.0625 Subd. 3b(e)(1)
	MN Medicaid pays for Store and Forward	MN Statutes 256B.0625 Subd 3b(e)(1)
	MN Medicaid pays for Remote Patient Monitoring	MN statutes 256B.0625 Subd 3h(b)
	MN has at least one in-state licensing requirement exception	Exceptions here Sec. 147.032 MN Statutes (Interstate practice of telehealth)
	MN has a telehealth licensure/registration process	MS 147.032 Subd. 2.

- Factor A.2 Current Certified Community Behavioral Health Clinics (CCBHCs): **22 CCBHCs with 178 active sites** (see attached list)
- Factor A.7 Hospitals that received a Medicaid disproportionate share hospital payment: **32** Minnesota hospitals received Medicaid disproportionate share hospital payment

III. Proposed Initiatives

The five initiatives described in this application will work in concert to move Minnesota toward the overall goals outlined in our rural health transformation plan and CMS's strategic goals. In all initiatives, we focus on balancing local control – recognizing that rural communities and providers know what their concerns, priorities and needs are – with a structure that allows us to engage a critical mass of providers in specific activities that drive toward common metrics. MDH will establish a strong foundation for RHTP activities by identifying and scaling successful

innovations, planning for sustainability, and establishing and maintaining a strong focus on accountability in all aspects of planning and implementation.

Organizations eligible for participation that receive direct year 1 funding must each choose at least two initiatives to participate in, and must submit to the State, prior to funding, a detailed plan for how funds will be spent on allowable activities within each initiative. All sub awardees must submit regular reports to MDH on their use of funds and on their progress toward initiative-specific and overarching metrics and must follow all state and federal funding requirements. For additional information on reporting on annual progress targets, see Section VI.

Initiative		Minnesota Goal	Use of Funds	Technical Score Factor	Page # in Application
1	Community-Based Preventive Care and Chronic Disease Management	1, 4	A, C, D, G, I	B.1, B.2, E.2, F.1, F.2, F.3	16
2	Recruit and Retain Talent in Rural Communities	2	A, E, H	B.1, C.1, D.1	20
3	Sustain Access to Services to Keep Care Closer to Home	1, 2, 3, 4	A, C, E, G, I, J	C.1, F.1, F.3	25
4	Create Regional Care Models to Improve Whole Person Health	3, 4	D, E, F, G, I, J	B.1, C.1, C.2, F.1	29
5	Invest in Technology, Infrastructure, and Collaboration for Financial Viability	4, 5	D, F, I	B.1, C.1, E.2, F.2	36

A. Initiative #1: Community-Based Preventive Care and Chronic Disease Management

Description

Cardiovascular disease, stroke, diabetes and cancer are leading causes of morbidity and mortality in Minnesota. These cardiometabolic diseases and cancer share common risk factors including high blood pressure, high cholesterol, chronic kidney disease, unhealthy diet, and physical inactivity. To ensure that Minnesotans living in rural areas are able to access community-based preventive care and support for their chronic diseases, Minnesota will support rural hospitals, clinics, Tribal health, and FQHCs to implement community and clinical based strategies aimed at increasing access to screenings, tools for self-management, coordinated access to healthy lifestyle programs and supports, and treatments. Based on rapid needs assessments, participants

will create annual workplans identifying strategies to strengthen or to fill gaps in current service offerings and will work with MDH to establish baseline and annual improvement targets and report progress annually. Technical Assistance providers will assist with use of technology for screening, implementation of bi-directional referrals, remote patient monitoring, and performance measure reporting. MDH will work through existing advisory councils such as the Minnesota 2035 Plan Leadership Team on Cardiovascular Health and Diabetes and the Minnesota Healthy Aging Council, which include rural hospitals, health plans, clinics, Tribal health, FQHCs and community members who bring expertise to guide initiative implementation and assess outcomes. Rural providers will engage in a statewide learning community to share progress, lessons learned, ideas and resources. Eligible providers engaging in this initiative must select at least three (3) of the following activities:

Chronic Disease screening, education, referral, and follow-up.

- Implement an innovative community-based care initiative by working in partnership with community-based partners and community-embedded frontline health care team members to implement screening, health education, referral and follow-up programs outside of clinical settings to reach at-risk populations. Outreach will include linking eligible people to enrollment in health insurance coverage, including dual enrollment in Medicaid/Medicare or screening services such as the Sage program or other programs.[xxxvi]
- Use new data technologies and team-based approaches to identify patients for screening, counseling, referral and follow-up, such as identification of those not yet seen, overdue for screening, partially screened for CKD, or who have high blood pressure or other risk factors (cancer, oral health conditions, dementia, etc.).

Chronic disease self-management in clinic and community.

- Engage in and support the development of community care hub models to provide referral to evidence-based chronic disease self-management programs such as Health Coaches for Hypertension Control and other lifestyle change programs in community settings.
- Increase use of clinic-based prevention and technology-driven remote self-management programs such as Diabetes Self-Management Education and Services (DSMES), Self-Measured Blood Pressure (SMBP) and Continuous Glucose Monitoring System (CGMS).

Physical activity, nutrition, and upstream drivers of health referrals.

- Partner with community care hubs, local public health, and community organizations to create and expand an infrastructure for bi-directional referral and follow up to address upstream drivers of health and implement policy, systems, and environmental change.
- Increase patient use of nutrition and physical activity programs. Partner with community-based programs to offer nutrition and physical activity programs such as Produce Rx for Chronic Disease Prevention, Walk with Ease and other programs.

Post-acute chronic disease care programs and support

- Collaborate with community organizations to provide social services to support recovery.
- Increase the number of patients participating in cardiac and stroke rehabilitation programs and using mobile health technologies following a cardiac/stroke event to improve patient outcomes, prevent secondary events, reduce mortality rates, and enhance quality of life.
- Increase access to telehealth specialty services following hospitalization for a cardiac event, stroke, or diabetes to increase access to care closer to home. See also initiative 4.

Main Strategic Goal	Make Rural America Healthy Again
Use of Funds	*A, C, D, F, G*
Technical Score Factors	B.1., B.2., E.2., F.1., F.2., F.3.
Key Stakeholders	Providers who select Initiative 1 may include rural hospitals, rural health clinics and primary care clinics, FQHCs, and Tribal Nations; Technical assistance providers will advise on screening, community care hub development, remote patient monitoring, and performance measure reporting; Partner organizations collaborating on

	community programs include community-based organizations and local public health departments.
Impacted Counties	This initiative has the potential to impact all 60 rural counties and two urban counties (*) that will partner with rural entities in this work; FIPS codes for these counties are: 27001, 27005, 27007, 27011, 27015, 27021, 27023, 27029, 27031, 27033, 27035, 27041, 27043, 27047, 27049, 27051, 27057, 27061, 27063, 27065, 27067, 27069, 27071, 27073, 27075, 27077, 27081, 27083, 27085, 27087, 27089, 27091, 27093, 27097, 27099, 27101, 27105, 27107, 27111, 27113, 27115, 27117, 27119*, 27121, 27125, 27127, 27129, 27131, 27133, 27135, 27137*, 27147, 27149, 27151, 27153, 27155, 27159, 27161, 27165, 27167, 27169, 27173
Estimated Required Funding	This initiative is estimated to cost $46,000,000 – $52,000,000 annually and $239,000,000 across five years.

Outcomes

Data will be collected by providers through their electronic health records (EHRs) and reported to MDH. Rural providers will establish baseline and target measures for each grant year. Provider progress toward goals will be monitored by MDH through semi-annual and annual reporting of aggregated patient data. MDH will use county-level data, where available, to monitor and evaluate the impact of RHTP investments to better assess regional variation, highlight effective strategies, and target support to needed areas. MDH does not expect to see effects until the end of year 2. The four measures will document improvements in fidelity to chronic disease screening recommendations (1.1), referrals to chronic disease self-management programs in clinical and community settings (1.2), connecting rural residents to services to address upstream drivers of health (1.3), and long-term improvements in chronic disease outcomes (1.4), and collectively lead to improved rates of cardiometabolic disease management in rural areas (key performance objective).

Initiative 1: Outcome Measures

Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
1.1 Cardiometabolic Screening	Not available at time of application	2025 baseline data reported	2 percentage point increase from baseline	4 percentage point increase from baseline	6 percentage point increase from baseline	8 percentage point increase from baseline
1.2 Chronic Disease Self-Management	Not available at time of application	2025 baseline data reported	2 percentage point increase from baseline	4 percentage point increase from baseline	6 percentage point increase from baseline	8 percentage point increase from baseline

1.3 Upstream Drivers of Health	Not available at time of application	2025 baseline data reported	2 percentage point increase from baseline	4 percentage point increase from baseline	6 percentage point increase from baseline	8 percentage point increase from baseline
1.4 Cardiometabolic Goal*	Not available at time of application	2025 baseline data reported	1 percentage point increase from baseline	2 percentage point increase from baseline	3 percentage point increase from baseline	4 percentage point increase from baseline
*** Data available at the county level to measure increases for counties where activities were implemented**						

B. Initiative #2: Recruit and Retain Talent in Rural Communities

Description:

A strong and sustainable health care workforce is foundational to the success of Minnesota's transformation efforts. Rural communities face persistent and well-documented workforce shortages that jeopardize access and outcomes for rural residents. Addressing these challenges requires coordinated investments in our people—supporting students who aspire to serve their hometowns, bringing training and education to rural areas, rooting clinical training in rural practice environments, and creating supportive systems that encourage health care professionals to serve rural residents long-term. To those ends, Minnesota proposes the following activities:

- **Introduce more high school students to health care careers** through an increase in the number of early exposure experiences like Scrubs Camps and supporting the growth of rural Health Occupations Students of America (HOSA) chapters in rural high schools to provide hands-on career exploration for youth and high-school students. These efforts, led by Minnesota State Colleges and Universities, will introduce students to high-demand careers such as Nursing Assistant, Community Health Worker, Community Paramedic, and EMT. Funds will be used to hire staff to support two new camps and six HOSA chapters each year, and to purchase simulation and training equipment and camp supplies.
- **Develop allied health pathways through "Earn and Train" programs** that allow incumbent rural workers to become apprentices and gain training and credentials for entry-level health care roles while working for rural health care employers like clinics, hospitals,

Tribal health facilities, and FQHCs. Employees will be able to work part-time, and providers will use grant funds to cover the costs of time for classes and studying, tuition and other related costs of training employees for high-demand health fields. Programs will align with local workforce needs, such as medical assistants, dental assistants, registered nurses, licensed alcohol and drug counselors, dental hygienists, radiographers, surgical technologists, respiratory therapists, paramedics, community paramedics, community health representatives, and community health workers. To ensure retention of these providers, recipients will be required to serve in rural areas for five years.

- **Expand rural clinical rotations** to expose students and medical residents to the opportunities available in rural Minnesota for health care professionals, give them a better understanding of the realities of rural practice and present them with an opportunity to develop relationships with rural practitioners that may open the doors for future employment. Physician residency programs, medical schools, and advanced practice provider training programs will be eligible applicants, and participants will spend eight to sixteen weeks at their rural rotation site. Funds will cover development costs, supervisor costs, student stipends, and in some cases, short-term housing and travel expenses.
- **Develop rural clinical training opportunities** by supporting **medical students** to experience rural health care delivery via **rotations in rural health systems.** Funds will cover rotation development costs, supervisor costs, student stipends, and in some cases, short-term housing and travel expenses. Funds will also be used to support academic-clinical partnerships to develop **residency/fellowship programs for Advanced Practice Providers (APPs) such as Advanced Practice Registered Nurses (APRNs), Physician Associates (PAs) and Psychologists** to better prepare newly licensed graduates for rural practice.

Participants will be salaried employees of rural health systems and participate in a 12-month long program with specialty clinical rotations based on local health needs, such as maternal or behavioral health, to gain exposure to the realities of rural practice, hone skills for complex clinical challenges as rural practitioners, develop tools to mitigate professional isolation, and develop overall rural clinical readiness. Graduates will be required to work in rural areas for 5 years after graduation from this program. To grow a rural-ready physician pipeline, Minnesota intends to **expand the number of rural physician residency programs** by providing funds to rural health systems to initiate the planning and development of up to 10 rural residencies or Rural Training Programs (RTPs) annually in primary care specialties. Residents will be expected to serve in rural areas for five years after their residency. Additionally, Minnesota will **develop a Family Medicine Obstetrics (FM-OB) Fellowship pilot** through the University of Minnesota Department of Family Medicine and Community Health. This will be a one-year, non-Accreditation Council for Graduate Medical Education (ACGME)-accredited fellowship for two rural family medicine physicians each year seeking additional training to prepare to practice full-scope obstetrics. The fellowships will be structured around longitudinal models with the aim of producing graduates capable of securing full operative privileges upon completion and serving as maternity care leaders in their local communities.

- **Develop a Technical Assistance Center (TAC) for Excellence in Rural Clinical Training** at the University of Minnesota Medical School. Grant funds will provide support to the TAC to transform the physician clinical training landscape in Minnesota by providing technical assistance to augment health professional clinical training capacity both in undergraduate medical education (UME) and graduate medical education (GME) to develop a pipeline of

rural-ready primary care providers. The TAC will support exploration, planning and development of rural residency programs; assist with faculty and curriculum development; provide technical assistance with ACGME site accreditation; and develop learning communities among rural physician residents and residency program directors and coordinators to increase workforce retention.

- Pilot the **Healthy Workplace strategy** with a subset of rural health systems to reduce burnout and increase work satisfaction and overall workforce retention in health systems through a five-step process that: 1) measures work conditions, 2) quantifies burnout and physiological accompaniments in providers and health care workers across Minnesota, 3) proposes pilot programs or integrates with existing value-based payment systems to reduce pressure to see too many patients in too little time, 4) uses a Learning Health System methodology to partner with health systems to perform rapid cycle improvements using evidence to quickly attenuate burnout across the system, and 5) creates within-practice, evidence-driven, culturally relevant support systems that will increase the likelihood of retention. Minnesota will award a grant to pilot this comprehensive process across 40 rural hospitals over the five-year RHTP grant period. By the end of five years, the hospitals in the pilot program will have higher retention rates, improved patient health outcomes and increased financial stability.

Main Strategic Goal	Workforce Development
Use of Funds	E. Workforce; A: Prevention and chronic disease; H: Behavioral health
Technical Score Factors	D1, C1, B1
Key Stakeholders	HealthForce Minnesota, located at Minnesota State Colleges and Universities, and rural high schools will host HOSA chapters and serve as recruitment sites for scrubs camps; FQHCs, rural hospitals, primary and specialty care clinics, Tribal Nations, and health systems will participate as sites for rotations/continuity clinics; University of Minnesota Medical School campuses will assist with rural GME development and technical assistance.

Impacted Counties	This initiative has the potential to impact all 60 rural counties, as well as six urban counties (*) that include possible subrecipients who will partner with rural providers to implement activities. FIPS codes for these counties are below. 27001, 27023, 27043, 27063, 27075, 27089, 27105, 27121, 27135, 27159, 27005, 27029, 27047, 27065, 27077, 27091, 27107, 27125, 27147, 27161, 27007, 27031, 27049, 27067, 27081, 27093, 27111, 27127, 27149, 27165, 27011, 27033, 27051, 27069, 27083, 27097, 27113, 27129, 27151, 27167, 27015, 27035, 27057, 27071, 27085, 27099, 27115, 27131, 27153, 27169, 27021, 27041, 27061, 27073, 27087, 27101, 27117, 27133, 27155, 27173, 27053*, 27109*, 27123*, 27137*, 27145*, 27163*
Estimated Required Funding	This initiative is estimated to cost $12,854,782 – $31,610,186 annually and $107,642,192 across five years.

Outcomes

Data will be collected through annual grantee progress reports submitted to MDH. MDH will reference baseline data and set annual targets for each grant year. MDH will use county-level data, where available, to monitor and evaluate the impact of the RHTP investments to better assess regional variation and impact, highlight effective strategies, and target support to areas needing additional resources. The four measures—numbers of rural high schoolers enrolled (2.1), number of new rural clinical trainees (2.2), number of participants successfully completing at least 90% of RHTP-funded training, and number of rural UME/GME TA sessions conducted (2.4)—are designed to capture changes in workforce pipeline growth and retention over time.

Initiative 2: Outcome Measures

Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
2.1 Rural high schoolers enrolled in Scrubs Camps*	280 annually	40 new campers	80 additional campers	120 additional campers	160 additional campers	200 additional campers
2.2 New rural clinical trainees (includes medical students, physician residents + APP + psychology + FM-OB fellows)	Rural residency Slots: 87 Rural clinical Rotations: 37	Planning and development underway at 16 residency sites, 1 fellowship site	20 APPs	20 APPs + 20 residents + 2 FM-OB Fellows	20 APPs + 60 residents + 2 FM-OB fellows	20 APPs + 120 residents + 2 FM-OB Fellows

Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
2.3 Participants successfully completing at least 90% of an RHTP-funded program	Data not available at this time.	40 campers	240 total: 80 campers; 120 apprentices; 20 resident rotations; 20 APPs	302 total: 120 campers; 120 apprentices; 20 resident rotations; 20 APPs; 20 residents; 2 fellows	382 total: 160 campers; 120 apprentices; 20 resident rotations; 20 APPs; 60 residents; 2 fellows	482 total: 200 campers; 120 apprentices; 20 resident rotations; 20 APPs; 120 residents; 2 fellows
2.4 Number of rural UME/GME technical assistance sessions conducted across counties*	0	Set up governance and operations; conduct environmental scan	Stakeholder engagement; TA framework development	TA to 5 recipients to increase new rural UME/GME	TA to 5 recipients to increase new rural UME/GME	TA to 5 recipients to increase new rural UME/GME
*** Data available at the county level to measure increases for counties where activities are implemented**						

C. Initiative #3: Sustain Access to Services to Keep Care Closer to Home

Description

Gaps in access to primary care, pharmacy services, oral health, behavioral health, maternal health, and other core services in many rural Minnesota communities lead to longer travel times, forgone care, higher expenses for residents, and the risk of worse health outcomes. To sustain access to core services in rural communities, this initiative encompasses technology-focused solutions, mobile care delivery, and integration of underused, community-embedded frontline health care team members such as community health workers (CHWs), community health representatives (CHRs), doulas, peer support specialists, and community paramedics in community and clinical settings in a financially sustainable way. These roles enhance care delivery and health education by providing support for community or home-based screenings, preventive care, chronic disease management, home visiting services, prenatal and postpartum follow-up visits in communities with limited access to these services and identifying and helping to address upstream drivers of health. Minnesota will enhance integration of these positions into

health care delivery in the following activities. Eligible organizations that use funds to implement this initiative will select at least one (1) of the following activities:

- **Implement or expand models that integrate frontline staffing into care settings** such as clinics and community-based organizations to broaden the set of providers poised to meet community needs. Eligible rural organizations will receive funds to develop administrative structures to embed positions such as CHWs using the IMPaCT or pathways hub models, doulas, community paramedics, CHRs, or peer support specialists into care teams. Funds will be used to establish operating procedures, administration, scope of practice, collaboration and professional development opportunities that support sustainability, and will not be used for reimbursable services. These workers address barriers to care in rural communities with home visits, health assessments, medication review, care coordination, and preventing avoidable emergency department visits and hospital readmissions. They provide cost-effective support that helps patients manage health concerns before they escalate.
- **Provide technical assistance to organizations interested in frontline workforce investment** that will guide the development of sustainable organizational and financial practices. The State will contract with a technical assistance vendor to provide this support. Organizations eligible for this TA include rural providers and organizations that would like to create new frontline staffing models or need significant support to modify existing programs that are not yet sustainable. TA will focus on building business plans, developing administrative infrastructure related workflows, and ensuring accurate documentation and billing methodologies for sustainable reimbursement.
- **Support Community-based Mental Health Postvention Programs** to invest in a train-the-trainer model to build community-based resources that are available to support family and

community members after a trauma. This model includes training up to six licensed mental health professionals under the National Alliance on Mental Illness Connect postvention model to activate response protocols following a trauma. Funds will also be used to train staff and community partners in Mental Health First Aid. Funding will support rural CCBHCs and Community Mental Health Centers (CMHCs) to engage the community in responding to crises.

Minnesota will establish or expand community-based telehealth access points or mobile care delivery to reduce barriers to care, bridge gaps in access and improve health outcomes through the following strategies:

- **Develop community telehealth access points** in schools, pharmacies, local public health department offices or Tribal health organizations for behavioral and preventive health screenings, provider consults, remote visits, and other services. Each site will have appropriate technology infrastructure that allows patients to securely visit with a provider that is connected to the remote site. Rural clinics, FQHCs, hospitals, CCHBCs, Tribal health providers or pharmacists can act as the primary initiating provider for the telehealth location. Locations will be attended by staff able to coordinate community outreach, care coordination, and referrals. Staffing models may include CHWs, CHRs, public health nurses (PHNs), community paramedics, or other staff who provide care, screenings, and/or care coordination/navigation between clinical and community partners, allowing clinicians to work at the top of their license. Funding will be made available through a competitive grant program and will include community-based organizations or schools that provide the sites for screenings, local public health, and the payor organization that provides the connection to primary care providers for follow-up.

- **Provide local care delivery with mobile units for physical or oral health**. Mobile medical services equipped with telehealth technology can reach more community members with in-person physical examinations or specialty medical services. Mobile health care vans will visit schools, community centers, Head Start sites, nursing homes, Tribal Nations, and other rural venues. Staffed primarily by nurses or advanced dental therapists or dental hygienists operating under collaborative practice agreements, the mobile units will provide screening, primary and preventive care, delivery of lab work, basic restorative dental care, and referrals for patients needing further treatment. In addition to receiving services directly in the mobile unit, patients may also link to specialists via telehealth. FQHCs, other clinics, and Tribal health organizations will serve as hubs for referrals from hospitals, primary care clinics, the mobile units, and community partners.

  Mobile units will expand hours and staffing to accommodate an increased volume of patients and may function as a training site for nurses, dental professionals, hygienists, or frontline workforce. The mobile delivery model offers opportunities to build the frontline workforce, reducing the burden on the limited number of rural health care professionals; expand the reach of a rural practice; provide physical and oral health support to community members; direct care away from emergency departments; and provide a flexible and cost-effective alternative to constructing new facilities that may not be sustainable over the long-term.

Main Strategic Goal	Sustainable Access, Innovative Care
Use of Funds	A, C, E, G, I, J
Technical Score Factors	C.1, F.1, F.3
Key Stakeholders	Rural hospitals, clinics, FQHCs, community mental health centers, CCBHCs, local public health, pharmacies, schools, Tribal Nations, community-based organizations
Impacted Counties	This initiative will impact all 60 rural counties, as well as five urban counties (*) that include possible subrecipients who will partner with rural providers to implement activities. FIPS codes for these counties are below. 27001, 27023, 27043, 27063, 27075, 27089, 27105, 27121, 27135, 27159, 27005, 27029, 27047, 27065, 27077, 27091, 27107, 27125, 27147, 27161, 27007, 27031, 27049, 27067, 27081, 27093, 27111, 27127, 27149, 27165, 27011, 27033, 27051, 27069, 27083, 27097, 27113, 27129, 27151, 27167, 27015, 27035, 27057, 27071,

	27085, 27099, 27115, 27131, 27153, 27169, 27021, 27041, 27061, 27073, 27087, 27101, 27117, 27133, 27155, 27173, 27053*, 27123*, 27109*, 27137*, 27145*
Estimated Required Funding	This initiative is estimated to cost $13,248,772 – $33,807-067 annually and $113,787,724 across five years.

Outcomes

Data will be collected by grantees through EHR reporting and grantee reports. MDH will work with grantees to establish baselines and monitor progress quarterly and data quality annually. MDH will use county-level data, where available, to monitor and evaluate the impact of the RHTP investments to better assess regional variation and impact. For most of the activities, year 1 will be used for implementation planning by the grantees. Together, the four measures selected—number of new telehealth sites (3.1); number of mobile vans for rural areas (3.2); rural patient encounters (3.2); and integration of rural frontline workers (3.4)—will reflect progress in expanding and sustaining access to core services for rural residents.

Initiative 3: Measures

Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
3.1 Number of <u>new</u> community-based rural telehealth access points*	0	Grants awarded & implementation planning underway	4 new sites	4 additional sites	4 additional sites	4 additional sites
3.2 Number of mobile units for rural areas*	0	Grants awarded and implementation planning underway	8	8	8	8
3.3 Rural patient encounters*	0	Grants awarded and implementation planning underway	100	150	200	250
3.4 Number of sites implementing programs employing allied health staff*	Est. 0-3	Grants awarded and implementation planning underway	8	8	8	8
*** Data available at the county level <u>to measure increases for counties where activities are implemented</u>**						

D. Initiative #4: Create Regional Care Models to Improve Whole Person Health

Description

Establishing or strengthening partnerships between provider organizations and between providers and other community organizations is critical for sustaining a well-trained workforce, building clinician skills to deal with infrequent but complex care needs, and addressing geographic access

gaps. This initiative will support establishment and deepening of collaborative regional activities to improve access to timely and appropriate health care, with a focus on essential obstetrics and mental health services. Health care providers and rural communities will receive funds to develop provider-to-provider telehealth linkages that provide access to professional services not available in the immediate community and connect primary care providers to specialist expertise when needed; develop sustainable models for urgent and emergency medical and behavioral health care services; and foster provider-to-provider learning and support networks using simulation training for obstetrics and ECHO programs to improve clinical knowledge, reduce professional isolation, and strengthen the quality of care in underserved regions. The activities proposed in this initiative will encourage development of collaborative care models that address emergency response through follow-up treatment and pathways to allow patients to keep close to home. Eligible organizations engaging in this initiative will select at least one (1) of the following activities:

- **Establish and strengthen telehealth connections between rural hospitals, clinics, Tribal health, FQHCs, and specialists or subspecialists** to expand access to specialty expertise for time-sensitive and complex cases. This activity focuses on establishing provider-to-provider consultation and clinical collaboration through secure telehealth platforms to access real-time or scheduled consultations with child and adolescent mental health providers, obstetricians, perinatologists, psychiatrists, neurologists, cardiologists, and other subspecialists, reducing the need for rural patients to travel for that expertise. Funding will be available on a competitive basis for providers to purchase and install telehealth equipment or credential new providers to bring services to their hospital.

- **Pilot a system to compensate ambulance services for 911 responses that result in patient contact but do not require transport to an emergency department** when care-in-place strategies are appropriate. Currently, ambulance services only receive reimbursement when a 911 call results in transferring a patient to an emergency department. Runs that do not result in an emergency department visit are not reimbursed for any services provided to the patient. Covering the cost of treatment-in-place will reduce unnecessary emergency department visits and support patients in their home. This work will be led by the Minnesota Office of Emergency Medical Services (OEMS) and funds will be used for treatment-in-place based on a combination of historical non-transport call data, project conversions, and applications from interested rural ambulance providers.
- **Support the building of a Children's Mental Health Initiative.** Funding will be awarded via grants to consortia coming together to regionally coordinate children's mental health crisis services and support children's mental health. Through a competitive grant program, rural counties and other entities will coordinate children's mental health crisis services across the region. Modeled after the Adult Mental Health Initiative model and adapted for children's services, eligible activities will include hiring regional planners, purchasing technology to improve access to services and support networks, and training the workforce on specific models of care.
- **Develop new mental health urgent care centers** to provide supportive alternatives to jail or hospitals for individuals experiencing a mental health or substance use crisis. Mental health urgent care centers provide individuals a place to safely de-escalate and/or receive assessments with on-site clinical support. They are available when individuals voluntarily recognize the need for urgent care, or individuals may be brought to the center by families or

friends, law enforcement or EMS. Once the individual is stabilized, the centers connect with an individual's current primary care provider or go through intake with them to establish care with a CCBHC. The urgent care model option includes development as an integrated substance use disorder/opioid use disorder crisis urgent care center, which could offer an alternative or supplemental support for withdrawal management in regions of the state where it is not available. Funding will be granted to up to three CCBHCs or CMHCs to be used for planning, development and implementation of new mental health urgent care centers.

- **Implement a Project ECHO network to connect rural primary care providers with mental health specialists** through virtual, case-based learning and mentorship. This model, led by an organization that will be selected via a competitive grant process, builds the skills and confidence of rural physicians, nurse practitioners, and physician associates who often serve as the main access point for mental health care. By expanding local expertise and linking providers to regional behavioral health resources, the network will strengthen and sustain rural mental health care capacity.
- Develop a **Rural Telehealth Services Center i**n Minnesota that oversees and coordinates the development of **regional telehealth hubs** that include smaller facilities and allow connections to specialty services; build data-driven referrals, EHR integration, and shared digital infrastructure; deliver a rural telehealth learning network**,** remote continuing education, and remote precepting; and implement co-investment and performance-based agreements for long-term financial stability. Funds will be awarded competitively to an organization that will plan and implement a telehealth resources center that will expand specialty access and support the rural workforce through innovation, training and shared

infrastructure. Future telehealth services delivered through this model will be those covered by established payment mechanisms and are not part of this grant.

- **Expand access to Medications for Opioid Use Disorder (MOUD)** in rural Minnesota with Strengthening Rural Pathways to MOUD (SRP-MOUD). This activity will use funds to expand access to MOUD across rural Minnesota through telehealth, provider training, and coordinated linkage to care to ensure every rural Minnesotan has a clear and sustainable pathway to recovery from substance use disorder. Emergency departments and EMS will be equipped to initiate MOUD in the acute-care setting and connect patients directly to ongoing treatment through primary care, community providers, or telehealth, eliminating delays to life-saving medication. By building a connected, low-barrier system, SRP-MOUD will close the rural treatment gap, strengthen continuity of care, and improve recovery outcomes.
- **Provide bridge grants to eligible hospitals or birthing centers** that will allow facilities to engage in planning efforts for balancing service line sustainability with regional population needs. Eligible sites must meet the following criteria: serve individuals enrolled in state and federal medical assistance programs; be in financial distress or at risk of eliminating labor and delivery services due to a low volume of deliveries at the hospital; be located in a HPSA; be located in a municipality with a population of less than 50,000; be located at least 35 miles from the nearest hospital providing labor and delivery services; and have had fewer than 200 births in the previous calendar year according to state records. The grants will model a population-based payment, and MDH will work with a technical assistance consultant to assess results and develop a population-based reimbursement methodology for making appropriate payments for maintenance of essential capacity for services with low volumes and high fixed costs. Providers funded through bridge grants will offer a provider-informed

pathway to addressing labor and delivery services across rural regions of the state. MDH will use the outputs from each grant to inform strategies to ensure labor and delivery services are available in a region that is otherwise at risk of becoming an OB desert.

- **Build rural obstetrics skills through high-fidelity simulation led by physician faculty** who will be supported through grant funds to the MN ROSE (Rural Obstetrics Simulation and Education) Program operated out of Community Memorial Hospital, a 25-bed critical access hospital located in Cloquet, MN. Funding will support two physician trainers who will use Minnesota's two high-fidelity mobile obstetrics simulators (RealMom Plus and C-Celia Emergency Obstetrics Suite) to provide scenario-based obstetrics skills training to providers at their practice sites, which are largely rural, low-volume birthing hospitals. The current program lacks dedicated physician support to meet demand. These physician instructors will enhance the training to meet continuing medical education requirements when providing skills training and running practice drills with physicians, residents, nurses and support staff to enable them to maintain necessary skills in labor and delivery at rural hospitals.
- **Implement an ECHO network that encompasses maternal health from prenatal through delivery to postpartum care**. ECHO is a virtual tele-mentoring program that connects local health care providers with specialists using a model called case-based learning. The network will be led by an organization that will be selected via a competitive grant. The topics this ECHO will cover include managing complex conditions during pregnancy, such as hypertension, perinatal mood disorders, substance use disorders, care coordination, postpartum depression, and other indicators of maternal morbidity and mortality. This ECHO will maintain a focus on case-based learning that is specific to rural

populations. Participants will learn from expert-led didactic presentations and discuss their own patient cases to gain new skills and implement evidence-based recommendations.

Main Strategic Goal	Sustainable Access
Use of Funds	D, E, F, G, I, J
Technical Score Factors	B.1, C.1, C.2, F.1
Key Stakeholders	Rural hospitals, rural health clinics, primary care clinics, EMS providers, Tribal Nations, community-based organizations, health care training organizations.
Impacted Counties	This initiative has the potential to impact all 60 rural counties, with the potential for positive impacts in selected urban counties based on locations that implement these activities. FIPS codes for these counties are below. 27001, 27023, 27043, 27063, 27075, 27089, 27105, 27121, 27135, 27159, 27005, 27029, 27047, 27065, 27077, 27091, 27107, 27125, 27147, 27161, 27007, 27031, 27049, 27067, 27081, 27093, 27111, 27127, 27149, 27165, 27011, 27033, 27051, 27069, 27083, 27097, 27113, 27129, 27151, 27167, 27015, 27035, 27057, 27071, 27085, 27099, 27115, 27131, 27153, 27169, 27021, 27041, 27061, 27073, 27087, 27101, 27117, 27133, 27155, 27173
Estimated Required Funding	This initiative is estimated to cost $15,961,960 – $46,676,505 annually and $228,800,375 across five years.

Outcomes

Data will be collected through established state data sources or by grantee reporting as needed. MDH will work with participants to establish baselines and annual targets and will monitor progress and data quality regularly. MDH will use county-level data, where available, to monitor and evaluate the impact of the RHTP investments to better assess regional variation and impact. The four measures noted below—rural health care entities engaged in provider-to-provider telehealth consultation (4.1), rates of ambulance transportation to emergency departments for unnecessary visits (4.2), number of patients prescribed MOUD in rural counties (4.3), and providers trained through the Rural Obstetrics Simulation program (4.4), collectively measure regional care models to deliver whole person care to rural residents.

Initiative 4: Outcome Measures

Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
4.1 Rural health care entities engaged in provider-to-provider telehealth consultation	To be documented Q1 2026	4 additional entities	4 additional entities	4 additional entities	4 additional entities	4 additional entities

4.2 Rates of rural ambulance transportation to emergency departments for unnecessary visits	To be documented Q1 2026	Treatment-in-place protocols learned & applied	Skills with telehealth access for remote access assistance developed	4% reduction from baseline	6% reduction from baseline	8% reduction from baseline
4.3 Patients prescribed MOUD in rural counties	To be documented Q1 2026	1% increase from baseline	2% increase from baseline	3% increase from baseline	4% increase from baseline	5% increase from baseline
4.4 Providers trained through Rural Obstetrics Simulation program, with at least 2 trainees per county*	0 providers	SIM faculty hired & trained	20 new trainees	20 new trainees	20 new trainees	20 new trainees
*** Data available at the county level to measure increases for counties where activities will be implemented**						

E. Initiative #5: Invest in Technology, Infrastructure, and Collaboration for Financial Viability

Description

Many rural providers struggle financially under cost-based reimbursement and low patient volumes, and they lack resources to invest in technology, data infrastructure, or new models of operation that could chart a path to a more stable future. Sustaining rural provider financial health is critical to sustaining access to care for rural residents.

Rural providers need different options and pathways to improved financial viability. Some providers are joining together in formalized partnerships, such as clinically integrated networks, that are characterized by strong governance, infrastructure to share data, and coordinated clinical operations. These partnerships offer the opportunity for small rural hospitals to leverage economies of scale in clinical operations and move toward participation in alternative payment models. Many small rural hospitals have expressed the need for technical assistance in exploring the potential benefits and costs for their hospital of alternative payment models, but they lack the upfront resources required to move forward on their own.

Other providers are working independently or in other types of collaborative arrangements to avail themselves of data and technology to both improve the quality of patient care and bolster their financial health. Tools such as artificial or augmented intelligence (AI) have the potential to

improve efficiency of clinical operations, allowing providers to care for more patients and focus more clinical staff time on patient care rather than documentation. Software tools can help providers identify and proactively coordinate care for high-risk patients, improving outcomes for patients and helping avoid costly hospital admissions or readmissions. Investments in these tools can be costly. Minnesota will use its RHTP funding to strengthen rural sustainability by providing resources to providers needing investments in technology and data infrastructure to sustain an independent practice or work together in clinically integrated networks and other collaborative arrangements. Eligible organizations electing to use funds to implement this initiative will select at least one (1) of the following activities:

- **Supporting the acquisition of data management software, licenses or technical assistance and skill-building for health care providers, to boost capabilities for internal data management and utilization needs,** increase efficiencies and improve quality of care and financial performance. Either individually or as part of a collaborative effort, rural providers will have the ability to purchase, license or upgrade a technical solution platform for data management and utilization that integrates clinical, claims, pharmacy, and lab data. Platforms may support data visualization, performance improvement, and other metrics for population health management and the necessary technology to integrate software with EHRs and clinical processes. Investments could also include participation in the Department of Human Services Encounter Alert System (EAS) or similar available commercial tools, which alert participating providers about hospital admissions, discharges, or transfers for their patients. The enhanced capabilities of these systems can facilitate improved patient care with functionality such as building AI-informed clinical insights into emergency department workflows, providing insight into patient health history with alerts at critical moments in care

delivery. Providers will receive technical assistance to support onboarding, development of standardized workflows, process improvement and troubleshooting during and after implementation. The State will invest in a technical assistance contract to assist MDH in reviewing proposals submitted by rural hospitals, clinics, FQHCs, CCBHCs, and Tribal Nations to ensure appropriate selection of software.

- **Providing funding to rural health care providers to leverage a range of AI applications to improve the efficiency of clinical operations and increase the capacity for clinical staff to work at the top of their license**. CCHBCs and Community Mental Health Centers can use AI tools to automate intake, assessments, and charting, which will save patients time and travel, reduce the wait between intake assessments and first appointments, allow providers more time for direct care and treatment, and support integration of EHRs with data warehouses to facilitate the use of analytical tools. Rural hospitals and FQHCs can also leverage AI tools for enhanced provider notes, diagnostics, advanced care coordination capabilities, and coding and billing strategies. Other uses include virtual scribes, used with patient consent, or AI embedded in EHRs to flag patients with gaps in care, recent emergency department or inpatient discharge, failed prescription refills or other elevated risk scores. These investments will free providers to see more patients in clinic without a significant increase in paperwork, give patients increased access to care, and improve provider job satisfaction by allowing them to focus on direct patient care.
- **Creating efficiencies for rural hospitals, clinics, FQHCs, and Tribal Nations through software tools to promote centralized care coordination and scheduling functions**. These platforms streamline clinical workflows and allow providers to prioritize high-impact tasks,

automate repetitive functions such as reminders and documentation, and use predictive analytics to identify rising-risk patients earlier and proactively intervene.

- **Investing in cybersecurity for eligible entities as a necessary tool for safe and secure operations of advanced technologies** to ensure protection of patient data. Investments may include cyber security and network penetration testing, simulated cyber-attacks, and follow-up support to ensure internal and external networks are secure.
- **Investing in revenue cycle management tools** so rural hospitals, FQHCs, other clinics, and Tribal Nations can automate and optimize billing, coding, claims processing, and payment collection, thus reducing denials, identifying errors, predicting reimbursement delays, and improving overall financial performance for health care organizations. EHR integration streamlines data inputs and uploads, reduces errors when data points are transferred, and supports automated quality measurement and reporting, increasing accuracy. Funds will support software license fees, set up and integration of new technology, and staff training.

This initiative will also support investment in a secure statewide integrated rural health data network to modernize rural health data infrastructure to support real-time clinical and referral data sharing across health care, public health, and community settings. This statewide effort will allow the use of data from rural providers for population health and quality improvement measures, ensuring rural providers can fully participate in statewide quality improvement initiatives and alternative payment arrangements while maintaining efficient, secure workflows.

Main Strategic Goal	Innovative Care and Tech Innovation
Use of Funds	D, F, I
Technical Score Factors	B1, C1, E2, F2
Key Stakeholders	Rural hospitals, FQHCs, Tribal Nations, rural health systems and clinics will receive funding to make IT investments. Rural clinical staff will benefit from making their work more efficient. Rural patients will have greater opportunity to receive care due to increased provider capacity to provide patient care.
Impacted Counties	This initiative has the potential to impact all 60 rural counties, with some activities possibly having broader positive effects in urban counties depending on how they

	are implemented. MDH will monitor scope of impact. FIPS codes for these 60 rural counties are below. 27001, 27023, 27043, 27063, 27075, 27089, 27105, 27121, 27135, 27159, 27005, 27029, 27047, 27065, 27077, 27091, 27107, 27125, 27147, 27161, 27007, 27031, 27049, 27067, 27081, 27093, 27111, 27127, 27149, 27165, 27011, 27033, 27051, 27069, 27083, 27097, 27113, 27129, 27151, 27167, 27015 , 27035 , 27057 , 27071 , 27085 , 27099, 27115, 27131, 27153, 27169,27021, 27041, 27061, 27073, 27087, 27101, 27117, 27133, 27155, 27173
Estimated Required Funding	This initiative is estimated to cost $50,872,297 – $70,220,442 annually and $307,081,517 million across five years.

Outcomes

Data will be collected through grantee reporting. MDH will work with participants to establish baselines and will monitor progress and data quality regularly. MDH will use county-level data, where available, to monitor and evaluate the impact of the RHTP investments to better assess regional variation and impact. The four measures noted below, related to the extent to which rural providers are using RHTP funded technology and the benefits of these technologies, are designed to capture the positive return on the state's investments in technology and infrastructure in driving efficiency and stabilizing rural provider financial viability.

Initiative 5: Outcome Measures

Measure	Baseline	Year 1	Year 2	Year 3		Year 4	Year 5
5.1 Number of providers that implement technology to support patient care, clinical & organizational decision-making*	TBD via annual value-based health care assessment tool; grantee reports	Tech & data systems procured, deployment underway	Limited integration across systems	5% increase in providers attain fully developed integration		7% increase in in providers attain fully developed integration	10% increase in providers attain fully developed integration
5.2 Number of providers that advance implementation of population health management tools to improve care*	TBD via annual value-based health care assessment tool; grantee reports	Tech & data systems procured, deployment underway	Limited integration across systems	5% increase in providers attain fully developed integration		7% increase in in providers attain fully developed integration	10% increase in providers attain fully developed integration
5.3 Increase in number of providers reporting use of analytic tools to	TBD via annual value-based health care	Pre-intervention Baseline data collected	Year one post intervention data collected	5% of providers report increases	10% of providers report increases	15% of providers report increases	

identify high risk patients	assessment tool						
5.4 Providers reporting increase in encounters per clinician due to technology and workflow improvements	Pre-intervention grantee reporting	Tech & data systems procured, deployment underway	Integration& optimization of tech tools	5% of providers report increases		10% of providers report increases	15% of providers report increases
* Data available at the county-level to measure increases for counties where activities were implemented							

IV. Implementation Plan & Timeline

The implementation plan demonstrates the overall implementation of the project's operating structure and program set-up, and specific stages for each initiative that demonstrate progress. This RHTP application was supported by an Interagency Workgroup with representation from the Office of Governor Walz, Minnesota Management and Budget (MMB), Department of Human Services (the State Medicaid Agency), and MDH Office of Rural Heath and Primary Care (ORHPC). The workgroup consulted Tribal Health Directors and coordinated input with Tribal Liaisons at MMB and MDH Office of American Indian Health.

The governance strategy for RHTP implementation will continue to focus on strong stakeholder and interagency engagement. MDH will remain the lead agency for overall grant management and initiative implementation. The program will be managed by an RHT Program Director supported by the interagency workgroup, which will serve as an overall governance body, and multiple advisory bodies that will ensure strong stakeholder involvement through existing committees, primarily the Rural Hospital Flexibility Advisory Committee and the Health Care Workforce and Education Committee. The Program Director, supported by agency leadership, will work with the interagency workgroup and program staff to coordinate subject matter experts on specific initiatives and activities as well as measurement, compliance, and initiative evaluation and will guide the tracking of metrics across agencies, coordinating cross-agency

work, ensuring funding is used effectively and efficiently, and implementing coordinated outreach to legislators and stakeholders.

Inclusive of the Program Director, Minnesota will hire a total of 26 FTE staff to implement its RHT program. Key personnel and team members include:

Role(s)	FTEs	Description
RHT Program director	1	Responsible for overall program oversight and management.
Compliance team	4	Two dedicated FTEs in the MDH financial management office, one dedicated attorney, and one management analyst within the Office of Rural Health and Primary Care (ORHPC) focused on ensuring compliance with all state and federal requirements related to the RHT Program.
Evaluation and Learning team	5	One dedicated FTE at MDH and one at MMB to focus on developing and implementing MN's evaluation framework; three FTEs at MDH to lead efforts to share learnings and best practices across rural MN communities. This work will be supported by an evaluation contractor and facilitator for regional convening sessions.
Program implementation team	16	One RHT Program supervisor, 10 dedicated grant managers and grant specialists to focus on procurement, grant development and implementation, 5 planners to support program development across the five initiatives. MDH will also use a competitive procurement process to identify and contract with an external contractor to assist in position and program development and overall project management for the first six months of the program.

This implementation plan provides details, by initiative and year, to describe how Minnesota will move ahead on successful implementation of this program. The timeline assumes that Year 1 will start in Q2 of the federal fiscal year (January 1, 2026).

	Operations and Program Structure
Year 0	• Stage 1. Initial planning is underway to prepare for project kick-off. Implementation plan and staffing structure complete by 12/31/25. • Milestone: By FFY 26 Q2, in coordination with agency partners (Finance, Procurement, HR, Legal), agency RHTP staffing plans are in place; RFPs and contract templates are developed for prospective grantees. • Stage 2. Build on outreach meetings held during application planning to share final projects proposed in RHTP application with stakeholders and invite input on refining implementation strategies by December 15, 2025. • Stage 2. Plan with partners for establishing baseline data for each metric. • Milestone: Develop process and timelines for Letters of Intent and other application materials by December 31, 2025 for rural providers eligible to participate in initiatives.
Year 1	• Stage 1. Hire state FTEs beginning in FFY 26 Q2. • Stage 1. Work with state agency partners to build project implementation and reporting readiness. • Milestone: Complete hiring of grant staff by end of Q3 (June 30, 2026). • Milestone: Procure/sign contracts with external resources to support program launch and implementation activities in Q2. • Milestone: Finalize and launch application for rural providers that may apply to participate in the grant by January 15, 2026. • Stage 1. Enter into subrecipient grant agreements with hospitals, FQHCs, CCHBCs and Tribes beginning in Q3.

	Operations and Program Structure
	• Milestone: Execute all subrecipient grant agreements by end of Q3 (June 30, 2026). • Conduct weekly meetings of interagency workgroup during Q1, moving to biweekly in Q3, and monthly for Q4 and throughout the grant period. • Stage 3. Conduct ongoing stakeholder engagement meetings. • Conduct competitive procurement for evaluation contractor in Q3. Milestone: Sign evaluation contract in Q4 and design evaluation plan. Contractor to begin design of evaluation plan in Q4. • Collect data on Year One implementation milestones in Q4 (or earlier as needed for CMS.) • Procure/sign contract with vendor to convene and facilitate learning sessions in Q4. • Milestone: Design protocols for program integrity reviews by Q2 (March 31, 2026). • Milestone: Train compliance staff on protocols by June 30, 2026. • Complete on-site program integrity reviews for subrecipients, per MDH policy by Sept. 30, 2027.
Year 2	• Stage 1. Create plan for learning sessions in Q1. • Milestone: Convene learning sessions with subgrantees and other stakeholders. • Milestone. Create evaluation data collection plan for all measures in Q1. • Stage 3. Conduct ongoing stakeholder engagement meetings. • Conduct on-site program integrity reviews for subrecipients as outlined in MDH policy. .
Year 3	• Stage 3. Convene learning sessions with subgrantees and other stakeholders. • Stage 3. Conduct ongoing stakeholder engagement meetings. Complete on-site program integrity reviews for subrecipients, consistent with MDH policy by September 30, 2028. .
Year 4	• Stage 3. Convene learning sessions with subgrantees and other stakeholders. • Stage 3. Conduct ongoing stakeholder engagement meetings. • Complete on-site program integrity reviews for subrecipients, per MDH policy by Sept 30, 2029. .
Year 5	• Milestone: Convene final learning sessions with subgrantees and stakeholders by Sept. 30, 2030. • Milestone: Conduct final stakeholder engagement meetings by September 30, 2030. • Milestone: Draft final report summarizing learnings and engagement by September 30, 2031. • Complete on-site program integrity reviews for subrecipients, per MDH policy by Sept. 30, 2030. .

	Initiative #1: Community-Based Preventive Care and Chronic Disease Management
Year 1	• Stage 0: RHTP Director leads program planners and grant staff; project planning underway to establish grants processes and project structures. RHTP staff engages with existing stakeholder groups for program planning. • Stage 1: Chronic disease: RHTP staff award funds to sites based on grant applications with each site following grant guidelines; Milestone: RHTP program staff will execute first cohort's contracts and grantees will begin implementation by Q2 2026; Stage 2: Cohorts form teams, conduct assessments, plan proposed interventions, purchase supplies for remote patient monitoring as necessary; establish baseline and target measures • Stage 1: 1 TA providers selected for health data consultation that supports performance measurement and implementation of work by rural providers. • Milestone: Report on baseline data. .
Year 2	• Stage 3: Cohort will continue to implement proposed programs and make progress toward goals, including increased screenings, disease self-management, upstream services referrals, and outcomes; RHTP staff will open new cohort of sites as needed. • Stage 2: TA providers continue health data and implementation consultation. • Milestone: Report on year 2 outcomes. .
Year 3	• Stage 2: Cohort continues implementation of proposed programs and make progress toward goals, including increased screenings, disease self-management, upstream services referrals, and outcomes; RHTP staff will open new cohort of sites as needed. • TA providers continue health and implementation consultation. • Milestone: Report on year 3 outcomes. .
Year 4	• Milestone: Cohort continues to scale initiatives, collect data to refine programs, develop sustainability plans; RHTP staff will open new cohort of sites as needed. • TA providers continue health data and implementation consultation.

	• Milestone: Report on year 4 outcomes. .
Year 5	• Milestone: 58 providers demonstrate improvements in health outcome measures, implement sustainability plans • TA providers continue health data consultation and capture learnings. Providers submit a final report at the end of the project period. • Milestone: Report on year 5 and overall grant outcomes. .

	Initiative #2: Recruit and Retain Talent in Rural Communities
Year 1	• Stage 0: RHTP Director and Workforce implementation staff lead program planners and grant staff; project planning underway to establish grants processes and project structures. • Stage 1: RHTP staff award funds for scrubs camps and rural high school HOSA chapter sites; apprenticeship sites; rural rotations, APP residencies, rural residencies and OB fellowships, UMN TAC and Healthy Workplace funds. Milestones: 2 rural scrubs camp locations established; 6 HOSA chapters live; apprenticeships in training by Q3 2026;infrastructure (site selection, faculty) for rural medical student rotations by Q1 2027; APP academic-clinical partnership sites identified, curricula and faculty identified; planning & development underway for rural residencies by Q3 2026; UMN TAC governance in place with plan to address needs; OB fellowship site selected by Q4 2026; procurement of retention pilot providers by Q3 2026. • Stage 2: Program evaluations underway; 140 new entry-level health care apprentices under training; 20 residents rotate at rural hospital sites by Q3 2026; 20 APPs matriculate into residency programs by Q3 2026; program directors and curriculum developed for rural residency sites. • Milestone: All award recipients report quarterly beginning first month following the end of the quarter (June, October 2026).
Year 2	• Stage 2: Workforce initiatives continue implementation and planning. New cohorts or sites identified. Milestones: 2 additional rural scrubs camp locations identified and new rural high schoolers enrolled in addition to previous cohort by Q3 2027; 6 additional new rural HOSA chapters started by Q2 2027; 140 new entry-level health care apprentice in training; 20 additional residents rotate at rural hospital sites by Q3 2027; 20 additional APPs matriculate into APP residency/fellowship programs; 10 rural sites apply for and receive ACGME accreditation by Q3 2027; 10 additional rural residency sites identified, planning and development underway by Q2 2027; FM-OB planning and development to begin FM-OB fellowship; UMN TAC stakeholder engagement and TA framework developed by Q4 2027; 10 rural health systems identified to participate in “Healthy Workplace” strategy, and implementation by Q1 2027. • Milestone: All award recipients from Year 1 and 2 report on a quarterly basis beginning first month following the end of the quarter (October 2026, January, April, June 2027).
Year 3	• Stage 3: Workforce initiatives continue implementation and planning; New cohorts or sites identified. Milestones: 2 additional rural scrubs camp locations identified; new rural high schoolers enrolled in addition to previous two cohorts; 6 additional new rural HOSA chapters started; 140 new entry-level health care apprentices; 20 additional residents rotate at rural hospital sites. Milestones: 20 APPs matriculate into residency/fellowship programs; 20 residents each match into sites 10; 10 sites apply for and receive ACGME accreditation; 10 new rural residency program sites identified, planning and development underway; 2 FM-OB fellows selected and begin fellowship by Q3 2028. • Stage 2: UMN TAC provides TA to rural residency sites as needed. • 10 additional rural hospitals/health system identified to participate in “Healthy Workplace” strategy. • Milestone: All award recipients from Years 1-3 report on a quarterly basis beginning first month following the end of the quarter (October 2027, January, April, June 2028).
Year 4	• Stage 3: Workforce initiatives continue implementation and planning; new cohorts or sites identified. Milestones: 2 additional rural scrubs camp locations identified, and new rural high schoolers enrolled in addition to previous 3 cohorts; 6 additional new rural HOSA chapters started; 140 new entry-level health care apprentices; 20 additional residents rotate at rural hospital sites; 8 APPs matriculate into residency/fellowship programs; 2 residents at sites A & B; 60 residents at 20 sites; 10 rural residency sites apply and receive ACGME accreditation; 2 FM-OB fellows selected and begin FM-OB fellowship; 10 additional rural hospitals/health system identified to participate in “Healthy Workplace” strategy.

	• Stage 3: UMN TAC provides TA to rural residency sites as needed. • Milestone: All award recipients from Years 1-4 report on a quarterly basis beginning first month following the end of the quarter (October 2028, January, April, June 2029).
Year 5	• Stage 5: New cohorts or sites identified as available. Milestone: 2 additional rural scrubs camp locations identified and new rural high schoolers enrolled in addition to previous 4 cohorts; 6 additional new rural HOSA chapters started; 140 new entry-level health care apprentices; 20 additional residents rotate at rural hospital sites; 20 APPs matriculate into residency/fellowship programs; 120 residents at 30 sites; 2 FM-OB fellows selected and begin FM-OB fellowship; 10 additional rural hospitals/health system identified to participate in "Healthy Workplace" strategy. • Stage 4: UMN TAC provides TA to rural residency sites as needed. • Milestone: All award recipients report on a quarterly basis beginning first month following the end of the quarter (October 2028, January, April, June 2030).

	Initiative #3: Sustain Access to Services to Keep Care Closer to Home
Year 1	• Stage 0: RHTP Director leads program planners and grant staff; project planning underway to establish grants processes and project structures. • Stage 1: Frontline staffing: RHTP staff award funds to selected sites based on grant applications with each site following grant guidelines; define scope of practice, referral workflows and communication; establish professional development and supervision. Milestone: RHTP staff execute first cohort's contracts and grantees begin implementation by Q2 2026. • Stage 1: TA contract: RHTP staff complete procurement process and implement contract; TA provider designs curriculum and recruits first cohort of participating organizations. Milestone: Selecting TA to serve throughout initiative by Q2 2026. • Stage 1: Community mental health: RHTP staff open applications and award to train first cohort of mental health professionals; grantees engage with community and community leaders; grantees conduct training of mental health professionals. Milestone: RHTP staff execute first cohort's contracts and grantees begin implementation by Q2 2026. • Stage 1: Telehealth access points and mobile care: RHTP staff award first cohort of awards for each type of care delivery; sites begin procurement of technology, vehicles, equipment, locations & train local staff in operations, tech security, patient support. Milestone: RHTP staff execute first cohort's contracts and grantees begin implementation by Q2 2026. • Milestone: All award recipients report quarterly beginning first month following the end of the quarter (June, October 2026).
Year 2	• Stage 2: Frontline staffing: RHTP staff and grantees adjust program as necessary based on community needs within scope of program; RHTP staff open new cohort of sites. Milestone: RHTP staff execute second cohort's contracts and grantees begin implementation by Q2 2027; first grant cohort begins providing support in their sites. • Stage 2: TA contract: begin delivering sessions by Q4 2026 with organizations developing sustainability and business plans. Milestone: First cohort in TA program pilots workflows for documentation and billing by Q2 2027. • Stage 2: Community mental health: First cohort begins training local community members, collects feedback from trained communities; RHTP staff open second cohort of mental health professional training. Milestone: RHTP staff execute second cohort's contracts and grantees will begin implementation by Q2 2027; first grant cohort provides mental health first aid in community. • Stage 2: Telehealth access points and mobile care: Grantees launch first sites, including training of workforce for all frontline staff and begin tracking utilization; RHTP staff open application for second cohort of recipients. Milestone: RHTP staff execute second cohort's contracts and grantees begin implementation by Q1 2027; first sites are operational and providing care by end of year 2. • Milestone: All award recipients from Year 1 and 2 report on a quarterly basis beginning first month following the end of the quarter (October 2026, January, April, June 2027).
Year 3	• Stage 3: Frontline staffing: RHTP staff and grantees continue to adjust based on community needs; grantees develop shared learning sessions and program highlights; RHTP staff open new cohort of sites; RHTP staff begin analyzing outcome data. Milestone: RHTP staff will execute third cohort's

	contracts and grantees will begin implementation by Q1 2028; new sites participate in frontline staffing integration and able to show community benefit by the end of year 3. • Stage 3: TA contract expands program offerings to third cohort, make course corrections based on participant feedback, showcase early pilot success on sustainability and business plans. Milestone: Second cohort pilots workflows for documentation and billing by Q2 2028; first cohort continues and begins to show reimbursement benefit of billing. • Stage 3: Community mental health: First and second cohorts provide training to local community members and collect feedback from trained communities; RHTP staff opens third grant cohort of mental health professional training. Milestone: RHTP staff executes third cohort's contracts grantee begins implementation by Q1 2028; additional communities across MN are trained in mental health first aid and are able to begin showing community benefit. • Stage 3: Telehealth access points and mobile care: Grantees launch second sites including training of workforce for all frontline staff and begin tracking utilization; RHTP staff opens application for third cohort of recipients; integration of care coordination. Milestone: RHTP staff executes third cohort's contracts and grantees begin implementation by Q1 2028; first and second cohorts are operational, tracking utilization and there is an increase in community access where sites are providing services. • Milestone: All award recipients from Years 1-3 report on a quarterly basis beginning first month following the end of the quarter (October 2027, January, April, June 2028).
Year 4	• Stage 4: Frontline staffing: RHTP staff continues analyzing outcome data; begins to prepare sustainability plans; documents lessons learned; launches final cohort of participants, if needed. Milestone: RHTP staff executes fourth cohort's contracts and grantees begin implementation by Q1 2029; cohorts 1-3 demonstrate increased care coordination at their sites. • Stage 4: TA contract: TA provider finalizes toolkits and sustainability frameworks, participants integrate strategies; begin planning for peer learning opportunities; launch third cohort of participants. Milestone: Third cohort pilots workflows for documentation and billing by Q2 2098; cohorts 1 and 2 have tangible data demonstrating benefit of billing and documentation procedures. • Stage 4: Community mental health: Cohorts 1-3 provide training to local community members & collect feedback from trained communities; RHTP staff opens final cohort (if needed) of mental health professional training; begin measuring community level crisis data. Milestone: RHTP staff to execute 4 cohort's contracts and grantees begin implementation by Q1 2029; training in cohort's 1-3 communities expands, impacting public awareness and ability to provide mental health first aid • Stage 4: Telehealth access points and mobile care: Launch third sites including training of workforce for all frontline staff and begin tracking utilization; open application for final cohort (if needed) of recipients; follow integration of care coordination; RHTP staff evaluates performance measures; begins developing sustainability strategies. Milestone: RHTP staff executes fourth cohort's contracts and grantees begin implementation by Q1 2029; sites from cohorts 1-3 are operational, tracking utilization and showing increase in community access. • Milestone: All award recipients from Years 1-4 report on a quarterly basis beginning first month following the end of the quarter (October 2028, January, April, June 2029).
Year 5	• Stage 5: Frontline staffing: All participants gather and report outcomes on improved access, reduced ED visits, increased care coordination in their communities; implement sustainability measures. Milestone: Initiative is fully implemented statewide. • Stage 5: TA contract: Publish statewide best practices and implementation guide; Milestone: Initiative fully implemented; all participants have sustainable billing practices for frontline workers. • Stage 5: Community mental health: Strengthen financial partnerships with communities and implement sustainability framework for ongoing mental health first aid training in communities. Milestone: Initiative implemented with established crisis infrastructure embedded within CCBHC and CMHC operations. • Stage 5: Telehealth access points and mobile care: Report on outcome measures including on access and cost savings; begin implementing sustainability measures; share results for long-term learning. Milestone: Initiative fully operational with mobile care/telehealth access points throughout MN. • Milestone: All award recipients report on a quarterly basis beginning first month following the end of the quarter (October 2028, January, April, June 2030).

	Initiative #4: Create Regional Care Models to Improve Whole Person Health
Year 1	• Stage 0: RHTP Director leads program staff in project planning to establish grants processes and project structures for all activities. • Stage 1: Provider to provider telehealth: RHTP staff awards funds to selected sites based on grant applications, each follows grant guidelines for procurement and installation of telehealth equipment and credentialing participating specialists; RHTP staff supports grantees in developing policies and workflows for scheduling, consultation, etc. Milestone: RHTP staff executes the first cohort's contracts grantees will begin implementation by Q3 2026 & select lead agency for telehealth hub. • Stage 1: EMS treatment in place: implement interagency agreement with MN's OEMS to develop documentation templates and reporting systems; RHTP staff award pilot funds to selected ambulance services. Milestone: The RHTP staff execute the first cohort's awards by Q3 2026 based on anticipated volumes and processed on reimbursement basis for services rendered. • Stage 1: Children's mental health: RHTP staff award funds to reginal entities/county consortia; hire regional planners and establish governance structures; initiate needs assessments in each region. Milestone: All region's awards for year 1 distributed by Q3 2026. • Stage 1: Mental health urgent care: RHTP staff will award funds to CCBHCs eligible to expand or create mental health urgent care centers; sites complete plans and engage community partners for referral pathways. Milestone: All participants receive awards for year 1 distributed by Q3 2026. • Stage 1: Mental health ECHO: RHTP staff will contract with a TA provider; design learning structure and recruit subject matter experts to support learning; develop curriculum. Milestone: TA provider procured and stage 1 activities by Q3 2026. • Stage 1: SRP-MOUD: Identify partner hospitals, EMS agencies and clinic sites; develop training materials; begin provider training and telehealth credentialling for MOUD; equip EDs and EMS to provide MOUD with grant funding to support programming. Milestone: TA provider procured to begin developing SRP-MOUD program by Q3 2026. • Stage 1: Rural OB sustainability: staff award funds to hospitals meeting low volume criteria; grantees are working on individual planning; procure TA to assist sites with planning grant. Milestone: Awards contracts go out by Q3 2026; TA provider procured by Q2 2026. • Stage 1: OB Sim: RHTP director will contract with providers of simulation training from the University of Minnesota Medical School to provide trainings in rural communities each year. Milestone: Contract with trainers executed by Q2 2026. • Stage 1: Maternal health ECHO: RHTP staff will contract with TA provider; design learning structure and recruit subject matter experts to support learning; develop curriculum. Milestone: TA provider procured and stage 1 activities by Q3 2026.
Year 2	• Stage 2: Provider to provider telehealth & telehealth hubs: RHTP staff support launching live and scheduled specialist consultations between rural and providing sites; establish regional hubs and integrate shared EHR systems; launch learning network. Milestone: first cohort begins consultations and wait times for those in rural areas of the cohort begin to decline; rural practitioners begin to gain knowledge from specialist counterparts; RHTP staff finalize second cohort's contracts and RHTP staff support beginning implementation by Q3 2027. • Stage 2: EMS treatment in place: Pilot sites continue and additional sites come on to program, as needed; monitor patient outcomes, quality and EMS system impact begins. Milestone: Ongoing first cohort's awards & second cohort awards based on anticipated volumes and processed on reimbursement basis for services rendered distributed by Q3 2027; increased rural patients are treated in place and EMS operations show beginnings of funding sustainability. • Stage 2: Children's mental health: Develop regional crisis response protocols; train staff on trauma-informed and youth-specific models of care. Milestone: Counties begin implementing cross-county coordination of crisis services for youth by Q3 2027. • Stage 2: Mental health urgent care: Awardees begin assessments, stabilization and referral for ongoing services. Milestone: Centers open with limited hours and service capacity by Q3 2027 • Stage 2: Mental health ECHO: TA provider and subject matter experts provide regular ECHO series and collect participation and satisfaction surveys from participants. Milestone: 12 ECHO sessions provided by Q3 2027. • Stage 2: SRP-MOUD: Continue coordinated MOUD initiation, referral processes, and telehealth MOUD network for providers; award second cohort of funding for providers to continue to equip

	Initiative #4: Create Regional Care Models to Improve Whole Person Health
	MOUD in rural EDs and EMS by Q3 2027. Milestone: MOUD TA provider serving 60 hours per week; rural sites are offering MOUD in EDs and in the rural field (by EMS) to patients. • Stage 2: Rural L&D sustainability: Award funds to hospitals meeting low volume criteria; grantees work on individual planning; TA to assist sites with planning grants. Milestone: Additional funding distributed by Q3 2027; TA works with each site to develop sustainability plans by Q3 2027. • Stage 2: OB Sim: UMN Medical School provides 10 trainings in rural communities each year. Milestone: All regions of MN offered OB sim training by Q3 2027. • Stage 2: Maternal health ECHO: TA provider and subject matter experts provide regular ECHO series and collect participation and satisfaction surveys from participating providers. Milestone: 12 ECHO sessions by Q3 2027. • Milestone: All recipients and contactors from Year 1 and 2 report to the RHTP staff quarterly beginning first month following the end of the quarter (October 2026, January, April, June 2027.
Year 3	• Stage 3: Provider to provider telehealth & telehealth hubs: RHTP staff will support grantees to expand connections to additional specialties; refine consultation and scheduling; integrate notes into EHRs and quality reporting; expand telehealth network participation. Milestone: Telehealth sites will secure credentialing; third cohort of telehealth provider to provider sites (if needed) contract and beginning implementation by Q3 2028. • Stage 3: EMS treatment in place providers continue treatment in place and additional sites come on to participate in the program, as needed; monitor patient outcomes, quality and EMS system impact. Milestone: RHTP staff provide ongoing awards to all participating sites based on anticipated volumes and processed on reimbursement basis for services rendered, distributed by Q3 2028; rural patients are treated in place, analyze midpoint data for cost-effectiveness and clinical outcomes • Stage 2: Children's mental health: subject matter experts, TA consultants develop regional response protocols; train staff on trauma-informed and youth-specific models of care. Milestone: Counties begin implementing cross-county coordination of crisis services for youth Q3 2027. • Stage 2: Mental health urgent care: Awardees continue providing assessments, stabilization and referral for ongoing services to rural communities; expand tele-mental health access, integrate data sharing systems. Milestone: Centers continue to open expanded hours and capacity by Q3 2028. • Stage 3: Mental health ECHO: TA provider and subject matter experts provide regular ECHO series and collect participation and satisfaction surveys from participating providers. Milestone: 12 new ECHO sessions by Q3 2028. • Stage 3: SRP-MOUD: Continue coordinated MOUD initiation, referral processes, and telehealth MOUD network for providers; award third cohort (if needed) of funding for providers to continue to equip MOUD in rural EDs and EMS by Q3 2028. Milestone: MOUD TA provider serving 60 hours/ week; three cohorts of rural sites offer MOUD in EDs and in the rural field (by EMS) to patients. • Stage 3: Rural L&D sustainability: RHTP staff award funds to hospitals meeting low volume criteria; grantees complete final plans, analyze cost and access data; TA offering sustainability assessment. Milestone: Additional funding of bridge grants distributed by Q3 2028; TA begins to develop recommendations for statewide OB sustainability by Q3 2027. • Stage 3: OB Sim: UMN Medical School provides 10 trainings in rural communities each year. Milestone: All regions of MN offered annual refresher OB sim training by Q3 2028. • Stage 3: Maternal health ECHO: TA provider and subject matter experts provide regular ECHO series, collect participation and satisfaction surveys from participants. Milestone: 12 new ECHO sessions by Q3 2028. • Milestone: All award recipients and contactors from Year 1-2 report to RHTP staff, quarterly beginning first month following the end of the quarter (October 2027, January, April, June 2028).
Year 4	• Stage 4: Provider to provider telehealth & telehealth hubs: RHTP staff evaluate patient transfers, cost savings, provider satisfaction; begin to develop sustainability strategies of shared services models; refine business model for ongoing telehealth hubs; continue learning network. Milestone: RHTP staff finalize final cohort of telehealth provider to provider sites (if needed) contract and beginning implementation by Q3 2029. • Stage 4: EMS treatment in place: EMS providers continue and additional sites come on to participate in the program, as needed; monitor patient outcomes, quality and EMS system impact; MN OEMS begins drafting policy recommendation on permanent reimbursement mechanisms.

	Initiative #4: Create Regional Care Models to Improve Whole Person Health
	Milestone: Ongoing awards to all participating sites based on anticipated volumes and processed on reimbursement basis for services rendered distributed by Q3 2029; continued treatment in place addresses access for rural patients. • Stage 4: Children's mental health: Revise draft of standardized practices and implementation; align initiative with existing adult mental health initiative in MN. • Stage 4: Mental health urgent care: Awardees continue providing assessments, stabilization and referral for ongoing services to rural communities; expand tele-mental health access and integrate data sharing systems; evaluate utilization; begin to form sustainability plans. Milestone: Centers across MN offer 24/7 coverage capacity by Q3 2028. • Stage 4: Mental health ECHO: TA provider and subject matter experts provide regular ECHO series, collect participation surveys from participants; begin planning sustainable peer to peer learning networks. Milestone: 12 new ECHO sessions provided by Q3 2029. • Stage 4: SRP-MOUD: Continue coordinated MOUD initiation, referral processes, and telehealth MOUD network for providers; award fourth cohort (if needed) of funding for providers to continue to equip MOUD in rural EDs and EMS by Q3 2029; integrate data-sharing and performance monitoring; begin sustainability planning. Milestone: MOUD TA provider serving 60 hours/week; four cohorts of rural sites are offering MOUD in EDs and the rural field (by EMS) to patients. • Stage 4: Rural L&D sustainability: RHTP staff award funds to hospitals meeting low volume criteria; TA provider develops recommendations on sustainability. Milestone: Additional funding of bridge grants distributed by Q3 2029; TA provider presents final recommendations to MDH on sustainability for future of labor and delivery by Q3 2029. • Stage 4: OB Sim: UMN Medical School provides 10 trainings in rural communities each year. Milestone: All regions of MN offered annual refresher OB sim training by Q3 2029. • Stage 4: Maternal health ECHO: TA provider and subject matter experts provide regular ECHO series and collect participation surveys from participating providers. Milestone: 12 new ECHO sessions provided by Q3 2029; begin planning sustainable for peer learning networks. • Milestone: All award recipients & contactors from Year 1 and 2 report on a quarterly basis beginning first month following the end of the quarter (October 2028, January, April, June 2029.
Year 5	• Stage 5: Provider to provider telehealth & telehealth hubs: Activity is fully operational with telehealth connection best practices available statewide. Milestone: MN Rural Telehealth Services Center is coordinating regional hubs statewide and rural providers can access provider to provider telehealth consultations by Q3 2030. • Stage 5: EMS treatment in place: RHTP staff process the final round of funding for participating EMS providers based on anticipated volumes and processed on reimbursement basis for services rendered distributed by Q3 2030. Milestone: Activity is fully operational with policy recommendations submitted by MN OEMS by Q3 2030. • Stage 5: Documented cost savings and improved access for replication statewide is developed by RHTP staff or TA consultant. Milestone: Fully operational regional networks are available in MN to respond to children's mental health crisis by Q3 2030. • Stage 5: Mental health urgent care: Awardees continue providing assessments, stabilization and referral for ongoing services to rural communities; expand tele-mental health access and integrate data sharing systems; outcomes evaluated; sustainability implemented. Milestone: Activity fully implemented with fully operational mental health urgent care centers at CCBHCs and CMHCs across rural MN by Q3 2030. • Stage 5: Mental health ECHO: TA provider and subject matter experts provide regular ECHO series, collect participation and satisfaction surveys from participating providers. Milestone: 12 new ECHO sessions provided, permanent peer learning network established by Q3. • Stage 5: SRP-MOUD: Low barrier network referral pathway development has clear project plan, quality improvement and sustainability implemented. Milestone: Activity fully implemented with MOUD TA serving 60 hours per week; four cohorts of rural sites offering MOUD in EDs and the rural field (by EMS) to patients, statewide connection to low-barrier MOUD system for providers. • Stage 5: Rural L&D sustainability: RHTP staff award final funds to hospitals meeting low volume criteria by Q3 2030. Milestone: TA provider findings available for population-based payment model.

	Initiative #4: Create Regional Care Models to Improve Whole Person Health
	• Stage 5: OB Sim: University of Minnesota Medical School provides 10 trainings in rural communities each year. Milestone: All regions of MN offered annual refresher OB sim training by Q3 2030; faculty-led rural network of trainers created • Stage 5: Maternal health ECHO: TA provider and subject matter experts provide regular ECHO and collect participation and satisfaction surveys from participating providers. Milestone: 12 new ECHO sessions provided, permanent peer learning network established by Q3 • Milestone: All award recipients & contactors from Year 1 and 2 report to RHTP staff quarterly beginning first month following the end of the quarter (October 2029, January, April, June 2030).

	Initiative #5: Invest in Technology, Infrastructure, and Collaboration Needed for Financial Viability
Year 1	• Stage 0: project planning is underway to establish grants processes and project structures. • Stage 0: MDH begins to document qualifications and duties for Health Information Technology (HIT) Advisory vendor. • Stage 1: Conduct procurement process beginning in January 2025 and award a contract to qualified vendor with expertise in health IT, rural health systems, and value-based care. Develop plan for review of technology proposals from rural providers. Milestone: HIT contractor begins review rural provider technology proposals. • Stage 1: MDH works to establish detailed measure specifications and data reporting requirements for Initiative #5 measures. Milestone: MDH collects baseline data by September 30, 2026. • Stage 1: 25 sites begin procurement for technology tools by September 30, 2026. • Stage 2: 10 sites procure automated revenue cycle management tools by September 30, 2026. • Stage 1: Develop requirements by end of Q2 for Statewide Integrated Data Network for competitive RFP & begin procurement process in FFYQ4.
Year 2	• Milestone: Award contract to build the Statewide Integrated Data Network by December 31, 2026. • Stage 2: MDH HIT Advisory vendor continues to review provider IT proposals. • Stage 2: 40 hospitals/clinics begin implementation of data management infrastructure advanced applications of admission/discharge/transfer alert system. • Stage 1: 25 additional sites begin procurement for technology tools. • Stage 2: 50 providers begin implementation of technology tools. Milestone: MDH collects Year One measure data by Sept 30, 2027. • 10 sites begin implementation of automated revenue cycle management tools.
Year 3	• Stage 3: Vendor building the Statewide Integrated Health Network continues IT build consistent with its workplan. • Stage 3: MDH Health IT Advisory vendor continues to review provider IT proposals. • Stage 3: 20 sites hospitals/clinics reach halfway point of implementation of data management infrastructure and EAS integration with other sites still working toward halfway point. • Stage 3: 25 sites (hospitals, clinics, FQHCs, CCBHCs, CMHCs, and Tribal Health) reach halfway point of implementation of technology, AI tools, and cybersecurity for case management, EHR integration, efficiency tools, care coordination, and intakes. • Milestone: MDH collects Year Two outcomes data by September 30, 2028. • Stage 3:10 sites reach halfway point of implementation of automated revenue cycle management tools by providing funding.
Year 4	• Stage 4: Vendor building the Statewide Integrated Health Network continues IT build consistent with its workplan. • Stage 4: MDH Health HIT Advisory vendor continues to review provider IT proposals. • Stage 4: 20 hospitals/clinics complete implementation of data management infrastructure and EAS integration, refine workflows and processes • Stage 4: 10 sites (hospitals, clinics, FQHCs, CCBHCs, CMHCs, and Tribal Health) complete implementation of technology, AI tools, and cybersecurity for case management, EHR integration, efficiency tools, care coordination, and intakes, refine workflows and processes ○ Milestone: MDH collects Year Three outcomes measure data by September 30, 2029.

	Initiative #5: Invest in Technology, Infrastructure, and Collaboration Needed for Financial Viability
	• Stage 3: 10 sites reach halfway complete implementation of automated revenue cycle management tools by providing funding and begin process improvement for workflows.
Year 5	• Stage 5: Statewide Integrated Health Network contractor completes IT build and moves forward with its launch of public facing dashboards. • Stage 5: MDH Health IT Advisory vendor continues to review provider IT proposals and provides advice to MDH on sub-recipient sustainability plans. • Stage 5: 20 hospitals/clinics complete implementation of data management infrastructure and EAS integration, refine workflows and processes • Stage 5: 10 sites (hospitals, clinics, FQHCs, CCBHCs, CMHCs, and Tribal Health) complete implementation of technology, AI tools, and cybersecurity for case management, EHR integration, efficiency tools, care coordination, and intakes. • Stage 5:10 sites complete implementation of automated revenue cycle management tools. Milestone: MDH collects Year Four outcomes measure data by September 30, 2030.

V. Stakeholder Engagement

Minnesota's application and program development involved an extensive stakeholder engagement process. We issued a request for public comment from September 9 – September 26 to seek input on the five strategic priorities laid out by CMS. We received 344 responses from individuals and organizations representing 77 of Minnesota's 87 counties and held more than 40 meetings with a wide range of stakeholders including rural hospital systems and CEOs, Tribal health leaders, organizations representing rural clinics, behavioral health providers and FQHCs, and community organizations. A number of those organizations wrote letters of support, which are attached to our application. MDH created a website to share information about the program and a mechanism for interested parties to subscribe for email updates.

The Governance strategy for RHTP implementation will continue to focus on strong stakeholder and interagency engagement. Minnesota will ensure that stakeholders from across rural Minnesota, including but not limited to rural residents and patients, rural providers, community based organizations in rural areas, local departments of health, and Tribal health providers, are consistently engaged in and have an opportunity to both contribute to and learn from the activities funded as part of this work to promote transparency, accountability, and continuous improvement and to help sustain and spread effective models beyond the grant period. As part of

our engagement framework, we will employ the following approaches to engage stakeholders over the five years of funding:

- The MDH RHTP website and email distribution list will be used to engage the public and share information about future webinars and learning opportunities, offer forums for feedback and identify upcoming competitive funding opportunities.
- We will regularly update, and seek input from, a wide range of existing advisory bodies and councils that are already in place in Minnesota. These include but are not limited to the statewide Rural Health Advisory Committee, eHealth Advisory Committee, Rural Hospital Flexibility Program Committee, Statewide Community Health Services Advisory Committee, the Healthy MN Partnership, and the Healthcare Workforce and Education Committee.
- The Minnesota RHTP team will provide regular updates to legislative committees on health and human services and ensure that legislators have the opportunity to provide insights into this work based on priorities in their districts, have information to propose potential policy changes, and can exercise any necessary oversight.
- We will convene multiple learning opportunities and regional meetings, including both initiative-specific learning collaboratives and regional or community meetings with a broader focus, to bring together providers, community members, and others who are involved in or impacted by RHTP activities to share learnings and best practices and to support a broad statewide effort to expand successful RHTP activities to new communities and settings.

As noted in the implementation plan (Section IV), the interagency group (including ORHPC, MMB, the State Medicaid agency, Tribal Health Liaison and others) will provide ongoing guidance and direction to this work and use their own relationships and advisory bodies to share information and learning.

VI. Metrics and Evaluation Plan

Performance Objectives and Strategic Alignment

Minnesota has deep expertise in collecting high-quality data and maintaining strong systems that support meaningful performance, goal-setting, monitoring, and rigorous evaluation of program implementation and impact. This foundation positions Minnesota to meet CMS's call for "system-wide transformation and sustainable impact" through the RHT program.

As noted above, the RHT program will improve health outcomes for rural Minnesotans by expanding telehealth in rural areas to support access, care coordination, and chronic disease management for rural residents; recruiting and retaining rural providers through career pathway programs and rural training experiences; reducing avoidable hospital utilization in rural areas by expanding preventive care and coordinating services outside hospital settings; improving cardiometabolic disease management in rural areas through targeted interventions; and increasing the capacity of participating rural providers to implement value-based care.

Noted below are performance measures in each initiative that will allow the State to closely track and attribute progress in achieving our goals. The State coordinated measure selection in consultation with subject matter experts on data sources to assess the availability of data needed for program outcome metrics. MDH will use county-level data, where available, to monitor and evaluate the impact of the RHTP investments to better assess regional variation and impact. Providing data to the State will be a requirement for any sub-recipient receiving funds from this program. Where data is not validated or routinely collected through existing data sources, the State will work with grantees to develop data collection instruments and monitor data quality.

Initiative Performance and Outcome Measures and Targets tables

Initiative 1: Preventive Care and Chronic Disease Management Measures

Outcome Name	Type	Analysis Unit	Data Source	Frequency	Notes
1.1 # and % of adults and children screened for cardiometabolic conditions	Health Access	County	Provider EHR reporting	Annually	Non-emergency care. Numerator: individuals screened Denominator: individuals served
1.2 # and % of adults completing chronic disease self-management programs	Health Quality	Geographic areas by county	Provider EHR reporting	Annually	Non-emergency care. Numerator: individuals completing Denominator: individuals referred
1.3 # and % of adults referred for and receiving services to address upstream drivers of health	Health Access	Geographic areas by county	Provider EHR and other source reporting	To be determined	Numerator: Unduplicated count referred Denominator: Unduplicated count served
1.4 # and % of adults with cardiometabolic diagnosis at clinical goal*	Health	Geographic areas **by county**.	Provider EHR reporting/ SQRMS	Annually	Numerator: at goal Denominator: unduplicated count with relevant condition

Initiative 1: Preventive Care and Chronic Disease Management Measure Targets

Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
1.1 Cardiometabolic Screening	None available at time of application	2025 baseline data reported	2 percentage point increase from base	4 percentage point increase from base	6 percentage point increase from base	8 percentage point increase from base
1.2 Chronic Disease Self-Management	None available at time of application	2025 baseline data reported	2 percentage point increase from base	4 percentage point increase from base	6 percentage point increase from base	8 percentage point increase from base
1.3 Upstream Drivers of Health	None available at time of application	2025 baseline data reported	2 percentage point increase from base	4 percentage point increase from base	6 percentage point increase from base	8 percentage point increase from base
1.4 Cardiometabolic Goal*	None available at time of application	2025 baseline data reported	1 percentage point increase from base	2 percentage point increase from base	3 percentage point increase from base	4 percentage point increase from base
*** Data available at the county-level to measure increases for counties where activities were implemented**						

Initiative 2: Workforce Development Measures

Outcome Name	Type	Analysis Unit	Data Source	Frequency	Notes
2.1 # of rural high schoolers enrolled in *Scrubs Camps*	Workforce Implement.	Camp Site	Grantee report	Quarterly	Unduplicated count
2.2 # of new rural clinical trainees	Workforce Implement.	Rural geographic areas by County	Grantee report	Annually	Includes number of residents/fellows trained
2.3 Participants successfully completing at least 90% of an RHTP-funded program	Workforce Implement.	Rural geographic areas by County	Grantee report	Annually	Includes new individuals engaged in

Outcome Name	Type	Analysis Unit	Data Source	Frequency	Notes
					all initiative-funded activities
2.4 Number of rural UME/GME technical assistance sessions conducted*	Access Implement. Workforce	**County**	Grantee report	Quarterly	Counts of number of sessions

Initiative 2: Workforce Development Measure Targets

Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
2.1 Rural high schoolers enrolled in *Scrubs Camps*	280 annually	40 new campers	80 additional campers	120 additional campers	160 additional campers	200 additional campers
2.2 New rural clinical trainees (includes physician residents + APP + psychology + FM-OB fellows)	Residency Slots: 87 Clinical Rotations: 37	Planning & development underway at 16 residency sites; 1 fellowship site	20 APPs	20 APPs + 20 residents + 2 FM-OB fellows	20 APPs + 60 residents + 2 FM-OB fellows	20 APPs + 120 residents + 2 FM-OB fellows
2.3 Participants successfully completing at least 90% of an RHTP-funded program	Data not available at this time.	40 campers	240 total: 80 campers; 120 apprentices; 20 resident rotations; 20 APPs	302 total: 120 campers; 120 apprentices; 20 resident rotations; 20 APPs; 20 residents; 2 fellows	382 total: 160 campers; 120 apprentices; 20 resident rotations; 20 APPs; 60 residents; 2 fellows	482 total: 200 campers; 120 apprentices; 20 resident rotations; 20 APPs; 120 residents; 2 fellows
2.4 Number of UME/GME technical assistance sessions conducted*	0	Set up governance &, operations; conduct environmental scan	Stakeholder engagement; TA framework development	TA to 5 recipients to increase new rural UME/GME	TA to 5 recipients to increase new rural UME/GME	TA to 5 recipients to increase new rural UME/GME
*** Data available at the county-level to measure increases for counties where activities were implemented**						

Initiative 3: Sustainable Access Measures

Outcome Name	Type	Analysis Unit	Data Source	Frequency	Notes
3.1 Number of <u>new</u> community-based rural telehealth access points*	Implement. Access Technology	**County**	Grantee report	Quarterly	Cumulative total new access points
3.2 Number of new mobile units for rural areas*	Access Implement.	**County**	Grantee report	Quarterly	Cumulative total new mobile units
3.3 Rural patient encounters at access points and mobile units*	Access	**County**	Provider EHR reporting	Quarterly	Cumulative total, unduplicated at provider level
3.4 Number of sites implementing programs employing allied health staff *	Access Health Workforce	**County**	Grantee report	Semi-annually	Cumulative total of sites employing at least 1 allied health staff

Initiative 3: Sustainable Access Measure Targets

Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
3.1 Number of new rural telehealth sites*	0	Grants awarded & implementation planning underway	4 new sites	4 additional sites	4 additional sites	4 additional sites
3.2 Number of mobile vans for rural areas*	0	Grants awarded & implementation planning underway	8	8	8	8
3.3 Rural patient encounters at access points and mobile units*	0	Grants awarded & implementation planning underway	100	150	200	250
3.4 Number of sites implementing programs employing allied health staff*	Est. 0-3	Grants awarded & implementation planning underway	8	8	8	8
*** Data available at the county-level to measure increases for counties where activities were implemented**						

Initiative 4: Regional Care Model Measures

Outcome Name	Type	Analysis Unit	Data Source	Frequency	Notes
4.1 Rural health care entities engaged in provider-to-provider telehealth consultation	Workforce Technology	State	All-Payer Claims Database	Annual	Unduplicated count of entities regardless of number of consultations
4.2 Rates of rural ambulance transportation to emergency departments for unnecessary visits	Health Quality	Rural geographic areas by county	National EMS Information System, patient acuity field	Annual	.Treatment accessed
4.3 Patients prescribed MOUD in rural counties	Health Access	Rural geographic areas by county	All-Payer Claims Database	Annual	Unduplicated count
4.4 Providers trained through Rural Obstetrics Simulation program*	Workforce Access Technology	**County**	Grantee report	Annual	Unduplicated, cumulative count

Initiative 4: Regional Care Model Measure Targets

Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
4.1 Rural health care entities engaged in provider-to-provider telehealth consultation	To be documented Q2 2026	10 additional entities	20 additional entities	30 additional entities	40 additional entities	50 additional entities
4.2 Rates of rural ambulance transportation to emergency departments for unnecessary visits	To be documented Q2 2026	Treatment in -place protocols learned & applied	Skills with telehealth access for remote access assistance developed	4% reduction from baseline	6% reduction from baseline	8% reduction from baseline
4.3 Patients prescribed MOUD in rural counties	To be documented Q2 2026	2% increase from baseline	7% increase from baseline	12% increase from baseline	17% increase from baseline	22% increase from baseline

Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
4.4 Providers trained through Rural Obstetrics Simulation program with at least 2 trainees per county*	0 providers	SIM faculty hired & trained	20 new trainees	20 new trainees	20 new trainees	20 new trainees,
*Data available at the county-level to measure increases for counties where activities were implemented						

Initiative 5: Technology & Infrastructure Measures

Outcome Name	Type	Analysis Unit	Data Source	Frequency	Notes
5.1 No. of providers that implement technology to support patient care, clinical & organizational decision-making*	Technology Use Program implementation	County	Value-based health care strategic planning tool	Annual	Unduplicated count
5.2 Number of providers that advance implementation of population health management tools to improve care*	Technology Use Program implementation	County	Value-based health care strategic planning tool	Annual	Unduplicated count
5.3 Increase in number of providers reporting use of analytic tools to identify high risk patients	Technology Use	Statewide	Value-based health care strategic planning tool	Annual	Unduplicated count
5.4 Providers reporting increase in encounters per clinician due to technology and workflow improvements	Improved access Technology Use	County	Grantee reporting	Annual	Unduplicated count

Initiative 5: Technology & Infrastructure Measure Targets

Measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
5.1 Number of providers that implement technology to support patient care, clinical & organizational decision-making*	TBD via annual value-based health care assessment tool; grantee reports	Tech & data systems procured, deployment underway	Limited integration across systems	5% increase in providers attain fully developed integration	7% increase in in providers attain fully developed integration	10% increase in providers attain fully developed integration
5.2 Number of providers that advance implementation of population health management tools to improve care*	TBD via annual value-based health care assessment tool; grantee reports	Tech & data systems procured, deployment underway	Limited integration across systems	5% increase in providers attain fully developed integration	7% increase in in providers attain fully developed integration	10% increase in providers attain fully developed integration
5.3 Increase in number of providers reporting use of	TBD via annual value-	Pre-intervention	Post-intervention	5% of providers	10% of providers	15% of providers

analytic tools to identify high risk patients	based health care assessment tool	baseline data collected	baseline data collected	report increases	report increases	report increases
5.4 Providers reporting increase in encounters per clinician due to technology and workflow improvements	TBD via pre-intervention grantee reporting	Tech & data systems procured, deployment underway	Integration& optimization of tech tools	5% of providers report increases	10% of providers report increases	15% of providers report increases
* Data available at the county-level to measure increases for counties where activities were implemented						

If performance targets are not met, the State will work collaboratively with grantees and stakeholders to understand the challenges, and identify clear, achievable steps to support progress toward goals. Throughout the RHTP performance period, the State will proactively engage with CMS to review progress and adjust strategies, ensuring accountability, and a structured approach to achieving all program goals.

Minnesota is committed to understanding our impact, identifying where to improve, and scaling and sustaining successful interventions beyond the grant period. MN will pursue a focused learning agenda that pairs routine performance monitoring with targeted formative and summative assessments to answer what works, where, and under what conditions.

Minnesota will have 2 FTEs and 1 external contract for performance monitoring, measurement, evaluation, and learning. MDH has deep experience conducting evaluations internally and with other state agencies, academic researchers, and external contractors and evaluators. These partnerships ensure evidence is rigorous, relevant, and used to inform decision-making. We will collaborate with CMS and or third party-led evaluation or monitoring activities.

VII. Sustainability Plan

A focus on sustainability is built into all of the activities under this grant, with an assumption that extensions of this time-limited funding will not be available. Many of the activities funded under this program are designed to serve as a gateway to sustainable reimbursement through Medicaid

and other payers, with technical assistance on billing and modeling of ROI, so that activities can be self-sustaining. Support for some funded activities will decrease over the five years, with funded organizations expected to take on a greater share of the costs themselves.

Minnesota's RHT Program also includes a strong focus on interagency collaboration and learning, with a goal of assessing evidence from program activities for consideration for future state policy and coverage changes, including evaluating the potential for changes to Medicaid coverage policies. Throughout the funded period, Minnesota will meet with grantees, partners, rural community members, advisory bodies such as the Rural Health Advisory Committee and the Statewide Health Improvement Partnership, and legislators to share learnings from successful initiatives, with a goal of identifying options for spreading successful approaches to new communities and priorities for legislative action or funding where needed.

In terms of staffing, positions created for the RHT Program will be shifted to state funding post-award if possible. During year 5, Minnesota will evaluate options for integrating RHT Program activities into existing work within the ORHPC, the MDH Health Promotion and Chronic Disease division, or other parts of the State enterprise where appropriate and where funding permits, to ensure continuation of projects post-award.

The table below provides more detailed sustainability plans for each of Minnesota's initiatives.

1. Chronic Disease Prevention/Make Rural America Healthy Again • RHTP funds will pay for start-up costs associated with planning and piloting new evidence-based chronic disease screening and management strategies. Once protocols and workflows are established, technology is secured, and new services are integrated, program maintenance costs may be supported by billing Medicaid, Medicare, and commercial insurance; MN will consider whether to implement policy changes related to Medicaid covered benefits and reimbursement for upstream drivers of health.
2. Recruit & Retain Talent in Rural Communities • RHTP funds will pay for startup costs for scrubs camps for the first 3 years at a decreasing share, becoming self-sustaining by year 4 with funding from long-term commitments through partnerships, registration fees, local sponsorships, and in-kind community contributions. HOSA chapters have no ongoing costs after set up. • Earn and Learn pathways are financially self-sustaining as employers learn firsthand that apprenticeship is a long-term, cost-effective strategy that reduces turnover and saves ongoing recruitment and onboarding costs. • Rural rotations are a longer-term strategy to expose more medical students/residents to rural practice, with the intent that they will choose to practice at rural sites, saving on recruitment costs by prospective employers.

- Rural *physician, APP residencies and fellowships* are upstream investments by employers aimed at reducing recruitment, onboarding costs and increasing health care access to their patients. Residents/fellows will be required to work in rural settings for at least five years post fellowship completion, providing longer-term sustainability for these services. Once accredited, physician residency programs will seek CMS funding for ongoing sustainability. On-going residency costs for programs that do not meet the CMS definition of rural will be supported by the State of Minnesota
- *University of MN TAC* will sustain expansion of residency programs by providing technical assistance, connection and education to new and existing sites, enhancing efficiencies in funding that will ensure sustainable programs.
- Retention pilot is an investment in reducing burnout, increasing job satisfaction, leading to workforce retention in rural areas. As the pilot is scaled to more sites, effective strategies will become part of routine business practices, minimizing need for outside support.

3. Sustain Access to Services to Keep Care Closer to Home

- The activities in this initiative rely on the technical assistance programs assisting providers in using the existing Medicaid, Medicare, and commercial payer billing mechanisms to capture reimbursement as allowed by those payors. Sustaining funding will come from more efficient billing of these services post-award. In addition to billable services, the community mental health postvention program will be sustained with financial commitments from community partners such as counties, law enforcement, and municipalities; CCBHCs will explore the ability to include costs of trainings and services in their future PPS rates.
- The Children's Mental Health Initiative will yield cost savings from ending current costly services, such as sending children out of state for care; billable services when available; and county, municipality, and other organizations committing funds.
- Through the 5-year implementation, cost saving measures because of this work will be documented and funding can be re-invested into these services.

4. Create Regional Care Models to Improve Whole Person Health

- Telehealth services and Strengthening Rural Pathways to MOUD (SRP-MOUD) program are designed to build durable infrastructure that strengthens rural Minnesota's capacity to deliver evidence-based care beyond the grant period. RHTP funds will support start-up and implementation activities. Ongoing operational costs will be sustained via existing reimbursement mechanisms through Medicaid, Medicare, and commercial insurers.
- Funding granted to CCBHCs or CMHCs to be used for planning and development of new mental health crisis urgent care centers that can achieve sustainability through billable services once the urgent care is operational.
- For EMS Treatment in Place, covering this cost will reduce unnecessary emergency department visits, support patients in their home, and lower health care system costs while creating a pathway to financial sustainability for financially stretched rural ambulance services. The State of Minnesota will seek policy action by Year 5 that focuses the emergency funding the State legislature provides to ambulance services to funding treatment-in-place as a more sustainable approach to enable ambulance services to bill for services.
- Grants to select low-volume OB CAHs to develop long-term sustainability plans while providing support to local labor and delivery services in rural areas at risk of becoming OB deserts will inform statewide recommendations for obstetric sustainability in rural communities, drafted by an outside consultant.
- Project ECHO's sustainability is centered around building capacity and strengthening the skills of local providers. The knowledge gained will empower local organizations and health care providers and foster continuous learning through the professional networks developed during the implementation.

5. Invest in Technology, Infrastructure, and Collaboration for Financial Viability

- Funding will be used to pay for upfront costs of acquiring, installing, and adapting to new technology. Providers will document efficiencies to cover ongoing costs of technology beyond RHTP funding.
- Activities designed to improve rural providers' financial stability and sustainability by supporting optimized billing, coding and claims management, increasing the proportion of rural providers benefitting from economies of scale for administrative and analytic functions, and encouraging more rural providers to participate in value-based payment initiatives that offer more predictable revenue and improved outcomes.
- For AI investments under this strategy, long-term sustainability comes from increased direct service time and the ability to include the cost of these new technologies in their cost reports.

[i] United States Census Bureau. (n.d.). *Profile for State, Minnesota.* https://data.census.gov/profile/Minnesota?g=040XX00US27

[ii] Minnesota Department of Administration, Minnesota State Demographic Center. (n.d.). *Data by topic: Our Projections / MN State Demographic Center*. https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/

[iii] Center for Rural Policy and Development (2025). *The state of rural 2025.* https://www.ruralmn.org/the-state-of-rural-2025/

[iv] Minnesota Department of Health. (n.d.). *Poverty in Minnesota counties: MNPH Data Access - MN Dept. of Health*. https://mndatamaps.web.health.state.mn.us/interactive/poverty.html

[v] MDH Health Economics Program analysis of All Payer Claims Database Public Use Files - Member (2020). Small town rural and isolated rural are combined. Monthly claims costs are based on payments made by insurers for health care services received by members divided by number of months with enrollment in that type of coverage; monthly member cost sharing is based on cost sharing (deductible, copayment or coinsurance) that was expected to be paid by member for health care services received divided by number of months with enrollment. For more information on the MNAPCD, or to get data: https://www.health.state.mn.us/data/apcd.

[vi] Minnesota Department of Health, Health Economics Program analysis of the Behavioral Risk Factor Surveillance System (2025). https://www.health.state.mn.us/data/mchs/surveys/brfss/index.html

[vii] Minnesota Department of Health, Center for Health Statistics, Lee, M.W. and Gupta, S. (2025). *Health Status Among Minnesota Adults, 2023: Behavioral Risk Factor Surveillance System (BRFSS)*. https://www.health.state.mn.us/data/mchs/pubs/healthstatus-brfss-2023.pdf

[viii] Minnesota Department of Health, Division of Injury Prevention and Mental Health. (2025, May 13). *Data Brief: Suicide Mortality Steady in 2024*. https://www.health.state.mn.us/communities/suicide/documents/2024suicidedatabrief.pdf

[ix] Minnesota Department of Health, Division of Health Policy. (2021, November 18). *Rural health care in Minnesota: data highlights*. https://www.health.state.mn.us/data/economics/docs/ruralhealthcb2021.pdf

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[xvi] MN's pregnancy-related mortality ratio (PRMR) for 2017-2019 was 8.9 pregnancy-related deaths per 100,000 births compared to the national PRMR of 17.6 pregnancy related death per 100,000 births in 2019. Minnesota Department of Health, Child and Family Health Division. (2024, January). *Minnesota Maternal Mortality Report: Reporting for 2017-2019.* https://www.health.state.mn.us/people/womeninfants/maternalmort/index.html

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[xviii] A time-critical diagnosis refers to medical emergencies like trauma, stroke, and STEMI (a severe heart attack), which require immediate and rapid medical intervention to improve outcomes. Often time-critical diagnoses require a coordinated response from both emergency medical services in the pre-hospital setting and appropriate activation of the necessary hospital services before patient arrival.

[xix] Minnesota Department of Health, Office of Rural Health and Primary Care. (2024) *Health Care in Rural Minnesota.* https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmn.pdf.
[xx] MDH analysis of data from the Minnesota Boards of Medical Practice and Nursing, October 2025. Provider counts include APRNs with Psychiatric focus, and Child and Adolescent Psychiatrists.
[xxi] Minnesota Department of Health, Office of Rural Health and Primary Care. (2024) *Health Care in Rural Minnesota.* https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmn.pdf.
xxii Minnesota Department of Health, Health Regulation Division (n.d.). Public Hearings Process. https://www.health.state.mn.us/about/org/hrd/hearing/index.html
[xxiii] Minnesota Department of Health, Cardiovascular Health Unit. (2024, April 8). *Pharmacy Access Gaps on Minnesota 2024.* https://www.health.state.mn.us/diseases/cardiovascular/documents/pharmacy.pdf
xxiv telestroke is a telehealth model that has been implemented across the stroke system and has demonstrated success in earlier interventions and more coordinated care for patients in the emergency department setting. This model has allowed for patients to stay within their own communities but implementation models vary across organizations. Models would be expanded to neurology coverage in hospital and outpatient settings for post-stroke management and secondary prevention.
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[xxxii] Minnesota Department of Health, Health Economics Program analysis of hospital annual reports, September 2024; 2023 data is considered preliminary. Services are considered “available” when they are provided on site by hospital staff, on site through contracted services, or off site through shared services agreement.
[xxxiii] Minnesota Department of Health, Health Economics Program. (n.d.). *Chartbook Section 8A: Health Care Providers and Services Availability: Hospitals.* https://www.health.state.mn.us/data/economics/chartbook/docs/section8a.pdf
[xxxiv] For details on data sources, refer to the “Other Supplementary Materials.”
[xxxv] Malone T. L., Planey A. M., Bozovich L. B., Thompson K. W., and Holmes G. M., “The Economic Effects of Rural Hospital Closures,” Health Services Research 57, no. 3 (2022): 614–623, 10.1111/1475-6773.13965. [DOI] [PMC free article] [PubMed] [Google Scholar]
Fritsma T., Henning-Smith C., Gauer J. L., et al., “Factors Associated With Health Care Professionals' Choice to Practice in Rural Minnesota,” JAMA Network Open 6, no. 5 (2023): e2310332, 10.1001/jamanetworkopen.2023.10332. [DOI] [PMC free article] [PubMed] [Google Scholar]
[xxxvi] The SAGE program provides breast and cervical cancer screenings to low and middle income Minnesotans. For more information see: Sage Cancer Screening - MN Dept. of Health