Project Abstract / Summary

Organization: The **North Carolina Department of Health & Human Services (NCDHHS)**, as the Governor's designee, will lead the North Carolina Rural Health Transformation Program (NCRHTP) through its Office of Rural Health. Implementation is guided by a statewide steering committee that includes Medicaid, Public Health, and Behavioral Health divisions.

Key subrecipients include the Duke-Margolis Health Policy Center, UNC The Cecil G. Sheps Center for Health Services Research and others to be determined.

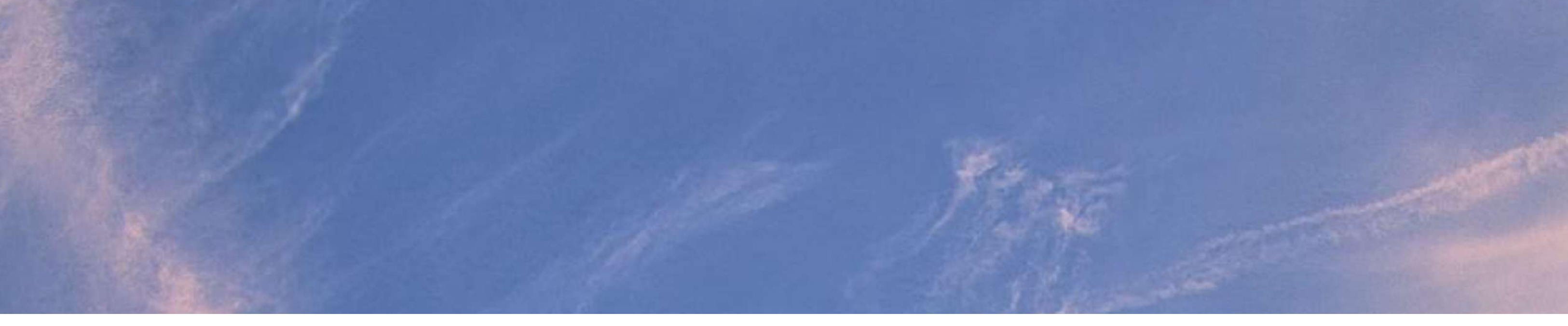
Project Goals: This transformative investment improves health outcomes and access for nearly 3 million rural North Carolinians across 85 of 100 NC counties through three goals; (1) catalyzing innovative care models, 2) transforming the rural care experience, and 3) creating a sustainable rural delivery system. **By FY2031**, NCRHTP will increase rural provider-to-population ratios, reduce preventable hospital readmissions and emergency visits, lower chronic disease risk factors, and expand access to integrated behavioral, mental health and substance use services. All while simultaneously investing directly into communities and stimulating rural economic development and job creation.

Total Budget $1,000,000,000 over 5 years (*indicative per CMS guidance*)

Fund Usage: Through 6 integrated initiatives, NCRHTP will sustainably transform rural health.

1. **Launch "NC ROOTS"[1] Hubs.** These locally governed, community-tailored networks connect medical, behavioral, and social services--making it easier for rural residents to access comprehensive care in one place. Each hub is tailored to its region, offering in-person services, care coordination, and direct support for families, while also leveraging virtual care and advanced AI to enhance access and share data.
2. **Improve prevention/screening, chronic disease management, maternal health, and nutrition** by scaling up effective programs for primary care access, food as medicine, diabetes and hypertension management, cancer screening, and perinatal health.
3. **Expand behavioral health and substance use disorder (SUD) services and integrate into regional care networks** through the growth of Certified Community Behavioral Health Clinics (CCBHCs), enhanced assessment and treatment programs to address critical care gaps, as well as new collaborative and non-traditional workforce models to connect residents to care.
4. **Modernize and sustain the rural health workforce** through catalyzing investments in rural training centers, fellowships, and certification programs to recruit, train, and retain clinicians, allied health professionals, and community health workers.
5. **Advance value-based payment (VBP)** by establishing capabilities for rural primary care practices to participate in advanced VBP models and laying the groundwork for rural hospital participation in VBP arrangements, with a focus on financial sustainability.
6. **Accelerate technological innovation, access, and interoperability** through increased health information exchange participation, digital literacy programs to ensure rural residents can access modern, connected care, and the broad implementation of state-of-the-art AI-based technology to support documentation and real-time expert clinical decision support to drive down business costs for rural providers and improve sustainability

[1] Rural Organizations Orchestrating Transformation for Sustainability



North Carolina Rural Health Transformation Program

CMS-RHT-26-001

North Carolina Department of Health & Human Services | Secretary Devdutta Sangvai

November 3, 2025

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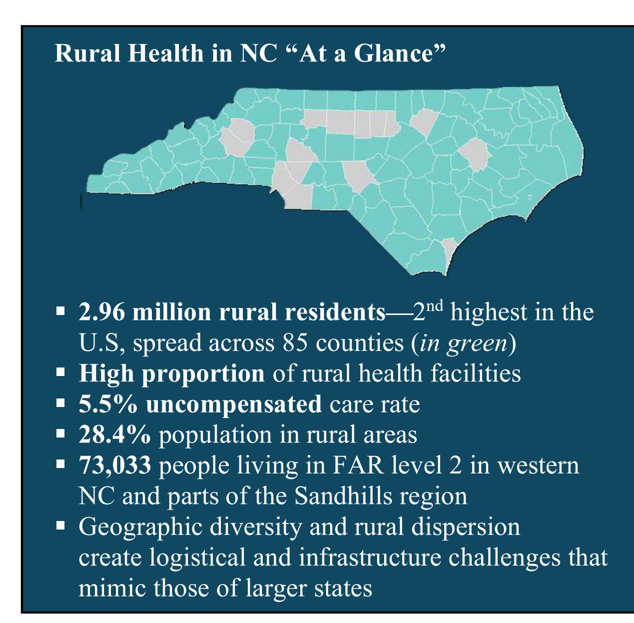
Project Narrative

A. Rural Health Needs and Target Population

From the Outer Banks to the Blue Ridge Mountains, **28.3% of North Carolinians live in rural areas**—reflecting the breadth of the state's people, geography, and local health systems. These communities face widening gaps in access, quality, and outcomes that demand bold, coordinated action. With nearly **3 million residents living in rural communities,** the rural population in North Carolina (NC) is geographically dispersed in 85 of 100 NC counties[i], second in size only to Texas, larger than the rural populations of 20 other states combined, and representing **5.23% of the entire U.S. rural population**. According to UNC Sheps Center RHTP Rural Score Estimates (2025), North Carolina ranks among the top ten of all states for its combined rural population and facility density under the CMS RHTP methodology.



The size of the challenge is significant, but the opportunity is clear. NC is poised to build upon a strong foundational infrastructure, leveraging and braiding in new funds that will put NC's rural health care facilities and regional clinical and social programs on a path to long-term sustainability and further the creation and adoption of evidence-based models that expand

Key Features of NC's Rural Population
Income levels: 37% of rural residents live below 200% of the Federal Poverty Level (FPL); rates exceed 50% among African American and American Indian populations, and 64% among Hispanic residents.
Employment sectors: Agriculture, manufacturing, services, healthcare.
Unemployment rates: Rural and urban counties face similar unemployment rates averaging around 3.7%, though a few rural counties have notably higher rates (e.g., Hyde county around 7.2%).
Educational Attainment: High school diploma or less (54% vs. 38% urban), bachelor's degree or higher (14% vs. 31% urban), 5% of adults (age 25+) hold a graduate degree compared urban NC (13%).
Insurance: 13% under age 65 are uninsured. 14 non-metro counties having uninsurance rates above 18%.
Veterans: NC ranks second in the highest number of rural veterans (estimated 730,000).

access to prevention-oriented care, leverage data and technology, and promote precision health. North Carolina's Rural Health Transformation Program (NCRHTP) is a critical catalyst for our work to *ensure every rural North Carolinian can access high-quality, integrated, and resilient care, regardless of where they live.*

Defining the NC Rural Health Landscape and Primary Health Challenges

85 of NC's 100 counties are considered rural. North Carolina defines "rural" using the Rural Health Grants Eligibility Analyzer and Federal Office of Rural Health Policy (FORHP) designations implemented by the Health Resources and Services Administration (HRSA). For the purposes of this application, these include counties of at least one census tract designated as rural. A full list of rural counties by Federal Information Processing Series (FIPS) codes is included as Annex 1. NC rural communities face persistent and complex challenges in tackling the root causes of disease (*Table 1*).

Table 1: Specific Rural Health Challenges and Insights from NC	
Challenge	**Insights**
Fragmented care delivery and limited integration of clinical, behavioral, and social services.	Most rural counties lack coordinated systems linking medical, behavioral, and social services; care is often siloed, leading to gaps in follow-up and support.
In Madison County, residents often travel more than 30 miles to Asheville for behavioral health and specialty care. The county lacks a hospital and has limited co-located services. These access challenges were worsened by Hurricane Helene (Sept 2024).	
High rates of chronic disease, substance use, and unmet behavioral health needs.	Diabetes prevalence is 46% higher than in urban areas, and cardiovascular disease rates are 53% higher in rural NC. Ninety out of 100 (90/100) NC counties are designated mental health shortage areas, with American Indian communities experiencing disproportionately high rates of mental health crises and substance use disorders, especially among adolescents aged 12–17.
In Robeson County, home to many members of the Lumbee tribe, diabetes prevalence is among the highest in the state, 15.2% (vs. 10.1% in urban counties); 42% of youth report substance use risk factors.[ii]	
Persistent provider shortages and workforce gaps, especially in primary care, behavioral health, oral health, and emergency medical services.	24 rural counties lack adequate primary care supply; NC faces an EMS shortage of ~800 providers over the next face years to maintain current staffing levels.
In Bertie County has one primary care physician per 3,500 residents (recommended: 1 per 1,500). Dental and mental health provider ratios are below state average.[iii]	
Financial instability among rural hospitals and clinics, with closures and conversions threatening local access.	Since 2006, 12 rural hospitals have closed or converted to limited-service models; 5 more are at immediate risk, jeopardizing emergency and inpatient care for thousands.

In Martin County, Martin General Hospital closed in 2023. Residents now travel more than 30 miles for emergency and inpatient care. This closure affected 22,000 residents.	
Barriers to digital health, resource navigation, and broadband connectivity.	Many rural communities lack access to reliable broadband, limiting telehealth access and digital care coordination. Digital literacy and navigation support are also limited.
In Swain County, a mountainous community, residents experience significant gaps in digital literacy. Residents reported needs for a 'go to' training person who could support device setup, tutoring and troubleshooting.	
Gaps in prevention, early intervention, and care coordination for vulnerable populations.	Rural families have less access to preventive screenings, early behavioral health intervention, and coordinated chronic disease management, especially for children and tribal youth.
In Sampson County, only 62% of children in receive recommended well-child visits;[iv] behavioral health screening rates are below state average.	

The characteristics of NC rural communities are very different. Strategies that recognize these differences and customize solutions with local rural community input will be critical to acceptance, and we have designed our program to be responsive to these needs.

Rural Health Outcomes

Rural communities in NC experience high rates of chronic disease and adverse maternal and child health outcomes. These disparities are driven by root causes of disease, such as limited access to preventive care, food insecurity, and environmental exposures that increase the risk of disease and poor health outcomes.

Table 2: Rural Health Outcomes in NC			
Indicator	**Rural Rate**	**Urban Rate or Statewide**	**Target (HNC 2030)***
Adult Diabetes Prevalence	14.7%	10.1% (Urban)	8.6%
Adult Obesity Rate	37.1%	31.9% (Urban)	29.0%
Cardiovascular Mortality Rate	53% higher than Urban	—	Reduce disparities
Infant Mortality Rate (per 1,000 live births)	7.4	6.8 (Statewide)	5.5
Low Birth Weight Rate	9.8%	9.2% (Statewide)	8.3%
*Targets and Data Sources defined in Healthy North Carolina 2030 statewide plan.			

Rural Community Health Care Access

Barriers to care in rural areas—such as long travel distances, further complicated by geographic features such as mountain regions and coastal barriers, provider shortages, and lack of transportation—contribute to delayed diagnoses and reduced access to timely treatment, which increase the risk of preventable complications and hospitalizations.

Table 3: NC Barriers to Healthcare Access		
Distance to Care	Many rural residents travel more than 30 miles to the nearest hospital/clinic.	Long travel times, especially in western and coastal counties.
Provider Availability	Thirty-eight counties above 1:1,500 primary care provider (PCP) ratio; shortages in behavioral, oral, emergency care.	Rural provider shortages acute.
Public Transportation	Limited or absent in most rural counties.	Older adults, people with disabilities face greatest barriers.
Facility Distribution	800+ rural health facilities (hospitals, clinics, federally qualified health centers (FQHCs), health departments).	Facilities unevenly distributed, many under-resourced.

Rural Facility Financial Health

North Carolina maintains one of the most extensive rural health infrastructures in the country, with over 880 rural-serving health facilities, including critical access hospitals (CAHs), rural health clinics, federally qualified health centers (FQHCs), and local health departments (LHDs). While these facilities are strategically located across 85 rural counties to serve geographically isolated populations, they are not evenly distributed. Many operate under significant financial strain, with limited staffing and outdated infrastructure, making them vulnerable to service reductions or closure. The scale and distribution of North Carolina's rural health system underscore the need to leverage NCRHTP funds to put facilities on a path of sustainability through a mix of strategies.

Current State: Rural Hospitals. The financial and operational fragility of rural hospitals in North Carolina is at a critical point. Since 2006, 12 rural hospitals have closed or been converted to limited-service models, including the 2023 closure of Martin General Hospital in Williamston, which left Martin County and the surrounding region of eastern NC without a hospital for the first time in decades.[v] These closures concentrated in high-poverty counties. Many rural facilities operate under financial strain, low volumes, and high uncompensated care (5.5% in our state).

Rural hospital facilities serve communities with limited alternatives, and additional closures would further strain regional health systems, increase travel times for emergency care, and deepen health disparities in already underserved areas.

Target Populations and Geographic Areas

NCRHTP is designed to positively impact North Carolinians living in all rural areas of the state, as defined above. The Initiatives the state plans to deploy will be tailored to the unique needs of different communities, anchored in the "NC ROOTS Hub" model described in Initiative 1. This enables programming to be tailored to the demographic, socioeconomic, and public health related factors present in a community or region.

Case for Change -- Why invest in North Carolina?

North Carolina has built a strong foundation for sustainable rural health transformation through robust cross-sector partnerships—uniting Medicaid, public health, hospital systems, and community-based organizations (CBOs). The state's advanced data infrastructure enables real-time tracking of rural health outcomes, provider capacity, and community needs, supporting effective monitoring and accountability.

North Carolina's rural health strategy aligns with federal priorities, emphasizing value-based care, fair access to care, and workforce development, and can be an engine for broader economic development. In addition to direct community investment, our program is designed to support healthier families, leading to a healthier workforce, further positive economic outcomes and prosperity for communities that have struggled for a generation or more. The state has developed several building blocks for the NCRHTP, including a robust infrastructure of mobile clinics, telehealth networks, and integrated physical and behavioral health services, leading workforce programs anchored in the states' community colleges and universities, and innovative partnerships such as North Carolina Area Health Education Centers (AHEC), among others.

With the focused investment planned in NCRHTP, NC is ready to rapidly scale its transformation efforts to all North Carolinians in all rural areas and put these communities on paths to a sustainable, high-quality, accessible delivery system and programs.

B. North Carolina Rural Health Transformation Plan

Vision and Goals

The State of North Carolina is pursuing a vision to *advance community-designed, community-led innovative solutions that foster independence, improve health, and promote well-being for rural North Carolinians.* Anchored in this vision, North Carolina will achieve three goals for rural communities: **1) Catalyze Innovative Care Models**, changing the way providers work together to care for patients in rural NC; **2) Transform the Rural Care Experience**, building community-based clinical, behavioral, and social supports close to home; and **3) Create a Sustainable Rural Delivery System** through underlying systems change in rural workforce pipelines and care team models, and rural provider financial models.

Program Strategies & Key Performance Objectives

By 2031, NCRHTP will achieve significant, measurable improvements in each rural community we serve in line with the overall goals of CMS' Rural Health Transformation Program. We set forth six overarching program initiatives linked to six key performance objectives as organized in *Figure 1* below.

Figure 1: Summary of NCRHTP

Vision *To advance community-designed, community-led innovative solutions that foster independence, improve health, and promote well-being for rural North Carolinians.*

Goal: Catalyze Innovative Care Models

Build Rural Community Care Network "Hubs"

- Design and deploy community-tailored services that address physical health, behavioral health, substance use, and upstream wellbeing needs
- Build platforms to improve information sharing, joint training, program coordination, and group purchasing

***Key Performance Objective**: Establish 6 NC "ROOTS" Hubs by program year 2.*
(Improves access, outcomes, and partnerships)

Modernize Rural Care Delivery Through Digital Forward Solutions

- Data exchange via rural provider connectivity to the state (HIE)
- New rural precision public health models
- Expanded rural provider adoption of AI tools, virtual care models for P2P consults and complex care management in regions where specialty care is limited
- Improved digital health literacy and digital patient tools in rural communities

***Key Performance Objective**: Reduce the gap in rural provider HIE connectivity by 70 practices by program year 3*
(Addresses technology use and data-driven solutions)

Changing the way providers work together for patients in rural NC

Goal: Transform the Rural Care Experience

Create Models & Capacity for Expanded Primary Care, Prevention, and Chronic Disease Management

- Expanded access to primary and specialists through digital-forward models
- Care coordination and navigation supports across local networks of care
- Upstream supports and interventions emphasizing prevention and wellness

Key Performance Objective**: Decrease the percentage of adults in the target rural population reporting three or more chronic health conditions from 12.1% to 9.7% by program year 5. **(Improves access, outcomes, and partnership)

Expand and Integrate Behavioral Health and SUD Services

- Expanded services through the CCBHC model expanded in rural counties
- Enhanced assessment and treatment programs to address critical care gaps in first episode psychosis, rural crisis, mobile, outreach and response, mobile opioid treatment and medication units, and school-based health
- New collaborative and non-traditional models to connect patients to care

Key Performance Objective:** Increase the number of Medicaid patients beginning mental health treatment by 5% year over year for those requiring services through program year 5. **(Improves access, outcomes, and partnerships)

Underlying systems-change

Goal: Create a Sustainable Rural Delivery System

Build a Robust & Resilient Workforce & Innovative Care Team Models for Rural Communities

- Expanded rural residencies and fellowships and training/certification for CHWs, peers, direct care workers and other health professionals
- Expanded simulation & interprofessional training
- Increased capacity for qualified training sites and faculty/teachers
- Outreach programs & high-school-to-job pipelines

***Key Performance Objective**: Decrease rural county provider vacancy rates by 10% by program year 5.*
(Strengthens workforce)

Ensure Fiscal Sustainability of Rural Health Providers Through Innovative Financial Models

- Rural Medicaid VBP models via two linked programs:
  - Primary care capitation pilot
  - Rural hospital VBP capacity building
- Reduce operating costs and inefficiencies in care delivery

***Key Performance Objective**: Increase participating rural hospital and primary care clinic readiness for or engagement in value-based payment models by 10-15% over baseline by program year 5*
(Financial solvency strategy and cause identification)

These overarching objectives align with state's broader health improvement plan, Healthy North Carolina 2030, and are augmented with additional objectives/outcomes that stem from the priorities and initiatives that will be undertaken as part of NCRHTP and included in our overall metrics and evaluation plan.

Legislative and Regulatory Action

North Carolina is committed to taking bold, sustained action to expand access, improve quality, and control costs for rural communities within the RHTP implementation timeline. *Table 4* below outlines North Carolina's current policies and proposed RHTP actions to achieve this.

Table 4: Legislative or Regulatory Action Table		
NC's Current Policy	**Proposed Action and Timeline**	**Access, Quality, Cost Impact**
B.2 Health & Lifestyle (Presidential Fitness Test)		
NC does not require the Presidential Fitness Test (PFT) in schools. Some local programs promote physical activity, but there is no statewide standard.	**By Dec. 2028**, reinstate the PFT statewide and expand school-based prevention programs.	This will help lower childhood obesity rates (currently ~35% in rural NC), encourage healthy habits, and reduce future chronic disease costs.
B.3 SNAP Waivers (Food Restriction)		
NC does not restrict SNAP purchases of sugary drinks or junk food. No waiver or bill is active.	NC does not have a current waiver. State operational focus is on reducing SNAP error rate from 10.2% to below 6% and cannot commit to specific actions by a certain date.	By focusing on SNAP error rate reduction, we will improve program integrity and ensure eligible households receive timely and accurate benefits. This will improve accuracy in benefit delivery and reduce administrative costs.
B.4 Nutrition continuing medical education (CME) Requirement		
Doctors in NC are not required to take nutrition-focused continuing education.	**By Dec. 2028**, pass a law requiring nutrition CME for physicians.	This will increase nutrition counseling rates helping patients manage diabetes and heart disease more effectively.
C.3 Certificate of Need (CON)		
As of late 2025, CON laws remain in effect but have been partially reformed through recent legislation (notably House Bill 76), which places NC around 65/100 per the Cicero index (See detailed methodology in Annex 4). Further CON reforms will be implemented in November 2025 and November 2026 per state law.	NC does not propose additional changes to CON laws as part of this application.	Recent legislative changes have reduced CON requirements for specific types of services and beds in rural counties and across the state.
D.2 Licensure Compacts		
NC participates in four of the five major licensure compacts. The state is a member of the Nurse Licensure Compact (since 2018), Psychology Interjurisdictional Compact (effective 2021), and	**By Dec. 2026**, implement legislation to join the EMS	Strengthens rural emergency response capacity, especially in counties with EMS staffing shortages. Supports cross-border

Table 4: Legislative or Regulatory Action Table		
NC's Current Policy	**Proposed Action and Timeline**	**Access, Quality, Cost Impact**
the Physician Assistant Compact (enacted July 2025). The Interstate Medical Licensure Compact (IMLC) was passed via HB 67 (July 2025) and will take effect January 1, 2026. NC is not currently a member of the EMS Compact.	Compact and begin implementation.	EMS deployment, which is critical during disasters and for rural regions near state lines.
D.3 Scope of Practice		
As of Oct. 2025, NC's provider practice authority scores reflect: PAs score 75, rated "Advanced" according to the AAPA, while Nurse Practitioners (NPs) score 0 due to the state's requirement for physician supervision. Pharmacists receive a score of 50, with recent legislation (HB 67, July 2025) expanding their scope but still mandating physician collaboration. Dental Hygienists also score 50, permitted to perform three types of tasks. The average score across these provider types is 43.75/100, indicating moderate progress toward full practice authority.	Current practice authority is a matter of ongoing interest and debate; accordingly NC cannot commit to specific actions by a date certain.	Recent changes have increased provider supply, improved access, and reduced wait times—especially in counties with few doctors.
E.3 Short-Term, Limited-Duration Insurance (STLDI)		
NC follows federal rules; there are no extra STLDI restrictions.	Maintain current policy.	Helps uninsured rural residents get coverage, reduces care costs.
F.1 Remote Care Services (Telehealth/Medicaid)		
NC Medicaid[vi] has broadly supportive state policies (per the NOFO) for access to remote care and telehealth services including: reimbursement for live video visits, store-and-forward, and remote patient monitoring (RPM). Providers are not subject to restrictive in-state licensing requirements, and no special telehealth license is required.	Given NC's advanced policy position is aligned with NOFO criteria, we do not anticipate additional changes.	Current policy enables vast expanded access to telehealth and remote monitoring for nearly 1 in 4 North Carolinians, resulting in improved chronic disease management, reduced travel costs, and reaching our rural residents.

Other Required Information

State policies (*See Table 4 above for NC's current policies*)

Factor A.2: Proportion of Rural Health Facilities. For Certified Community Behavioral Health Clinics (CCBHCs), all active sites and addresses are listed in Annex 2.

Factor A.7: Medicaid Disproportionate Share Hospital Payment (DSH)

As outlined in the NOFO Appendix, we encourage CMS to use data from the latest DSH audit available to CMS to calculate NC's score.

C. Proposed Initiatives and Use of Funds

NC's six proposed initiatives are designed as an integrated, statewide transformation plan—each reinforcing the others to build a durable, data-driven rural health system. Every strategy is structured for long-term sustainability, transitioning into enduring funding mechanisms through multi-payer alignment, value-based payment, community and philanthropic investment.

Initiative 1: Build Rural Community Care Network "Hubs"

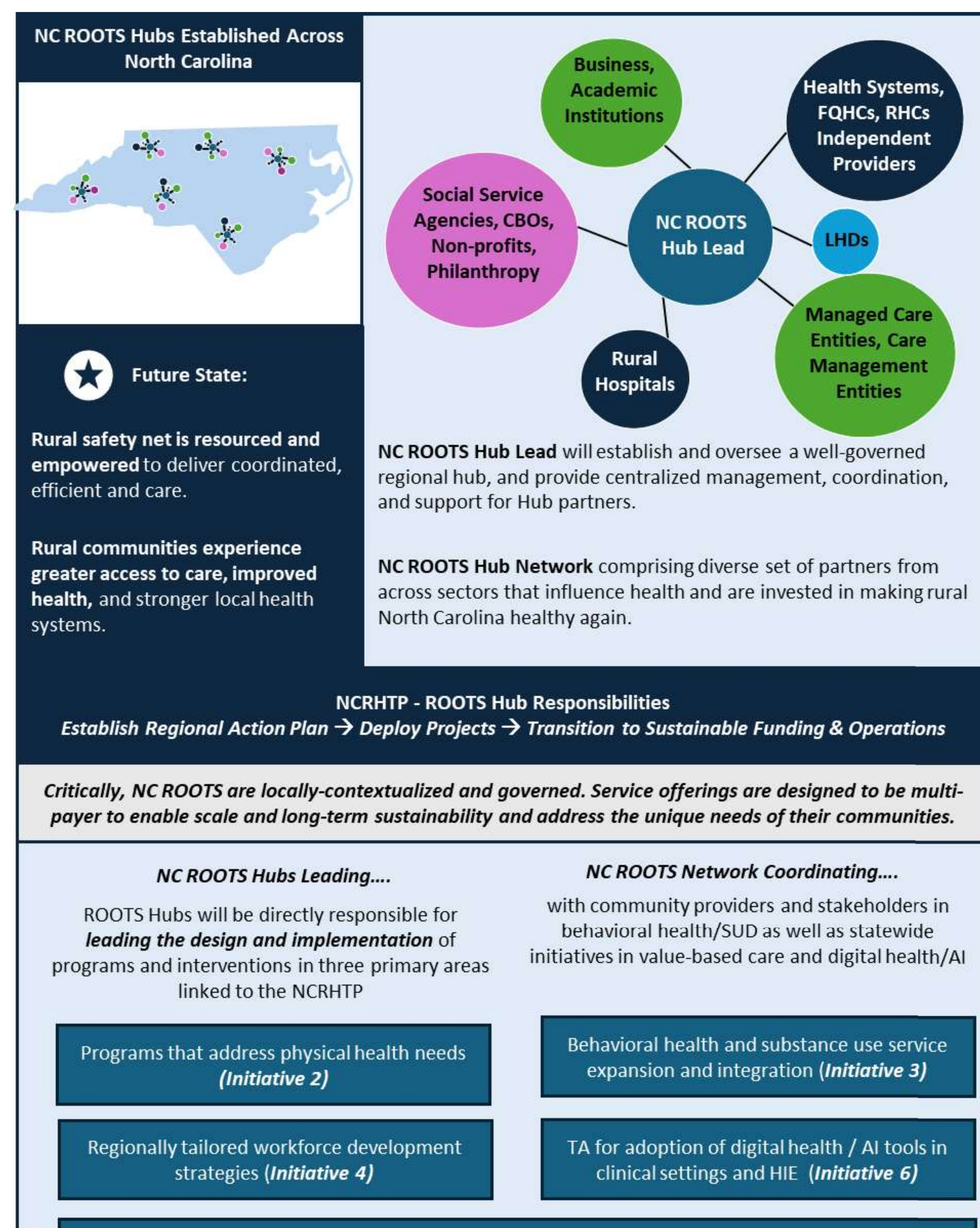
Challenge: Rural health care in North Carolina is delivered through a fragmented network of providers, many working independently. While each provides essential services, the lack of coordination leads to missed opportunities for collaboration, efficiency, and scaling, resulting in suboptimal health outcomes and health care costs for North Carolinians. Community voice is not reflected in the health system design locally.

Future State	**Summary of Activities:**
Future State: Hubs coordinating strategic priorities across community partners and supporting the NCDHHS in the distribution of supports and services that address the unique needs of rural North Carolinians. Each Hub establishes and oversees a well-governed network focused on shared regional priorities that spans across payers and works to address the multigenerational needs of their community in areas like preventive care, chronic disease, behavioral health, and maternal health.	• Procure up to six Hubs based on detailed regional rural health needs assessments. • Enhance IT systems and infrastructure for Hubs to fulfill responsibilities (i.e., facilitate and track payments, monitor progress toward outcomes, and report to NCDHHS). • Deploy rural health improvement programs in each region anchored in each NCRHTP initiative (2-6) in the application including those relating to primary care, chronic disease, maternal and infant health, behavioral health, workforce, digital health, and value-based payment.

Main Strategic Goal: Goal 2: Sustainable Access.
Use of Funds: D, G, K | **Technical Score Factors:** B.1, C.1. | **Estimated Required Funding**: $349M
Impacted Counties (FIPS): All 85 rural counties as described in Section IIA (see Annex 1).

Description: This first initiative will establish North Carolina Rural Organizations Orchestrating Transformation for Sustainability ("NC ROOTS") Hubs across the state. NC ROOTS Hubs will be responsible for tailoring NCRHTP initiatives and activities to meet the specific rural needs and geography in that region, ensuring maximum impact. Each NC ROOTS Hub will consist of the Hub Lead and the Hub Network. Each Hub will be responsible for implementing a set of mandatory projects associated with NCRHTP Initiatives 2-6 as defined by NCDHHS and will have the option to implement additional projects suited to the needs of their region. *Figure 2* below summarizes the Hubs and their networks, as well as the role they will have in implementation of NCRHTP.

Figure 2: NCRHTP ROOTS Program Structure



For each initiative, the Hub Lead will develop a strategic plan to implement the projects most aligned with the target outcomes, as determined with the Hub Network partners that are jointly accountable for achieving them. NCDHHS will require Hubs to coordinate closely with regional CCBHCs for the provision of mental health and substance use services, for which CCBHCs are anchors in the community. To operationalize Initiative 1, two activities will be undertaken:

> **NCRHTP in Action – Year 1**
> North Carolina has several innovative technology and data solutions that ROOTS Hubs will be able to leverage on day 1:
>
>
>
> **NCCARE360:** The nation's first statewide, coordinated care network to electronically connect those with identified needs to community resources through a closed-loop on outcomes. Established through a public-private partnership and leveraging the Unite Us software, NCCARE360 helps bridge the gap between health and human services by providing community engagement, resource navigation, and referral coordination.
>
> UNITE US **UNITE US**: A leading software and data infrastructure for coordinating whole-person care across healthcare, government, and community-based organizations (CBOs)

1a. NCDHHS will secure Hub Leads in six NC ROOTS Hub regions across the state; for example, NC ROOTS Hub regions may align with the Medicaid Standard Plan regions. Prospective entities will be expected to provide detailed proposals describing their:

- Ability to fulfill the Hub Lead role based on NCDHHS definition Hub Network, including letters of commitment from required partners and its process for recruiting any additional members
- Proposed Hub governance and grantmaking structure and process for managing strategy, data and communications among the Hub Network
- Assessment of regional needs and potential regional RHTP Initiatives projects it will implement based on regional needs and barriers

> **Innovations in NC**
> In 2021, NCDHHS procured three Network Lead (NL) entities, Impact Health, Community Care of the Lower Cape Fear, and Access East. NL's have been critical regional hub entities, bridging health and human services in the Medicaid program. The Network Leads would serve as the inaugural NC ROOTS, foundational in the establishment of NC's RHTP.

- How projects and funding will leverage existing local or state infrastructure without duplicating existing funding or supports
- Processes for routine program monitoring and oversight of its Hub Network and assessing progress towards outcomes
- Sustainability plan, which includes the utilization of public-private partnerships to strengthen the funding structure of the Hub Lead and Hub Network
- Budget and budget narrative

1b. NCDHHS will support Hub Leads to ensure the success of the Hub. Supports include, but are not limited to, technical assistance, strategic partnership, outcome monitoring, convening support, policy guidance, and cross-jurisdictional leverage. Potential uses of funds are summarized in Table 5:

Opportunity Spotlight:

Tribal Health Hub

North Carolina is home to **eight state-recognized tribal communities**, including the federally recognized **Eastern Band of Cherokee Indians**. A Tribal Health Hub would serve as a culturally grounded, community-led ecosystem tailored to the needs of Native populations in rural NC. It would integrate telehealth for elders and high-risk members, embed behavioral health and peer support in tribal clinics, and grow a Native-led workforce through navigator and technical training programs. The hub would also coordinate non-medical drivers of health—transportation, food access, healthy housing—and offer transitional housing and early intervention for families. This model promotes **intergenerational wellness, economic stability, and culturally responsive care**.

Table 5. Example Uses of Funds
• Securing Hub Lead entities and infrastructure development for Hub Leads • Establishing necessary staffing • Formation of Hub Lead's regional governance structure • Development of a grantmaking and reimbursement infrastructure • Determination of shared metrics and monitoring and reporting processes • Technical assistance to establish the NC ROOTS Hub, including organization framework to establish and operate the Hub Network • Investing in the development of services shared among the Hub Network which support the implementation of RHTP Initiatives, such as AI scribe and telehealth, Hub Network-wide staff recruitment and retention, billing and coding support for providers, and capacity building to enable Hub Network partners to take part in value-based health care models, such as quality measure tracking • Creation, implementation, or enhancement of Hub Lead and Hub Network IT systems, software, or data sharing infrastructure to facilitate and track payments, monitor progress toward outcomes, and facilitate reporting to NCDHHS • Assessment of regional rural needs related to development of the Hub Action Plan to implement the RHTP Initiatives, including identification of the strategies and actions • Technical assistance to Hub Network to implement the projects defined in Hub Action Plan

Table 6. Initiative 1 Key Stakeholders		
NCDHHS Community members Rural hospitals, LHDs FQHCs RHCs Private physician practices	CCBHCs Care management entities Medicaid MCOs Health systems CBOs Social service agencies	Community Health Workers (CHWs) Philanthropic organizations Academic institutions Local businesses Other private sector entities

Initiative 1: Outcomes, Metrics, Baseline, Target, and Timeline
Outcomes: The proposed activities under Initiative 1 are designed to strengthen the infrastructure, partnerships, and operational capacity needed to transform rural health delivery. The selected metrics below—ranging from Hub establishment to referral success—track the sequential and reinforcing steps of this transformation. Together, they measure how well the Hubs are being stood up, how representative their networks are, how effectively they are deploying community-specific solutions, and whether those solutions are improving care coordination and access for patients. The ROOTS Hubs established under Initiative 1 will serve as regional anchors for the expanded primary care, prevention, and chronic disease management efforts described in Initiative 2.
1. Establish NC ROOTS Hubs* By PY2 (2027), six NC ROOTS Hubs will be established (baseline: 0). Hubs provide the structure for launching and coordinating all other initiatives (Activity 1a). **2. Safety Net Provider Participation*** By PY2 (2027), Hubs will engage a representative share of eligible hospitals, providers, and CBOs (baseline: 0%).** This ensures regionally responsive collaboration (Activity 1b). **3. Deploy Community-Based Initiatives*** By PY3 (2028), Hubs will launch targeted initiatives tailored to local needs (baseline: 0).** This demonstrates the Hubs' ability to drive community-level impact (Activity 1b). **4. Referral Activity for Hub Services*** By PY5 (2031), Hubs will track successful referrals to community providers (baseline: 0%).** This reflects the strength of regional partnerships and integrated care (Activity 1b).
* = Metrics to be reported at county/rural community level (i.e., ROOTS Hub Region) ** = Proportion depends upon eligible Hub Network entities per region, established via Hub Lead identification.

Initiative 2: Create Models & Capacity for Expanded Primary Care, Prevention, and Chronic Disease Management

Challenge: Persistent differences in access to health care services in rural communities lead to poorer outcomes in key focus areas for the state, including prevention/wellness, chronic care management, and perinatal health.

Future State: NC ROOTS Hubs will serve as anchors for whole-person health, connecting families to fresh produce and nutrition education. Schools and community organizations will partner to make movement and wellness a daily reality with expanded physical activity programs and safe spaces for exercise. NC ROOTS partners will deliver enhanced primary care, prevention, and chronic disease management services, identify and work with rural "near-dual eligible" residents to optimize aging in place, and provide critical care for pregnant women during and after birth.

Planned Activities:

- Expand primary care access
- Expand access to perinatal services in maternal care deserts through strengthened consultation, transfer systems, and networks of academic-community partners
- Create targeted programs in diabetes management, hypertension reduction, smoking cessation, physical fitness, and cancer prevention and detection that enhance rural facility capacity and service access to patients
- Expand a fresh produce Rx program in collaboration with community partners
- "Near-duals" program to proactively preempt health events for Medicare patients at risk of long-term disability

Main Strategic Goal: Goal 1: Make Rural America Healthy Again.
Use of Funds: A, B, G, I | **Technical Score Factors**: B.1, B.2 (Inc. Presidential Fitness Test), C.1, E.2., F.1.
Estimated Required Funding: $120M
Impacted Counties (FIPS): All 85 rural counties as described in Section IIA (see Annex 1).

Description: This initiative organizes programs and supports for rural communities to address priority public health issues in three areas: 1) Perinatal Health, 2) Chronic Disease, Prevention, Cancer and Physical Fitness, and 3) Food is Medicine. NC ROOTS Hubs will each pursue a minimum number of projects which closely align with the needs of their community and address the three focus areas.

2a. **Perinatal Health:** North Carolina's perinatal health efforts focus on reducing maternal and infant morbidity and mortality by extending evidence-based models to rural communities. These projects strengthen local capacity, connect rural providers to academic specialists, and expand access to comprehensive prenatal and postpartum services. Together, they build a coordinated perinatal care system that supports women and infants across all levels of care. Each NC ROOTS hub region must **expand access in maternity-care deserts** by strengthening consultation and transfer systems. NC ROOTS Hubs will work with a consortium of academic medical partners (ECU, UNC, MAHEC, etc.) to customize regional approaches that scale AI-enabled ultrasound technology, simulation-based emergency obstetric training, and emergency medical services obstetric training. NC ROOTS Hubs will work with existing regional perinatal nurse champions to complement and align with ongoing evidence-based approaches in the region to promote maternal health, such as the "I Gave Birth" model (*see textbox)* to promote post-partum health and increase awareness of Post-Birth Warning Signs. In addition to the core work in each region, regions may pursue additional projects to improve access to perinatal care:

Innovations in NC

"I Gave Birth"

A postpartum care model that uses a simple but powerful tool: a bracelet worn by postpartum patients. Healthcare workers, including emergency department staff, are trained to recognize the bracelet and follow a standardized protocol to assess and support postpartum needs, including mental health, physical recovery, and care coordination. After the concept and training program was introduced at ECU Health Medical Center, fewer new moms had to come back to the hospital, **readmissions dropped by nearly a third—**because they were getting the right care at the right time.

Table 7: Initially Planned Perinatal Health Projects	** = Required activities*
Project	**Purpose / Key Activities**
LOCATe Analysis*	Partner with local health care systems to use the Level of Care Assessment Tool (LOCATe) to determine the capacity of local health systems, identify gaps, and opportunities for improvement.
Expand Access in Maternity Care Deserts*	Strengthen consultation and transfer systems and work with a consortia of academic and AHEC partners (ECU, UNC, MAHEC, etc.) to customize regional approaches that scale AI-enabled ultrasound technology, simulation-based emergency obstetric training, and emergency medical services obstetric training.
Perinatal Project ECHO	Virtual mentoring network linking rural prenatal providers with academic specialists to improve screening, trauma-informed care, and coordination. Also supports patients receiving care with providers in their own rural communities to assist with reduced travel and trust building.
Academic Regional Obstetrical Collaborative (AROC)	Places academic obstetricians in community hospitals while maintaining university affiliation to expand local maternity capacity.

2b. Chronic Disease, Prevention, Cancer and Physical Fitness. This portfolio advances prevention and chronic-disease management through evidence-based, community-integrated models addressing diabetes, hypertension, sickle-cell disease, tobacco use, cancer, and physical fitness. Projects that the NC ROOTS Hubs will undertake combine access, patient education, and care-coordination infrastructure to reduce disparities and strengthen rural provider capacity. To ensure a consistent, evidence-based approach to chronic disease prevention across all ROOTS Hub regions, each region will be charged to increase access to, and utilization of, evidence-based chronic disease prevention and self-management programs. Each NC ROOTS region will conduct a structured gap assessment to evaluate disease burden, and the availability, accessibility, and utilization of the following evidence-based programs for the prevention and management of chronic conditions, including diabetes, hypertension, tobacco-use, and cancer based upon regional data. Each region should use existing data sources, such as Community Heath Assessments and Community Health Improvement Plans. Based on the findings, regions will identify priority areas for strengthening program delivery and outreach. Each region’s approach must include a **provider education and engagement strategy** designed to:

- Increase awareness of available programs

- Improve referral workflows through electronic health record (EHR) integration
- Offer training on eligibility criteria and referral processes
- Promote culturally and linguistically appropriate outreach materials
- Expand health care team for chronic disease management (i.e. pharmacists, CHWs, EMTs)

This dual approach—combining system-level gap analysis with provider-level engagement—will ensure that high-risk individuals are not only identified but also successfully connected to the resources they need to prevent or manage chronic disease. Among focus areas and specific projects that the NC ROOTS Hubs might select include:

Table 8: Chronic Care/Prevention Initially Planned Projects	** = Required activities*
Project	**Purpose / Key Activities**
Risk Factor Gap Assessment*	Conduct a structured gap assessment to evaluate disease burden, and the availability, accessibility, and utilization of evidence-based programs for the prevention and management of chronic conditions, including diabetes, hypertension, tobacco-use, and cancer based upon regional data. Based on the findings, regions will identify priority areas for strengthening program delivery and outreach.
Provider Education and Engagement Strategy*	Design and implement a program to increase awareness of available programs, improve referral workflows through EHR integration;
Expand Healthcare Team for Chronic Disease Management*	Conduct training and outreach with providers to expand services, such as tobacco treatment program specialists, integrating nutrition support, and enhancing cancer screening outreach and follow-up within primary care and community settings.
Diabetes Services Expansion	Train and equip rural providers and FQHCs to deliver Diabetes Self-Management Education and Support (DSMES), Diabetes Prevention Program (DPP), and Family Healthy Weight Programs across the lifespan. This includes deployment of Facilitated Remote DSMES in rural areas lacking internal capacity, and integration with the FHWP through electronic referral systems to increase the enrollment of children and families.
Hypertension Reduction Initiative	Scale self-measured blood-pressure (SMBP) programs and embed into clinical workflows, embed evidence-based workflows in rural practices, train CHWs and community pharmacists in the Healthy Heart Ambassador Program-Blood Pressure Self-Monitoring model.
Sickle Cell ECHO Network	Tele-mentoring that links rural providers with hematology specialists to deliver evidenced based care for individuals living with sickle cell disease (CD) in rural communities.
Rural Tobacco-Free Futures	Partner with existing LHD-based tobacco collaboratives to identify and respond to gaps in tobacco cessation efforts, including QuitlineNC referrals, and training rural providers in tobacco-treatment protocols.
Rural Integrated Cancer Hubs	The NC ROOTS Hubs will coordinate existing mobile units to deliver cancer and chronic disease screenings, embed CHW-led outreach and navigation, provide telehealth consultations with specialists, and establish formal referral agreements among FQHCs, CAHs, and diagnostic centers. These integrated efforts will expand access to care and ensure timely follow-up.
Physical Activity Access & Integration	Implement evidence-based physical activity programs in rural communities. Train CHWs and local partners to deliver or refer to these programs. Embed physical activity referrals into EHR workflows. Partner with schools, YMCAs, and senior centers to expand reach.

“Near-Duals” Services*	Train and equip rural providers to identify Medicare patients and provide supports to connect patients to resources and services that will help to age in place and prevent clinical events that lead to disability and/or situations where spend down into Medicaid is needed. For residents that do qualify, services to connect into dual-eligible plans will be provided.

2c. Food is Medicine. Nutrition insecurity is a cornerstone non-medical driver of chronic disease in rural NC. In this activity, NC ROOTS Hubs will lead and coordinate a comprehensive “Food is Medicine” strategy that advances the Healthy Foods and Healthy Families priority from the Make Our Children Healthy Again plan. The strategy is expected to consider the coordination of nutrition supports with other non-medical drivers of health needs in each region, e.g. transportation access and housing insecurity. All activities are designed to build sustainable infrastructure and capacity for rural North Carolinians to experience healthier lives. By embedding nutrition access and education into existing health and social service networks—and focusing investments on infrastructure capacity, training, and systems—NC ROOTS Hubs will ensure these efforts are sustainable and locally responsive. Key approaches include:

Potential for Partnership

The American Heart Association’s “Food is Medicine” initiative has demonstrated measurable impact in rural communities by expanding access to nutrition counseling and food benefits through mobile platforms. This evidence-based approach connects patients to healthy food and care—showing what’s possible for rural health transformation.

Table 9: Food is Medicine Approaches	
Project	**Purpose / Key Activities**
Expand healthy grocery box and meal initiatives	Build the partnerships and infrastructure needed to connect patients and families to nutrition supports, including healthy food boxes, medically tailored meals, and nutrition education through CBOs (e.g. food pantries, clinics, and YMCAs).
Strengthen NC Regional Food Hubs and facilitate farm-to-hospital, mobile food markets, and community-based food access	Invest in locally based food infrastructure, farmers, community food banks, technology, and logistics to more effectively coordinate whole-person health by addressing non-medical drivers of health, including delivering fresh, local, and culturally relevant foods. Possible strategies include mobile food markets, farmers market SNAP/WIC-match voucher access (e.g., Double Bucks programs), and farm-to-hospital programs.
Build local capacity	Expand CBO and CHW capacity to provide supports that address non-medical drivers of health, like evidence-based nutrition education curricula, empowering

	families with practical knowledge such as food preparation, budgeting, and making healthy choices regardless of budget or location.
Implement electronic referral and tracking systems	Connect patients experiencing non-medical drivers of health like food insecurity, housing insecurity, and transportation insecurity to resources, monitor usage of resources, and ensure efficient program evaluation.

Table 10. Initiative 2 Key Stakeholders	
Healthcare Providers: Rural primary care and specialty care providers, rural hospitals, LHDs, FQHCs, CHCs, EDs, EMS, CHWs	**Community & Support Organizations**: Local Community Collaboratives, CBOs, Faith-Based Organizations. Local farmers, food banks, community organizations.

Table 11: Initiative 2: Outcomes, Metrics, Baseline, Target, and Timeline
Outcomes: Proposed metrics for Initiative 2 capture how expanded access to perinatal care, strengthened chronic disease management, increased tobacco cessation, and improved nutrition infrastructure work synergistically to prevent avoidable hospitalizations and promote whole-person health for rural North Carolinians.
1. Increase Access to Perinatal Care* By PY5 (2023), % of births to women residing in rural counties who receive prenatal care during first trimester of pregnancy increase to 80% (statewide baseline: 72%; rural county rates to be established). Accessing timely prenatal care is correlated with positive maternal and early child health outcomes (Activity 3a). **2. Reduce Chronic Disease High-Cost Comorbidity Burden*** By PY5 (2031), 9.7% reduction in the % of adults in target population reporting three or more chronic health conditions (baseline: NC ROOTS Hubs to develop new baselines). Demonstrates how effectively the five chronic disease projects slow disease progression. Note: We expect the number of uninsured people to rise during this period so maintaining current outcomes would be a success. (Activity 3b). **3. Increase Patient Use of Self-Monitoring Blood Pressure*** By PY3 and PY5 (2029 / 2031), # of eligible patients offered/received SMBP increase by 5% and 10% respectively (baseline: to be established per NC ROOTS Hub region). Correlates with better cardiovascular outcomes for patients with chronic disease (Activity 3b). **4. Decrease Tobacco Use*** By PY3 and PY5 (2029 / 2031), % increase of referrals to QuitlineNC from participating counties / organizations increased by 5% and 10% respectively (baseline: to be established per ROOTS Hub region). Referrals to QuitlineNC relate to successful smoking cessation result (Activity 3c). **5. Increase access to healthy food prescriptions** By PY5 (2031), 15-20% of high-risk individuals (as defined by NC DHHS) receiving healthy food boxes increases (baseline: to be established per NC ROOTS Hub region). Healthy food access is linked to lower risk of chronic illness (Activity 3c).
* = Metrics to be reported at county/rural community level (i.e., ROOTS Hub Region)

Initiative 3: Expand and Integrate Behavioral Health and Substance Use Disorder Services

Challenge: Persistent rural gaps in access to behavioral health services including inconsistent availability of mental health and substance use disorder services, gaps in crisis response and school-based care, underdeveloped care coordination, and fragmented service delivery systems.

Future State: A foundational behavioral health system with a standard array of services available in every region, supported by integrated care networks, school-based and community-based programs, mobile services, and data-driven quality improvement.	**Summary of Activities:** • Expand CCBHCs in rural counties and launch a statewide quality initiative. • Develop new rural Community Crisis Centers to strengthen 24/7 crisis response and stabilization services. • Expand Mobile Outreach Response Engagement and Stabilization programs. • Increase access to integrated physical and behavioral health care for youth through the expansion of school-based health centers (SBHCs) in rural areas. • Expand NC Maternal Mental Health Matters program to rural communities. • Expand paramedic-initiated medication assisted treatment pilot for opioid use disorder (OUD) to new rural counties • Deploy mobile and co-located opioid treatment units to improve access to medications for OUD in underserved rural communities.

Main Strategic Goal: Make Rural America Healthy Again
Use of Funds: A, D, G, H, I, K | **Technical Score Factors:** B1, C1, F1 | **Estimated Required Funding:** $155M
Impacted Counties (FIPS): All 85 rural counties as described in Section IIA (see Annex 1).

Description: NC will implement a series of regional activities to expand the state's successful programs and models into rural communities more robustly than has been possible given funding and operational barriers. Our approach is anchored in the state's CCBHC model. CCBHCs are specially designated clinics that provide a full range of mental health and substance use services—like therapy, psychiatric care, peer support, and crisis intervention—all under one roof, with a focus on care coordination and accessibility. NCRHTP will fully expand CCBHC reach to rural communities, coordinated with the regional ROOTS Hubs, and with an enhanced and scaled menu of innovative programs, established infrastructure, and strong commitment to addressing unique rural behavioral health needs. NC is well positioned to lead this effort and set a national standard for integrated, community-based behavioral health (BH) care. NC will undertake nine activities organized to meet three objectives:

Innovations in NC

Hazel Health Expands School-Based Behavioral Health Access.

In March 2025, the NCDHHS partnered with school-based telehealth provider Hazel Health to provide high-quality, virtual mental health care for nearly 400,000 K-12 students—almost 30% of the state's student population. The approaches address provider shortages and cost barriers, aiming to improve student well-being, academic performance, and long-term development.

Hazel Health

3a. Expand CCBHCs to rural communities and standardize the state's CCBHC model

Activity 3a.1. CCBHC Expansion. Expand reach by creating 3-4 new CCBHCs helping rural residents access and navigate BH, physical health, and social services. By expanding the model into rural areas and adding services to address critical community service gaps, this initiative will ensure that a standard array of critical mental health and substance use services are available in rural parts of the state.

> **Innovations in NC**
>
> ***Trillium Ultimate Living Assistant (TULA)***
>
> TULA is a digital platform developed in NC to help individuals and families connect to mental health, physical health, and intellectual/developmental disability services—especially in areas with limited provider availability. By reducing the need for in-person navigation and streamlining administrative tasks, TULA enables providers to focus more on care delivery, while being responsive to community needs in rural and underserved regions.
>
> TULA
> Trillium Ultimate Living Assistant

Activity 3a.2. CCBHC Quality Improvement (QI). Launch a statewide QI activity to enhance the performance, accountability, and sustainability of CCBHCs, focusing on data quality, clinical outcomes, and care coordination. The Department will align this QI initiative with the existing Health Home model, which NC Medicaid implemented to provide person-centered care management for Medicaid beneficiaries with BH, intellectual and developmental disabilities (IDD), traumatic brain injury and SUD needs, and its quality approach.

3b. Deliver enhanced assessment & treatment programs to address critical care gaps

Activity 3b.1. First Episode Psychosis Programs. Expand the Coordinated Specialty Care (CSC) model with rural adaptations to increase access, such as a hub and spoke model that incorporates tele-psychiatry with community-based teams to reduce geographic barriers. CSC provides an interprofessional team-based approach for early intervention with youth with emerging psychosis.

The CCBHC structure ensures that robust early serious mental illness services (early screening, diagnosis, outpatient and family therapy, psychiatric care, peer support, and supported employment/education) are accessible and integrated into whole person care. Universal screening practices incorporated across CCBHC services will identify and support individuals at high risk of developing serious mental illness prior and connect them to integrated care, mitigating or delaying onset, and often preventing Emergency Department encounters.

23 out of 100

Counties in NC still lack active psychologists, and youth suicide is now the leading cause of death among ages 10–14.

Activity 3b.2. Rural Crisis Centers. Integrate new community crisis centers into CCBHCs in total areas to provide 24/7 assessment, stabilization, health evaluations, substance use interventions, and referral services. By integrating crisis centers with the longer term and more comprehensive care offered at a CCBHC, individuals who experience a mental health crisis will be more likely to receive ongoing care to support recovery after a crisis.

Activity 3b.3. Mobile Outreach Response Engagement and Stabilization (MORES). On any given night in North Carolina, an average of 74 youth spends the night in an emergency room due to a mental health crisis. Often, families seek care at an emergency room even though another care setting is more appropriate for their needs. This project will help to reduce ED utilization for youth experiencing a mental health crisis by expanding access to MORES—a team-based crisis response intervention for youth experiencing escalating behavioral needs—in 8–10 rural counties to provide timely, community-based crisis response and stabilization for children and their families, reducing dependence on emergency services. We intend to further innovate on this model by linking MORES to

1 of 13

North Carolina is one of only 13 states where this innovative model is deployed to provide both mobile crisis and extended care management to youth experiencing behavioral health *crises*.

CCBHCs, increasing connections to ongoing care to ensure youth treatment needs are met to support recovery after a crisis.

Activity 3b.4. SBHCs: Youth are six times more likely to complete evidence-based treatment when offered in schools vs. other community settings. This initiative will remove barriers to care by expanding SBHCs in rural areas to provide youth with integrated behavioral and physical health services. SBHCs are co-located on school campuses and therefore are particularly effective in rural areas where residents often face significant access barriers.

Activity 3b.5. Mobile Opioid Treatment Programs (OTP) and Medication Units (OTP): Deliver Medications for Opioid Use Disorder (MOUD), including methadone, and other clinical and supportive wrap-around services in hard-to-reach rural communities. North Carolina is operating 1 of only 71 Drug Enforcement Administration (DEA) approved Mobile OTPs nationwide and is in the process of launching an additional 10 to support OTP access for remote and rural areas. This initiative will further support access for rural areas by connecting brick-and-mortar OTPs with rural communities that have inadequate access to all FDA-approved forms of MOUD. This is achieved through strategic partnerships between OTPs and rural community organizations, enabling service delivery via mobile units or co-located medication units within existing health centers (e.g. FQHCs). Funds would be used to purchase mobile units and/or re-purposing existing health centers to serve as OTP medication units. Through flexible, targeted outreach, this approach will seek to connect high need populations, particularly pregnant and breastfeeding women, to critical OUD treatment services.

3c. Leverage collaborative and non-traditional workforce models to connect North Carolinians to care

Activity 3c.1. NC Maternal Mental Health MATTERS (Making Access to Treatment, Evaluation, Resources, and Screening Better). NC MATTERS is North Carolina's innovative perinatal psychiatry access program that bridges obstetric, primary care, and mental health providers to create a more coordinated system of care for pregnant and postpartum individuals with behavioral health and substance use needs. The program, which is unique to NC, has reached providers in 52 of 100 counties but does not have reach in the most rural areas of the state. While 1 in 7 women nationally experience perinatal depression, research shows that up to 1 in 3 pregnant women in rural Southern clinics are at risk—underscoring the urgent need to expand NC MATTERS into rural counties like Chowan, Dare, Ashe, Chatham, Granville, and Rockingham, where emergency departments and CAHs often serve as the only behavioral health entry point. Funds will support clinical coverage for phone consultation, clinical onsite leads, travel for hospital visits and on-site collaborative meetings, training, education, and provider.

Activity 3c.2. Paramedic Initiated Medication Assisted Treatment Access. Strengthen access to medications for mental health and SUD in rural communities by leveraging paramedics to initiate Medication Assisted Treatment after an overdose. Evaluations show that individuals who receive EMS-initiated buprenorphine are more likely to engage in substance use treatment after an overdose. NC is currently piloting this initiative in 20 counties and proposes utilizing this grant to expand to an additional 10 counties in rural areas.

Table 12. Initiative 3 Example Stakeholder Partners	
Partner	
• CCBHCs • Rural Primary Care Providers (PCPs), Pediatricians, NPs, PAs • Behavioral Health Providers & Autism/DD Service Providers • Opioid Treatment Programs (OTPs), Peer Support & Recovery Organizations • LHDs& FQHC • Consumer and Family Advisory Committees (CFACs)	• Rural Hospitals, EDs, EMS • NC-Based Health Systems (e.g., Duke Health, UNC SOM) • Community Care of North Carolina (CCNC) • Tailored and Standard Health Plans • Community-Based & Faith-Based Organizations • Philanthropic Partners (e.g., Duke Endowment, Leon Levine Foundation, Dogwood Health Trust, BlueCross BlueShield NC Foundation) • SBHCs & Educational Institutions inc. Community colleges

Initiative 3: Outcomes, Metrics, Baseline, Target, and Timeline
Outcomes: Proposed Initiative 3 activities are designed to build a cohesive and accessible behavioral health system in rural North Carolina. The selected metrics—ranging from CCBHC expansion to reduced emergency department use—track how these efforts strengthen care coordination, expand service availability, and improve access to timely, appropriate treatment. Together, they measure how well the activities are closing rural care gaps, integrating behavioral health services, and ensuring patients receive the right care in the right setting.
1. Establish New Rural CCBHCs By PY2 (2027), five CCBHCs will be established (baseline: 0). New CCBHCs are foundational to coordinate rural provision of planned behavioral health activities (Activity 2a). **2. Increase in Percent of Medicaid Members Beginning Mental Health Treatment*** By PY5 (2031), % of Medicaid members beginning mental health treatment increased by 5% each year (baseline: 20%). Service penetration measures how easily eligible people can reach and use a given service or set of services. (Activities 2a, 2b, 2c). **3. Decrease ED Utilization for Mental Health Needs** By PY5 (2031), average daily # of individuals in the ED seeking treatment for mental health needs have decreased by 8 – 10% each year (baseline: 409). Demonstrates diversion to more appropriate treatment settings and increase in upstream access to treatment (Activities 2a, 2b, 2c). **4. Decreased ED Utilization for Opioid Overdose** By PY5 (2031), # of annual ED encounters related to opioid overdose decreased by 20% (baseline: 4,971). Demonstrates diversion to more appropriate treatment alternatives through increased availability and accessibility of medications for OUD and other clinical services (Activities 2b, 2c). **5. Decreased ED Occupancy for Youth Mental Health Needs** By PY5 (2031), average daily ED occupancy rate of members under the 18 for visits > 24 hours will decrease by 8 – 10% (baseline: 74). A decrease demonstrates diversion to more appropriate treatment settings and increase in upstream access to treatment (Activities 2b, 2c)
* = Metrics to be reported at county/rural community level (i.e., ROOTS Hub Region)

Initiative 4: Build a Robust & Resilient Workforce & Innovative Care Team Models for Rural Communities

Challenge: Persistent rural health workforce shortages in North Carolina are driven by uncoordinated and fragmented programming, limited training sites and faculty shortages, and placement and retention challenges.

Future State: A modernized, sustainable rural health workforce supported by integrated training hubs, expanded residencies/fellowships and upskilling programs.	**Activities**: • Launch new rural residencies and fellowships Expand simulation labs and interprofessional training • Increase qualified training sites and clinical faculty • Build high school-to-health care and invest in upskilling pipelines Expand certification programs in key workforce shortage areas • Provide paid internships, tuition-free certification, and employment incentives/ placement services for five-year rural service commitment

Main Strategic Goal: Goal 3: Workforce Development.
Use of Funds: D, E, H, I |**Technical Score Factors:** B.1, B.4. (Nutrition CME Policy) C.1, C.2, D.1 | **Estimated Required Funding:** $136M
Impacted Counties (FIPS): All 85 rural counties as described in Section IIA (see Annex 1).

Description: This initiative strengthens and modernizes North Carolina's rural health workforce through direct investment in CBOs to lead expanded education and training programs. We will achieve this by:

1. Expanding existing programs to support education, training, and placement into rural communities for more high-need provider types
2. Ensuring sufficient staff/faculty to educate (precept, train, etc.) students
3. Translating "train" into "retain" - keeping people in rural health positions where turnover is currently high, including high school outreach programs such as the NC Chamber High School to Healthcare program; and
4. Leveraging data to tailor solutions to regional specific needs / avoiding one size fits all approach.

95 out of **100**
counties in NC are designated as a Health Professional Shortage Areas for primary care *(NC Rural Snapshot, 2025)*

NC proposes to undertake three projects in support of North Carolina's statewide workforce development goals.

4a. Establish Regional Rural Training Hubs. Coordinated via the ROOTS Hubs, with programs led by regional partners including rural hospitals, universities, community colleges, K-12 schools' career and technical education departments, and other rural community-based groups, training hubs will organize and deliver a broad menu of technical support, training, and administrative services to bolster the rural healthcare workforce across the state (*Table 13).*

Table 13. Rural Training Hub Projects & Use of Funds
• **Launching new rural residencies and fellowships** in high-need medical specialties (*see table below*) • **Providing simulation labs** for medical trainees and practicing clinicians to prepare for high-acuity, low-occurrence events, such as obstetric emergencies and trauma, and offering **interprofessional training** to foster collaborative care among doctors, nurses, pharmacists, social workers, and paramedics. • **Offering technical assistance, training, and start-up and operating funding** to increase the number of qualified training sites and the number of clinical teaching faculty/preceptors • **Coordinating outreach, education, and clinical practice pipelines** to guide students from high school and community college through health career pathways and into rural clinical practice, with a focus on retention.

Table 13. Rural Training Hub Projects & Use of Funds
Rural training hubs will also engage NCWorks career centers to connect jobseekers with education, training, and career services. • **Promoting community-based, interprofessional training** and preparation for innovative care models such as shared maternity care, community paramedicine, and models anchored by CHWs • Building pipeline programs to **enable workforce "upskilling"** and ladders within high-need professions including administrative staff (i.e., practice managers) • Building culturally responsive health career pathway programs, including in **tribal communities**, developed in collaboration with high schools and community colleges, to expand entry into and retention in these communities.

Training Hubs will initially focus on six high-need provider categories and will be coordinated with existing regional and statewide initiatives and will require a five-year service commitment:

Table 14. Initiative 4 Initial Focus Areas for High Needs

Primary Care Providers	Specialists	Oral Health	Nurses, Caregivers & Allied Health Professionals	Mental Health & Substance Use Professionals	Emergency Medical Services
Physician Assistants (PAs), Nurse Practitioners (NPs) Medical Doctors (MD and DOs)	Psychiatry, Maternal Health (OB/GYN, Midwives, Doulas)	Dentists; Dental Hygienists	Licensed Practical Nurses (LPNs), Registered Nurses (RNs), Nurse Anesthetists (CRNA), Direct Care Workers, Pharmacists, Pharmacy Technicians, Surgical, Radiology, Lab Technicians CHWs	Social Workers, Peer Support Specialists	Paramedics, Emergency Medical Technicians (EMTs)

4b. Expand the Rural Behavioral Health Workforce Development Certification Program. This statewide program expands the Qualified Professional (QP) Certification Program in partnership with the NC Community College System (NCCCS) to strengthen the behavioral health workforce in rural and underserved counties. The project will provide paid work-based learning, tuition-free certification opportunities, and selective awards and placement services to prepare and place community-based practitioners for behavioral health and substance use treatment roles. Training will emphasize rural practice, integrated care, telehealth, and trauma-informed approaches.

Innovations in NC

Governor's Council on Workforce & Apprenticeships (2025)

Sets ambitious targets for doubling registered apprentices, expanding work-based learning, and engaging employers across key sectors—including health care. These goals align with Initiative 4's focus on building high school-to-healthcare pipelines, expanding rural residencies, and launching innovative care team models. Sector-based strategies and employer partnerships are central to both statewide and rural workforce development efforts.

Graduates will receive employment placement support and tuition reimbursement for serving in

designated rural communities, addressing workforce shortages and improving access to behavioral health care.

4.c. Expand Social Work Rural Scholars Program: Strengthening Behavioral Health Access and Leadership. This statewide program will train and retain a new generation of social workers to serve rural and frontier NC communities. The activity will support paid field placements and tuition reimbursement for undergraduate and graduate students committed to rural behavioral health, substance use, and aging services.[vii] Participants will receive specialized training in rural practice, tele-behavioral health, and workforce resiliency, and commit to five years of rural service post-graduation. By focusing on structured training, mentorship, and service commitments, the program will strengthen the pipeline of licensed professionals and improve access to behavioral health care in high-need rural counties.

4.d. Develop a community doula and community health worker program. This program will train and certify doulas for rural deployment and integrate them with CHWs to provide culturally appropriate perinatal support in rural communities.

The CHW will serve as the frontline staff responsible for creating awareness about the program within the community, using social media, community events, and presentations to churches, schools and providers, to recruit pregnant women as early in pregnancy as possible in efforts to increase the number of women receiving prenatal care in the first trimester. The CHW will also be responsible for facilitating opportunities to build social support among the pregnant, postpartum, and interconnection women participating in the program. The doulas will each be assigned a number of women for which they will be the primary doula. The doulas will work collaboratively to ensure that all pregnant women have continuous labor support; therefore,

providing back-up coverage for each other. The doula and/or CHW will be expected to maintain contact with the woman beginning prenatally through the postpartum period.

Key Stakeholders: Examples of organizations that will partner on these efforts are summarized in Table 15.

Table 15: Initiative 4 Example Stakeholder Partners

Partner	Summary
The University of North Carolina System	North Carolina is home to 16 public universities, including five Historically Black Colleges and Universities (HBCUs) such as Elizabeth City State University, located in a rural area. The state also hosts rural campuses in both the western region—Western Carolina University and Appalachian State University—and the eastern region, where UNC Pembroke stands as the state's only designated historically American Indian university. The UNC Cecil G. Sheps Center for Health Services Research, known for its rural health expertise, will also support this initiative.
NC AHEC	Provides and supports educational activities with a focus on primary care in rural communities and those with less access to resources to recruit, train, and retain the health workforce. Includes the NC Center on the Workforce for Health, which works to strengthen NC's health workforce by convening employers, educators, workers, regulators, and other stakeholders to research, discuss, and develop solutions for the state's workforce challenges.
The NC Community College System (NCCCS)	Includes 58 community colleges, with a campus within 30 miles of almost every North Carolinian. NCDHHS has existing educational partnerships with the NCCCS to deliver CHW and behavioral health training.
NC's extensive network of rural hospitals including those in the HRSA FLEX and SHIP Programs	North Carolina's vast network of rural hospitals—including 11 Small Rural Hospitals and 20 Critical Access Hospitals (CAHs) supported through the HRSA FLEX and SHIP programs—forms a critical foundation for statewide transformation. These facilities, many of which serve as the sole source of inpatient and emergency care in their regions, are supported by the Office of Rural Health (ORH) in partnership with the NC Healthcare Association to deliver technical assistance and capacity-building support. Systems like Scotland Health exemplify the resilience and innovation of rural providers, demonstrating how targeted investment and collaboration can sustain access to care in underserved communities.
NC Department of Commerce & NCWorks Commission	Provide access to braided funding for tuition and work-based learning as well as local job placement support at the more than 70 NC Career Centers.

Initiative 4: Outcomes, Metrics, Baseline, Target, and Timeline
Outcomes: The outcomes and metrics for Initiative 4 are designed to measure progress toward building a sustainable rural health workforce and care team infrastructure across North Carolina. By tracking the launch of new rural residency and fellowship programs, the placement of CHWs and EMS professionals, reductions in clinician vacancy rates, and improvements in primary care clinician ratios, these metrics ensure that each activity contributes to long-term workforce stability and capacity.

Initiative 4: Outcomes, Metrics, Baseline, Target, and Timeline
1. Increase Rural Residencies & Fellowship Programs* By PY5 (2031), 8 – 12 new programs in high need specialties (baseline: 10). Expanding rural GME based programs is a proven strategy to increase rural provider retention (Activity 4a)
2. Increase EMS Professionals in Rural Communities* For each of PY 2 - 5 (2017 - 2031), 150 new EMTs per year (baseline: 0). Addresses a major workforce gap in rural communities, with projections to worsen (Activity 4a).
3. Improve Rural Clinician Vacancy Rates* By PY5 (2031), 10% reduction in county-level xix-month clinician vacancy rate. Filling vacancies is critical to ensuring sustainable access to care (Activity 4a, 4b)
4. Improve Rural County Primary Care Clinician Ratio* By PY5 (2031), 15% reduction in # of rural counties where ratio of population to primary care clinician is less than 1500:1 (Midwives, NP, PCP). This metric reflects the initiative's impact on access to care (Activity 4a).
* = Metrics to be reported at county/rural community level (i.e., ROOTS Hub Region)

Initiative 5: Ensure Fiscal Sustainability of Rural Health Providers Through Innovative Financial Models

Challenge: Rural patients encounter a fragmented care delivery system, while many providers struggle to stay financially viable. Value-based payment (VBP) can offer a path forward—when providers have the experience and skills to succeed.

Future State: Coordinated health care VBP programs supporting rural primary care practices and rural hospitals, to facilitate a reliable revenue stream. This enables providers to invest in team-based care, adopt innovative ways of working, and focus on improving outcomes rather than volume. **For patients**, this transformation means greater access to coordinated, preventive, and whole-person care—delivered closer to home.

Summary of Activities:
- Develop and build rural primary care and hospital VBP capacity building program
- Develop and build Medicaid rural primary care capitation pilot

Main Strategic Goal: 2) Sustainable access
Use of Funds: D, F, G, K | **Technical Score Factors**: B.1, C.1, E.1, | **Estimated Required Funding**: $82M
Impacted Counties (FIPS): All 85 rural counties as described in Section IIA (see Annex 1).

Description: This initiative will provide technical assistance, infrastructure funding and coordination of regional coalition networks to develop and administer paired rural value-based payment (VBP) strategies to build capacity for rural primary care providers and hospitals. VBP is a model that shifts health care payments from volume to value—rewarding providers for delivering high-quality, coordinated care rather than the number of services rendered. This approach is especially beneficial in rural settings, where providers often face financial instability and fragmented care systems. This initiative will build on existing NC efforts to move providers to higher level VBP models. A planned primary care capitation pilot builds on NC Medicaid's

years of investment in population health and VBP, including its longstanding commitment to coordinated patient-centered medical homes and value-based contracting through its managed care transformation. Planned VBP capacity building for hospitals builds on NC's small rural hospital network in the established Medicare Rural Hospital Flexibility Program (Flex) and the statewide rural health clinic network at the NC Office of Rural Health (ORH), which provides a framework to partner with regional networks to prevent or reduce transfers to larger urban hospitals. Note that RHTP funds will support development and implementation of these pilots, but will not pay for delivery of patient care, including capitation payments.

Where We Are in NC – Rural Value Based Care	
Primary Care • NC Medicaid's medical home program includes nearly 3,000 practice locations, with 27% (805) in rural counties. • Of rural Medicaid medical homes, 57% participate in Tier 3 of the Advanced Medical Home (AMH) program; most Tier 3 contracts are pay-for-performance, with some in shared savings and Medicare VBP programs.[viii] • AMH Tier 3 provides per member per month payments (PMPM) to support care management and infrastructure. **Rationale for focus:** • NC providers support expanding AMH to include prospective payments, replacing fee-for-service. • Capitation allows rural practices to invest in team-based care and provides financial stability, especially for smaller practices vulnerable to unexpected shifts.	**Hospitals** • NC has 55 rural hospitals: 20 CAH and 35 short-term PPS hospitals. • Many rural hospitals face financial instability and do not provide optimal service mix or geographic coverage. **Rationale for focus:** • VBP programs can target resources to community health outcomes, but rural hospitals need foundational capacity building—financial expertise, data analysis, and IT systems—to participate successfully.

Proposed Programs:

NC will use RHTP funds to launch two complementary efforts to support VBP for rural hospitals and primary care providers:

- Capacity building for rural health care providers and hospital networks - including CAH, regional partner hospitals, and primary care providers - to successfully participate in VBP.
- A Medicaid primary care/pediatrics capitation pilot to provide an opportunity for rural primary care providers to test an advanced value-based payment program.

These programs will leverage NC ROOTS Hubs to administer VBP capacity building funds, develop key elements of the primary care capitation pilot with stakeholder input, oversee hospital quality metric reporting, and promote shared learning across regions to accelerate best practice adoption. Incorporating regional organizations and partner feedback in the program design will ensure the programs address specific regional needs and geographies within the required parameters, rather than relying on a one-size-fits-all approach.

Both components of this initiative share two primary goals:

- Transitioning rural providers to higher level value-based arrangements to improve outcomes and reduce total cost of care and promoting eventual multiplayer involvement.
- Maintaining strong access to healthcare services in rural communities strained by provider sustainability and healthcare workforce challenges.

5.a. Rural Hospital VBP Capacity Building: The rural hospital VBP capacity building program will be administered by the NC Roots Hubs which will implement a competitive process to select qualified CAHs and their selected primary care partners. The regional hubs will distribute capacity building funds based on requested components within the selected proposals and the cooperating entities' focus on two community-selected and regionally approved quality metrics. Through the application process, participating hospitals and their regional hospital partners will describe how infrastructure investments will be utilized to support the hospital and one or more local primary care partners. These investments may include some of the following approaches:

- Investment in technology to support VBP readiness, such as referral systems and population health tools.
- Financial expertise or tools.

- Acquiring new staff or contracted roles to support quality metric improvement or value-based expertise.

5.b. Primary Care Capitation Pilot: NCDHHS, via NC Medicaid, aims to launch a primary care capitation pilot for rural providers beginning in 2028. This pilot will provide an opportunity to design and test a primary care capitation model, which if successful in improving outcomes and lowering total cost of care, could be implemented more broadly at the end of the RHTP period as a second phase of the Department's efforts to increase Medicaid provider participation in higher level VBP risk arrangements. In designing the program, NC Medicaid will continue to align its program design and requirements to opportunities from other payers, including Medicare (e.g., CMMI's AHEAD model), to support increased effectiveness and lower administrative burden for providers. NC Medicaid will implement this pilot through its contracted managed care organizations, RHTP funds will not support capitation payments. Key features of primary care practice pilot will include (to be further developed and designed with local input):

- *Predictable prospective payments*. Participating rural primary care practices will receive predictable per-member-per-month (PMPM) payments through prospective budgeting. This model ensures financial stability while allowing practices to plan and invest in care delivery. Select high-value services will remain reimbursed through fee-for-service (FFS) carveouts to preserve access and incentivize their use. (As stated above, while RHTP funds would support development and implementation of the pilot, Medicaid funds would be used for prospective payments; no RHTP funds would be used to pay for delivery of patient care.)
- *Performance-based quality incentives*. Practices will be evaluated using a set of primary care quality measures aligned with existing Medicaid and national standards. Performance

incentives will reward improvements in care quality, patient outcomes, and population health.

- *Upfront transition support.* Opportunity for pilot participants to receive upfront funds, administered by the ROOTS hubs, to support transition to, and initial participation in, a capitated model (e.g., technology investments; financial expertise or tools; acquiring new staff or contracted roles).[ix]

Innovations in NC commure

Tech companies in NC are implementing AI-powered platforms to streamline clinical documentation, revenue cycle management, and patient access workflows for rural providers—reducing administrative burden and improving care quality. In NC, Commure's deployment across health systems has led to:

- 31% reduction in documentation errors
- 24% faster edit times
- 18% reduction in time to complete Histories & Physicals (H&Ps)
- 2+ hours saved per clinician in documentation time

Key Stakeholders: This initiative will be implemented through ROOTS hub partners, participating CAH and regional system partners, primary care providers, NC Medicaid and its contracted health plans, the NC ORH, and other partners supporting VBP advancement. Examples of organizations that will partner on these efforts are summarized in Table 16.

Table 16. Initiative 5 Example Stakeholder Partners

Partner	Summary
NC ORH	Works closely with rural hospitals, FQHCs, RHCs, LHDs, School-based clinics and other rural health employers. NC ORH also administers provider grant and incentive programs funded by substantial recurring funds from the NCGA.
NC Medicaid	Provides health care coverage to more than 3 million eligible low-income adults, children, pregnant women, seniors and people with disabilities, including through contract with Medicaid Prepaid Health Plans and implementation of value-based payment programs.
NC County EMS Systems	NC's county 911 response systems, providing assessment, treatment and transport.
NC AHECs	Provides and supports educational activities with a focus on primary care in rural communities and those with less access to resources to recruit, train, and retain the health workforce. Includes the NC Center on the Workforce for Health, which works to strengthen NC's health workforce by convening employers, educators, workers, regulators, and other stakeholders to research, discuss, and develop solutions for the state's workforce challenges.
Rural health care providers and their representatives	FQHCs, RHCs, LHDs, other rural primary care providers including Medicaid AMHs, groups such as the NC Medical Society, Pediatric Society and the North Carolina Academy of Family Physicians.
Support entities	Accountable Care Organizations, Clinically Integrated Networks

Initiative 5: Outcomes, Metrics, Baseline, Target, and Timeline
Outcomes: The activities under Initiative 5 are designed to pilot and implement innovative financial models that support the fiscal sustainability of rural health providers. By introducing new payment approaches—such as primary care capitation and hospital value-based payment pilots—and building provider capacity, these efforts aim to create a more stable financial environment for rural hospitals and clinics. The outcomes measured in this table, including increased access to preventive and ambulatory care for adults, improved rates of well-child visits, greater participation in value-based payment models, and reduced transfers to urban hospitals, represent the intended results of these approaches. Together, these activities demonstrate how targeted financial innovation can help rural providers maintain essential services, respond to community health needs, and achieve long-term sustainability.
1. PCP Pilot: Improve Adults' Access to Preventative / Ambulatory Health Care (AAP) By PY5 (2031), improve the % of persons 20 years of age and older who had an ambulatory or preventative care visit (baseline: comparable AAP rate for most recent year data available). Pilot aims to promote preventative care for rural residents (Activity 5b). **2. PCP Pilot:** Improving Perinatal Care, Well Child Visits By PY5 (2031), improve the % of children receiving recommended well-child visits in the first 30 months of life (baseline: comparable WCV rate for most recent year data available). Pilot aims to promote preventative care for rural residents (Activity 5b). **3. VBP:** Primary Care By PY5 (2031), increase in the # of rural primary care practices participating in a primary care capitation payment model (baseline: 0). Pilot aims to promote readiness for VBP models (Activity 5b). **4. Hospital VBP Capacity Building Pilot**: Reduce Transfers to Urban Hospitals***** By PY5 (2031), reduction, to be determined during implementation planning, in # of patients transferred from participating rural hospital to larger, urban hospital for care. Pilot aims to promote readiness for VBP models (Activity 5a).
***** = Metrics to be reported at county/rural community level (i.e., ROOTS Hub Region)

Initiative 6: Modernize Rural Care Delivery Through Digital Forward Solutions

Challenge: Rural providers face persistent barriers to coordinated, tech-enabled care, including limited participation in NC Health Connex, complex and slow IT procurement processes, scarce clinical decision support, and low patient health data literacy that hinders engagement with telehealth and remote monitoring tools.

Future state: Rural patients will have more ways to get care, more support using technology, and better communication with their health team—no matter where they live. Providers will have better tools, easier access to information, and more support to deliver high-quality care to rural communities. This connected, equitable digital health system will use real-time data sharing, smart technology, and digital navigators to make care more accessible and effective for everyone.

Activities:
- Institutionalize the Rural Health Innovation Fund (RHIF)
- Support rural provider use of AI
- Increase the number and quality of rural provider connections to the state Health Information Exchange (HIE)
- Improve digital health literacy in rural communities
- Expand virtual care models and technology enabled navigation;

Main Strategic Goal: Tech innovation.
Use of Funds: C, D, F, G, K, | **Technical Score Factors**: B.1, C.1, F.1. (Inc. Remote Care Policy), F.2, F3 | **Estimated Required Funding**: $156M
Impacted Counties (FIPS): All 85 rural counties as described in Section IIA (see Annex 1).

Description: This initiative strengthens NC's rural health infrastructure through a coordinated set of activities that leverage technology to ease the "business of health care", while enhancing

rural provider connectivity, interoperability, digital capacity, and addressing health data literacy gaps. NC will achieve this by undertaking projects to support rural providers and patients:

> **Innovations in NC**
>
> ***Broadband Commitment***
>
> NC's investment in rural broadband and telehealth is making a real difference. Through the NC Broadband Infrastructure Office's $30M Digital Opportunity Grants and the NC ORH's $20M Telehealth Infrastructure Grant Program, rural healthcare providers, care managers, and mobile health workers can receive up to $10,000 per year for five years to support high-speed internet access.
>
> This support helps clinics and mobile teams connect with patients, use telehealth, and participate in statewide health initiatives. As rural practices grow and show better health outcomes, broadband costs shift into their regular budgets, supported by telehealth payments and savings from less travel and better patient retention—creating a sustainable foundation for digital health in rural NC.
>
> **These broadband investments lay groundwork for other NCRHTP projects,** such as remote patient monitoring, digital health literacy programs, and technology-enabled mental health navigation, ensuring that every initiative can reach more communities and deliver greater impact.

6a. Institutionalize the Rural Health Innovation Fund (RHIF). [x] Administered by NCDHHS, or in partnership with another entity, the Rural Health Innovation Fund (RHIF) is a catalytic investment that will help rural health providers modernize their business operations and health IT infrastructure, while testing and scaling novel digital solutions that can help future-proof rural health systems as the digital landscape evolves. Capitalizing on the NC's streamlined funding modalities at state level, the program offers direct financial support to help providers assess current data systems, identify needs for new health IT, vet vendors, manage procurement and implementation, and establish effective governance for health information technology. The Fund also enables providers to pilot and adopt innovative solutions and emerging technologies, giving them the flexibility to test and integrate tools that improve care, streamline workflows, and enhance patient engagement. Funding for these efforts will be distributed by the fund office based on a standardized application process. Key examples of supported technologies and tools include:

- Expanding telehealth and e-consult capabilities

- Selecting, optimizing, and implementing AI tools, such as for clinical decision support (CDS) (***see text box***)
- Upgrading electronic health records (EHRs)
- Implementing business IT platforms
- Support procuring and adopting robotics solutions, such as telepresence robots for remote clinical support, medication dispensing robots, or logistics robots to automate internal hospital deliveries
- Strengthening cybersecurity
- Adopting remote patient monitoring and patient/consumer engagement tools (e.g., apps and portals)
- Piloting new and emerging technologies to advance rural health care delivery

DHHS will work in concert with partners to ensure that RHIF investments are not only responsive to provider needs but also scalable, sustainable, and aligned with broader efforts to improve care quality and reduce avoidable costs.

By equipping rural primary care providers across NC with artificial intelligence (AI)-powered ambient transcription tools. These tools reduce administrative burden by listening to patient visits and automatically generating clinical documentation, allowing providers to focus more fully on patient care.

While today's technology primarily supports documentation, it lays the groundwork for more advanced CDS capabilities. Soon, these systems are expected to evolve into intelligent assistants that offer real-time, evidence-based insights to support diagnosis and treatment—particularly valuable in rural settings where access to specialists and diagnostic resources may be limited. These CDS tools aim to passively deliver relevant information during the clinical encounter, helping improve care quality, reduce unnecessary testing, and strengthen provider knowledge.

Over time, the cost is expected to be offset by gains in provider productivity, improved performance on quality measures, and reduced administrative staffing needs. As VBP models expand (*see Initiative 5*), these tools will also support care gap closure and quality bonus attainment—creating a sustainable path forward.

6b. Support Rural Providers in Adopting AI and Emerging Digital Technologies. To complement the RHIF and ensure rural providers are equipped to adopt and sustain cutting-edge

digital solutions, this activity will establish the **NC Rural Digital Health Collaborative (NCRDHC).** Currently, there is no centralized resource to support rural providers in navigating the rapidly evolving digital health landscape, including understanding which AI tools are safe, effective, and sustainable in their practice. The aim of NCRDHC will be to provide the infrastructure to assist rural providers in addressing the unique challenges they face as they navigate the rapid evolution of AI, remote monitoring, robotics, and other digital solutions in health care, while maintaining a focus on data protection and privacy. Specifically, NCRDHC will be composed of two interrelated components: (1) *A Rural Community of Practice* to foster collaboration, shared learning, and centralized support for rural providers, and (2) *A Rural Technical Assistance Center (TAC)* A hands-on resource center that provides education, implementation guidance, and real-time feedback loops to help rural providers evaluate, adopt, and monitor digital health technologies safely and effectively. Together, the NCRDHC will equip rural providers with the knowledge, tools, and support needed to confidently adopt AI and other tech solutions that enhance care delivery, safeguard patient outcomes, and promote long-term sustainability.

Partnership Opportunity

Multi-payer alignment for innovation

North Carolina's leadership in health system transformation presents a powerful opportunity **to align multiple payers around shared investments in digital innovation**. By leveraging the state's infrastructure and policy momentum, we can attract and sustain high-impact technology solutions that ease the administrative burden of care delivery and improve outcomes across populations.

A central pillar of this multi-payer landscape is **the State Health Plan (SHP)—which covers more than 750,000 North Carolinians,** including public school teachers, state employees, retirees, and their families. Many of these members live in rural communities, where interoperable, accessible, and coordinated care is especially critical.

6c. Connect Rural Providers to the state HIE: Advancing Data Sharing and Care Coordination. NC Health Connex, NC's state-designated HIE operated by the NC Health Information Exchange Authority (HIEA), is supported by $9 million in annual state

funding and federal Implementation Advance Planning Document (IAPD) resources, enabling sustainable, fee-free data exchange for providers statewide. Investment is needed that builds on that foundation by targeting rural participation, addressing key barriers, and upgrading rural connections to meet data quality standards—positioning rural communities to lead in statewide data sharing and precision health innovation.

While NC Health Connex connects all acute care hospitals and over 10,000 ambulatory facilities, only 41% of rural providers are actively exchanging data. This project addresses operational, technical, and financial barriers by providing capacity-building and support to professional staff across various areas including information exchange, offering tailored connection solutions, implementation-focused technical assistance, and strategic and sustainability planning support. Participation Agreements will be required for funding, ensuring accountability and meaningful engagement. The initiative also upgrades existing rural connections to meet data quality standards for completeness, timeliness, and accuracy. This project fills a critical gap by enabling rural providers to leverage the HIE for population health innovation, care gap identification, clinical decision making and improved health outcomes, positioning rural communities as leaders in statewide data sharing. Over time, this infrastructure will also support the advancement of rural precision medicine by enabling more targeted, data-driven care tailored to local population needs.

6d. Improve Digital Health Literacy in Rural Communities: Empowering Patients Through Embedded Support. Digital health literacy is essential for ensuring that patients can benefit from the growing number of technology-enabled health

Innovations in NC

Meeting People Where They Are

Dogwood Health Trust has invested in expanding digital skills across Western North Carolina, including supporting libraries as trusted access points for digital navigation—helping rural residents connect to broadband, telehealth, and essential digital health tools.

services. In rural areas, where access to in-person care may be limited, digital tools offer a lifeline—but only if patients know how to use them. This activity strengthens digital health literacy among rural residents, enabling them to fully participate in telehealth, health information exchange, and patient-facing digital tools such as health questionnaires and educational resources. Critically, the project helps ensure inclusion of the 65 and older population, which has grown faster in rural areas, particularly in the Western and Northeastern NC (*see also "Near Duals" Strategy" in initiative 1*). The project expands a successful partnership between the NCDIT Division of Broadband and Digital Opportunity and NC 211, leveraging NC 211's multilingual, 24/7 support line and statewide digital navigation infrastructure—which has already assisted over 26,000 residents in 2025. Through this partnership, Digital Navigators will collaborate with NC AHECs and rural provider practices to deliver personalized, one-on-one training on essential digital health skills such as scheduling and utilizing telehealth appointments, accessing patient portals, and using remote monitoring devices. These sessions will be hosted at regional AHEC hubs, embedding digital literacy support directly into care delivery sites. To ensure equitable access, the initiative also includes digital skills assessments and connections to low-cost internet and device programs, helping patients overcome barriers to digital participation. By aligning digital support with broadband infrastructure and asynchronous care tools deployed statewide, this initiative transforms technology investments into meaningful improvements in health access, engagement, and outcomes for rural communities.

6e. Integrate RPM and CCM into Rural Health Care. This statewide project strengthens rural health by deploying Remote Patient Monitoring (RPM), Chronic Care Management (CCM), Hospital at Home, and virtual-first care-type models. Focused on high-risk populations with chronic conditions, the project will improve patient throughput, enhance workforce

efficiency, and expand access in underserved communities. A state-selected vendor will deliver RPM and CCM services integrated with NC Health Connex, beginning with a pilot in two to three rural provider settings and to scale statewide. Sustainability will be achieved through reimbursement alignment, workforce optimization, and scalable care pathways. This initiative supports CMS 2025 pillars of excellence by reducing preventable costs, demonstrating VBC effectiveness, and empowering healthier living through patient-centered management.

Key Stakeholders: This initiative will be implemented through a broad coalition of state agencies, CBOs, academic institutions, rural providers, and private-sector partners. Examples of organizations that will partner on these efforts are summarized in Table 17.

Table 17. Initiative 6 Example Stakeholder Partners

Partner	Summary
NC Department of State Treasurer (NCDST)	As one of the largest health purchasers in the state, NCDST brings financial acumen and alignment with long-term cost containment and quality improvement strategies.
NC Health Information Exchange Authority	The NC HIEA operates NC's state-designated health information exchange, NC HealthConnex, a secure, standardized electronic system in which providers can share important patient health information.
NC AHEC	Provides and supports educational activities with a focus on primary care in rural communities and those with less access to resources to recruit, train, and retain the health workforce. Includes the NC Center on the Workforce for Health, which works to strengthen the workforce by convening employers, educators, workers, regulators, and other stakeholders to develop solutions.
NC Department of Information Technology's Office of Digital Opportunity and Broadband Infrastructure Office (BIO)	The Digital Opportunity Office coordinates 74 partner organizations (e.g., CBOs, academic institutions) across the state that are working to address the digital needs of rural residents. DIT's BIO specifically manages broadband deployment and mapping, which is critical for rural telehealth and remote monitoring.
Duke University	Duke's School of Medicine; Clinical & Translational Science Institute; Health AI Evaluation and Governance Programs provides AI evaluation, safety monitoring, and governance frameworks for ambient clinical decision support and other AI-enabled technologies.
UNC Center for ViVE (Virtual care Value and Excellence):	Provides expertise in virtual care delivery models and telehealth implementation strategies for rural and underserved communities.
Tribal Health Partners: (1 federally recognized and 7 state-recognized Tribes)	Tribal communities were engaged during stakeholder sessions and are often underserved in digital health infrastructure. These partners ensure culturally appropriate implementation of digital tools and equitable access for tribal populations.
Dogwood Health Trust	A private foundation serving Western NC, the Trust supports broadband expansion, digital skills training, and the use of libraries and other trusted community spaces as access points for digital navigation and access to care efforts.

Initiative 6: Outcomes, Metrics, Baseline, Target, and Timeline
Outcomes: The metrics in Initiative 6 are designed to work in concert—each one capturing a distinct but interconnected aspect of digital transformation in rural health. Together, they reflect a full ecosystem approach: from provider readiness and infrastructure (e.g., HIE connectivity, AI tool adoption), to workforce capacity (e.g., participation in technical assistance), to patient empowerment (e.g., digital literacy training). By measuring both provider- and patient-facing outcomes, the initiative ensures that technology investments translate into real-world improvements in access, engagement, and care quality across rural communities. As providers are rapidly adopting these technologies, baselines will be established during implementation to define and drive target rates.
1. Improve Rural Provider HIE Connectivity* By PY3 (2029), improve % of rural provider practices connected to NC Health Connex (baseline: 1,153; target: 100 new or repaired rural provider practices). Required to bridge the gap of providers who are digitally isolated (Activity 6a). **2. Increase Rural Provider Usage of AI Clinical Decision Support Tools** By PY5 (2031), improve the % of rural providers utilizing ambient CDS tools (baseline: TBD; target TBD). Improves efficiency, information delivery medical decision making, and the range of primary care practices (Activity 6a, 6b). **3. Increase Rural Provider Capacity for Emerging Tech** By PY5 (2031), increase in # of providers participating in TACs (baseline: TBD; target TBD). Improves overall understanding on how to effectively leverage, evaluate, and adopt emerging technologies into their practice (Activity 6a, 6b). **4. Improve Rural Resident Engagement** By PY5 (2031), increased # of rural residents who receive 1:1 training or attend a group training session (baseline: 0; target TBD). Ensures rural patients can benefit from existing technology resources and new investments (Activity 6a, 6d).
* = Metrics to be reported at county/rural community level (i.e., ROOTS Hub Region)

D. Implementation Plan

Key: Stage 0 | Stage 1 | Stage 2 | Stage 3 | Stage 4 | Stage 5

RHT Program Management	PY1				PY2				PY3				PY4				PY5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Hire NCRHTP team																				
Establish Governance Committees																				
Draft legislative changes																				
Implement legislation to join EMS compact																				
Initiate sustainability planning; stand up NCHRTP reporting																				
Implement PFT; expand school-based prevention programs; pass law requiring nutrition CME																				
Evolve sustainability planning based on early implementation																				
All activities underway via ROOTS Hubs / statewide projects																				
Finalize long-term governance																				
Transition to steady state																				
Initiative 1	PY1				PY2				PY3				PY4				PY5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop/release ROOTS Hub RFP																				
Proposal submission and selection																				
Hub Leads develop and launch ROOTS Hub; conduct regional health needs assessment																				
ROOTS Hub Network deploys Action Plan																				
TA and Refinements																				
Hub Network expands projects																				
ROOTS Hub fully active																				
Initiative 2	PY1				PY2				PY3				PY4				PY5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Select perinatal, chronic disease and Food is Medicine projects start																				
ROOTS Hubs select additional projects based on Action Plans																				

Projects underway; refinements																				
ROOTS Hub expand projects																				
Projects embedded; dissemination																				

Initiative 3	PY1				PY2				PY3				PY4				PY5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Establish CCBHC Quality Improvement (QI) Governance																				
Begin expansion of mobile OTP																				
Initiate CCBHC QI projects																				
MORES linking to CCBHCs																				
Begin FEP and Mental Health MATTERS expansion																				
Begin CCBHC expansion																				
Integrate community crisis centers into CCBHCs																				
Expand SBHCs																				
Expand EMS MAT access																				
CCBHC QI fully embedded																				
Finish opening new CCBHCs																				

Initiative 4	PY1				PY2				PY3				PY4				PY5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Training sites/partners identified																				
Begin expanding Social Work Rural Scholars / Rural BH Workforce Development Certification Programs																				
Establish Regional Rural Training Hubs; develop training menu																				
Develop doula and CHW program																				
TA and Refinements																				
Launch doula and CHW program																				
All workforce projects operational																				

Initiative 5	PY1				PY2				PY3				PY4				PY5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Engage with hospitals and practices to clarify needs and concerns related to VBP																				
Identify pilot sites																				
ROOTS Hubs release capacity building funds to pilot sites																				

ROOTS Hubs launch TA																				
Initial refinements underway																				
TA and capacity building fully operational																				
Long-term planning and refinements																				

Initiative 6	PY1				PY2				PY3				PY4				PY5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
NCRDHC governance established																				
Stand up RHIF; pilot sites established																				
Rural providers submit applications to RHIF (annually)																				
RHIF releases funds; providers implement solutions (annually)																				
Providers begin connecting to HIE																				
NCRDHC activities begin																				
Hubs begin coordinating digital literacy projects																				
NCRHDHC rural AI study developed; released																				
Half of identified providers connected to HIE																				
All identified providers HIE connected																				

Governance and Project Management Structure

The NCDHHS will serve as the lead agency for the NCRHTP, with the Office of Rural Health (ORH) as the administrative home. The ORH will coordinate closely with the Divisions of Public Health (DPH), NC Medicaid, Mental Health (DMH), Health Service Regulation (DHSHR), and IT/Data to ensure strategic alignment and programmatic success. Offices within NCDHHS are designed specifically for the purpose of cross-agency collaboration; NCDHHS has a track record of success in managing complex programs across its major divisions similar to what is planned for the RHTP.

Key Personnel and Roles

We will dedicate a core team of 27 Full-Time Equivalents (FTEs) to support RHTP governance and implementation across initiatives. Additional FTEs are detailed in the budget narrative supporting direct implementation across initiatives.

Table 18: Key Personnel and NC RHTP Program Administration

Personnel	FTE	Role
Project Director	1	Oversees the program, serves as the primary CMS contact, and coordinates across divisions.
Program Management Team	5	Team dedicated to the initiatives being undertaken as part of the plan; coordinate with teams across NCDHHS as needed.
Monitoring, Evaluation & Data Team	3	Team manages data collection, dashboard development, CMS reporting, continuous improvement and outcome measurement.
Finance, Administration, and Compliance Team	17	Team ensures budget oversight, compliance with 2 CFR 200/300, procurement, and subrecipient monitoring.
Communications & Engagement Team	1	Leads external communications and engagement for the program and internal cross-NCDHHS communications.

Governance Structure and Decision-Making

To ensure cross-divisional coordination and strategic oversight, NCDHHS will establish a multi-tiered governance model:

Table 19: Program Governance and Decision-Making Bodies		
Structure	**Members**	**Role**
Steering Committee (Quarterly)	Senior leaders from ORH, DPH, NC Medicaid, DHSR, DMH, Senior Department leaders including from legislative affairs, operational and technology	Provides strategic guidance, policy alignment, and issue escalation.
Program Implementation Team (Monthly)	Initiative leads, program managers, grant/finance officer, and evaluation lead	Oversees day-to-day project execution, resolves coordination issues across NCDHHS and leads stakeholder engagement activities.
NC ROOTS Hub Workgroups (Ad Hoc)	Hub and network partner leaders, community representatives	Oversees regional hub activities in line with overall program plan; engages key community stakeholders in regional plan design, execution, and reporting, and plans for long-term community sustainability.

This structure ensures frequent communication, defined decision-making protocols, and flexibility to respond to challenges. Ultimate accountability for decision-making will rest with the Secretary of NCDHHS should issues arise in program management that are not resolved via the program Steering Committee.

Key Management & Governance Features

Table 20: Key Management & Governance Features	
Feature	Detail
Decision-Making Processes	• Decisions regarding program implementation will be made at different levels as by the Project Director. The Steering Committee will be a forum to discuss major implementation issues, and the Project Director will bring forward issues and decisions that require cross-Agency input and coordination.
Coordination with State Agencies & External Stakeholders	• RHTP coordination will leverage both existing interagency workgroups (e.g., Medicaid Transformation, Rural Health Advisory, Behavioral Health Integration) and others. • All advisory bodies will follow formal engagement frameworks, and their input will be integrated into planning, implementation, and evaluation cycles.
Oversight & Reporting	• Fiscal and compliance oversight will be managed by the Grants and Fiscal Officer, in coordination with the NCDHHS finance office. ORH will maintain internal tracking and reporting systems aligned with 2 CFR 200 and 300, including: Subrecipient agreements, risk-based monitoring plans, budget reconciliations, timely reporting to CMS using CMS-specified templates • Data and Evaluation activities will use a hybrid model: internal analytics staff and an external evaluator. Key performance dashboards will monitor the outcomes and metrics plan described in the application.
Sustainability & Future Governance	• From the outset, RHTP governance will be designed to transition into NC's ongoing rural health strategy. We anticipate that: • The Steering Committee will become a permanent Rural Health Transformation Oversight Council • The Program Implementation Team structure will remain in place to support future initiatives and state innovation efforts • Advisory councils will continue as standing forums beyond the grant period • This forward-looking approach demonstrates readiness, ensures accountability, and supports sustainable transformation.

E. Stakeholder Engagement

Application Development

NCDHHS deployed a robust, multi-channel engagement strategy to inform the RHTP application. Central to this process was the creation of a Stakeholder Input Form, made available on the NCDHHS website in August 2025, which enabled a wide range of partners—including hospitals, public health agencies, FQHCs, behavioral health providers, CBOs, advocacy groups, and technology vendors—to submit feedback directly. In addition to the online form, NCDHHS received input via targeted emails, listening sessions, webinars, small group convenings, and virtual town halls, ensuring that voices from every region and sector were represented.

Feedback dashboard. NCDHHS synthesized feedback into a dashboard updated weekly to track and analyze responses, key themes, interested communities and organization types. NCDHHS received more than 420 entries, referencing 79 counties and all Medicaid regions. Engagement was particularly strong in Brunswick, Robeson, Duplin, New Hanover, and Pender counties.

Evidence of support. Our application demonstrates robust and far-reaching support, as evidenced by the inclusion of **11 Letters of Support in Annex 6.** These letters represent a dynamic, multi-sector coalition of stakeholders and partners spanning philanthropy, academia (including NC's vast community college network), government, rural health centers, healthcare, and the North Carolina Commission of Indian Affairs. This coalition reflects a unified commitment to advancing rural health transformation and innovation across the state.

External discussions. NCDHHS leadership also participated in external meetings and roundtables organized by rural hospital networks, tribal communities (including the Eastern Band of Cherokee Indians and NC Commission of Indian Affairs), provider associations, policy leaders, legislative members, philanthropic groups, business leaders and other key partners. These sessions provided opportunities for stakeholders to hear directly from NCDHHS about the

RHTP vision, share priorities and concerns, and suggest mechanisms for ongoing program improvement. NCDHHS remains committed to transparent and locally responsive engagement, with ongoing advisory meetings, tribal engagements, public advisory opportunities, and data sharing to inform continuous improvement as the program is implemented.

Ongoing Engagement

Ongoing stakeholder engagement will be conducted at three levels. First, the NC ROOTS Hubs will each have a distinct governance structure that is required to include community stakeholders and groups as members, and NC ROOTS Hubs will be required as part of their contract with NCDHHS to engage stakeholders: 1) In the design of regional needs assessments and 2) in the implementation of activities and projects. As part of regular reporting to NCDHHS, ROOTS Hubs will be required to summarize their engagement processes.

Second, the overall design of each initiative outside of the NC ROOTS Hubs involves key stakeholder partners. Examples of those were included in each initiative description. NCDHHS will require that teams implementing each initiative engage with these stakeholders, and others, in design and deployment of major projects.

Third, NCDHHS will establish an external stakeholder engagement plan for the overall program, including a public website, regular external newsletters/updates, public forums for input into implementation and review of results and progress, and other mechanisms to ensure that community members and organizations remain connected to the NCRHTP and help shape it year over year, in particular as the state works to create long-term sustainability pathways as noted in our program plan. As part of this

Innovations in NC

North Carolina's approach to stakeholder engagement draws lessons learned from implementation of other collaborative models such as the Integrated Care for Kids (INCK) model, which demonstrate how partnerships across multiple entities—and the use of data from various public sources—can identify patient needs, evaluate progress, and drive improved outcomes. INCK exemplifies the power of coordinated multi-sector efforts to improve care for children and families by leveraging shared data and continuous evaluation.

component, NCDHHS plans to contract with the Duke Margolis Health Policy Institute to lead regular convenings including listening sessions, lead site visits to NC ROOTS Hubs to engage communities in design and implementation of programming, partner with local leaders and officials to document concerns and successes and produce regular reports to the public.

F. Metrics and Evaluation Plan

Overview of Measurement Approach

NC will build on experience measuring quality and health outcomes, as well as extensive investments made in developing structures to support community level quality reporting and develop digital clinical data. Since its groundbreaking primary care medical home model launched in 1998,[xi] North Carolina's Medicaid program has supported the development of coordinating entities that assist community primary care practices throughout the state with a range of functions including performance measurement and quality reporting. Since then, North Carolina has continued to build measurement and reporting capacity through investments in digital quality and performance reporting, including a range of efforts specifically focused on rural communities in the wake of Hurricane Helene.[xii] NC's approach to measurement for its rural health transformation effort will align with rural community needs as well as Healthy North Carolina 2030 goals.

NC also recognizes that NCRHTP will be implemented during a broader time of transformation, as administration promotes new vision for state- and federally funded health insurance programs. NC's measurement approach will take this into account by

- Recognizing that utilization benchmarks based on historical Medicaid data may need adjustment to account for changes in approach to eligibility and enrollment
- Emphasizing areas of focus including nutrition and chronic disease burden
- Leveraging technology to minimize provider reporting effort

Evaluation plan:

NC will partner with the UNC Sheps Center to assess program performance, with the goals of gathering all actionable lessons on improving rural health and building a case for multi-payer participation. The Sheps Center's NC Rural Health Research program[xiii] provides an extensive base of rural health expertise and experience engaging with rural communities and leaders. The evaluation will be comprised of annual rapid cycle assessments, targeted at ensuring real-time learnings to allow NCDHHS to implement data-informed program modifications, and a summative evaluation which will assess longitudinal progress toward the target outcomes. This evaluation will include both qualitative and quantitative data and will use quasi-experimental approaches to compare outcomes associated with different regional approaches to common challenges, using individual rural regions as laboratories for improvement. NC will cooperate with any CMS-led evaluation or monitoring. A table summarizing NC's selected measures by initiative are shown below[1]:

[1] Note: Outcomes/metrics noted with a (*) will be analyzed at regional/county level.

	Outcome	Metric	Baseline	Target Timeline	Relation to Initiative/Activity	Data Source(s) / Ability to Analyze
Initiative 1	Establish NC ROOTS Hubs*	Number of NC ROOTS Hubs established	0	6 By PY2	Establishment of NC ROOTS Hubs provides the structure for launching other initiatives *(relates to Activity 1a)*	NCDHHS/NCDHHS Overseeing Program
	Safety Net Provider Hub Participation*	Proportion of eligible hospitals, providers, and CBOs participating in Hub collaborative activities	0%	Dependent upon eligible Hub Network entities per region. By PY2	Participation of representative providers ensures that Hubs are engaged and working to address regional needs *(relates to Activity 1b)*	Self-report from NC ROOTS Hub Annual to NCDHHS
	Deploy Community Based Initiatives*	Number of community-specific targeted initiatives deployed, relative to baseline	0	Dependent upon eligible Hub Network entities per region. By PY3	Deployment of initiatives demonstrates that NC ROOTS Hubs are making concrete changes in the regions they serve *(relates to Activity 1b)*	Self-report from NC ROOTS Hub Annual to NCDHHS
	Referral Activity for Hub Services*	% of successful referrals to community provider network	0%	Dependent upon eligible Hub Network entities per region. By PY5	Successful referrals reinforce relationships between regional partners and lay groundwork for future joint efforts *(relates to Activity 1b)*	Derived from Referral Management System (e.g. NCCARE360) Annual to NCDHHS
Initiative 2	**Perinatal Care:** Increase Access to Prenatal Care*	% of births to women who receive prenatal care during the first trimester of pregnancy	Statewide: 72%[2]	80% By PY5	Accessing timely prenatal care is correlated with positive maternal and early child health outcomes *(relates to Activity 2a)*	NC State Center for Health Statistics Annual State dashboard
	Chronic Disease: Reduction in Chronic Disease High-Cost Comorbidity Burden*	Reduction in the % of adults in the target rural population reporting three or more chronic health conditions	12.1%[3]	9.7%[4] By PY5	Reduction in comorbidity is critical for financial solvency because patients with multiple chronic conditions cost healthcare systems more than six times. *(relates to Activity 2b)*	Annual EMR data Collected at the regional level by ROOTS hubs.
	Chronic Care:	% increase in # of patients who are	TBD[5]	5% PY3	Utilization of SMBP correlates with better	Annual EMR data

[2] Rural county rates to be established from existing data.
[3] Hubs to establish new baselines for region.
[4] Note: during this period, we anticipate a boost in uninsured populations. Maintaining would be a success.
[5] To be established for each NC ROOTS Region.

	Outcome	Metric	Baseline	Target Timeline	Relation to Initiative/Activity	Data Source(s) / Ability to Analyze
	Increase Patient Use of Self-Monitoring Blood Pressure*	offered/received SMBP out of those eligible		10% PY5	cardiovascular outcomes for patients with chronic disease (relates to Activity 2b)	Collected at the regional level by ROOTS hubs.
	Chronic Care: Decrease Tobacco Use*	% increase of referrals to QuitlineNC from participating counties / organizations	TBD	5% PY 3 10% PY5	Referrals to QuitlineNC relate to successful smoking cessation result (relates to Activity 2c)	(QuitlineNC Vendor) Quarterly report to NCDHHS
	Food As Medicine: Increase access to healthy food prescriptions	% of high-risk individuals (as defined by NCDHHS) receiving healthy food boxes.	TBD[6]	15-20% By PY5	Healthy food access linked to lower risk of chronic illness (relates to Activity 2c)	Collected at the regional level by ROOTS hubs.
Initiative 3	Establish New Rural CCBHCs*	Number of rural CCBHCs	0	5 By PY2	Necessary to coordinate rural provision of planned activities (*relates to Activity 3a)*	NCDHHS/NCDHHS Overseeing Program
Initiative 3	Increase in Percent of Individuals Medicaid Members Beginning Mental Health Treatment	% of Medicaid members beginning treatment	20%	5% increase each year By PY5	Indicator of system access is used to characterize how accessible a particular service or group of services is for persons eligible to receive those services (r*elates to Activities 3a, 3b, 3c)*	Quarterly reporting from Medicaid Managed Care Tailored Plans to NCDHHS
Initiative 3	Decrease ED Utilization for Mental Health Needs	Average daily # individuals in the emergency department seeking treatment for mental health needs	409	8-10% decrease By PY5	Diversion of individuals experiencing mental health crises to appropriate treatment settings and increase in upstream access to treatment (r*elates to Activities 3a, 3b, 3c)*	Quarterly reporting from NC Detect to NCDHHS
Initiative 3	Decrease ED Utilization for Opioid Overdose	# of annual ED encounters related to opioid overdose	4,971	20% decrease By PY5	Diversion of individuals to more appropriate treatment alternatives through increased availability and improved accessibility of medications (r*elates to Activities 3b, 3c)*	Monthly reporting from NC Detect to NCDHHS

[6] To be established for each NC ROOTS Region.

	Outcome	Metric	Baseline	Target Timeline	Relation to Initiative/Activity	Data Source(s) / Ability to Analyze
	Decrease ED Occupancy for Youth Mental Health Needs	Average daily ED occupancy rate of members under the age of 18 for visits > 24 hours related to mental health needs	74	8-10% decrease By PY5	Diversion of youth experiencing mental health crises to more appropriate treatment settings and increase in upstream access to treatment (*relates to Activities 3a, 3b)*	Quarterly reporting from NC Detect to NCDHHS
Initiative 4	Increase Rural Residencies & Fellowship Programs*	# of rural residency and fellowship programs launched in rural counties	10	8-12 new programs in high-need specialties By PY5	Expanding rural GME based programs is a proven strategy to increase rural provider retention *(relates to activity 4a)*	UNC System Office, Sheps Center Technical Assistance Center (TAC) Annual Report Routinely analyzed
Initiative 4	Increase EMS Professionals in Rural Communities*	# of graduates each year accepting full/part-time positions in rural counties	0/New Baseline	150 EMTs per year For each of PY 2-5	Major workforce gap in rural communities with projections to worsen (*relates to activity 4a)*	Annual Report From regional partners to ROOTS Hubs
Initiative 4	Improve Rural Clinician Vacancy Rates*	County-level six-month clinician vacancy rate	TBD	10% reduction By PY5	Filling vacancies is critical to ensuring sustainable access to care *(relates to activity 4a and 4b)*	Annual Report From regional partners to ROOTS Hubs
Initiative 4	Improve Rural County Primary Care Clinician Ratio*	Number of rural counties where ratio of population to primary care clinician is less than 1500:1	TBD	15% reduction By PY5	This metric reflects the initiative's impact on access to care *(relates to activity 4a)*	NC State Center for Health Statistics Annual State Dashboard Routinely analyzed
Initiative 5	**PCP Pilot -** Adults' Access to Preventive /Ambulatory Health Care (AAP)	Adults' Access to Preventive/Ambulatory Health Services: The percentage of persons 20 years of age and older who had an ambulatory or preventive care visit.	Comparable (rural, regional) AAP rate for most recent year data available	Improvement by greater than statewide trend By PY5	Pilot aims to promote preventive care for rural residents *(relates to activity 5b)*	Administrative data stratified by rurality and region This measure is a HEDIS measure and is routinely assessed
Initiative 5	**PCP Pilot -** Improving Perinatal Care: Well Child Visits	% of children receiving recommended well-child visits in the first 30 months of life	Comparable (rural, regional) WCV rate for most recent year data available	Improvement by greater than statewide trend By PY5	Pilot aims to promote preventive care for rural residents *(relates to activity 5b)*	Administrative data stratified by rurality and region This measure is a HEDIS measure and is routinely assessed
Initiative 5	**Value-Based Care -** Primary Care	Increase in number of rural primary care practices participating in a primary care capitation payment model.	0	To be determined during implementation planning with rural practices	Pilot aims to promote readiness for VBP models *(relates to activity 5b)*	PHP Data PHPs report practice VBP participation on an annual basis using an existing format

	Outcome	Metric	Baseline	Target Timeline	Relation to Initiative/Activity	Data Source(s) / Ability to Analyze
				By PY5		
	Hospital VBP Capacity Building Pilot - Reduce Transfers to Urban Hospitals*	Number of patients transferred from participating rural hospital to larger, urban hospital for care (county level performance based on hospital county)	Comparable rate for most recent year data available	To be determined during implementation planning with rural hospitals By PY5	Pilot aims to promote readiness for VBP models *(relates to activity 5a)*	Admission, Discharge and Transfer (ADT) data These data are available for DHHS analysis
Initiative 6	Rural Provider HIE Connectivity*	% of rural providers connected to NC Health Connex	1,153 rural practices currently connected	100 additional rural practices connected (new or repaired connections) By PY3	Required to bridge the gap of providers who are digitally isolated *(relates to activity 6a)*	NC HealthConnex routinely tracks provider connections
Initiative 6	AI Tools: Clinical Decision Support	% of rural providers utilizing ambient CDS tools	TBD	TBD By PY5	Improves efficiency, information delivery, medical decision making, and the range of primary care practice *(relates to activity 6a, 6b)*	Provider survey conducted by NC ROOTS Hub
Initiative 6	Emerging tech: Provider Education	# of rural providers participating in TACs (Technical Assistance Centers)	TBD	TBD By PY5	Improves overall understanding on how to effectively leverage, evaluate, and adopt emerging technologies into their practice *relates to activity 6a, 6b)*	Activity registration data collected by NC ROOTS Hub
Initiative 6	Rural Resident Engagement	Number of rural residents who receive 1:1 training or attend a group training session	0 (not yet launched)	TBD By PY5	Ensures rural patients can benefit directly from existing technology resources and new investments *(relates to activity 6a, 6d)*	Activity registration data collected by NC ROOTS Hub

G. Sustainability Plan

North Carolina's sustainability strategy begins with project inception. From the outset, each initiative will include a clear transition plan, and all subgrantees will be required to submit sustainability strategies as a condition of funding, anchored in multi-payer models, continued partnerships with academic and community partners to continue select program operations, and continued funding from state, local, and private sources.

Table 21. Sustainability Plan
Overall
In addition to leveraging durable, multi-payer financing mechanisms such as value-based payment models and continued support via state appropriations, the state will actively engage philanthropic partners to extend the reach and longevity of high-impact programs. Lessons learned will be integrated into ongoing policy through regulatory updates, technical assistance platforms, and alignment with long-term system transformation goals.
Initiative 1: Build Rural Community Care Network "Hubs"
This initiative is designed to promote the sustainability of community organizations, including the Hub Lead, with NC ROOTS Hub entities operating as part of North Carolina communities and coordinating across a diverse array of payers and funders. By taking a regional approach through the implementation of the NC ROOTS and requiring robust cross-sector collaboration, Hubs will be able to build resilient and diversified funding structures. Over the five-year grant period, NC ROOTS Hubs will develop strategic relationships with the network partners and build financial and operational structures that will support their continued operation. In addition to payers in Medicaid and commercial insurance, we anticipate community-based organizations, local government agencies, and others to be integral parts of the NC ROOTS Hubs that will together lead the work of the entities after the grant funds are expended. We see the grant as seed funding and a catalyst for regional "ownership" of the model going forward.
Initiative 2: Create Models & Capacity for Expanded Primary Care, Prevention, and Chronic Disease Management
This initiative is designed with sustainability at its core by leveraging and strengthening existing infrastructure rather than creating new, resource-intensive systems. The regionally tailored approach allows communities to integrate the work into existing workflows and funding streams, ensuring its relevance and durability over time. The program pairs NC ROOTS Hubs with subject matter experts at academic institutions to customize and connect providers with existing systems of care. Rather than create new models, the approach aligns with existing perinatal heath models and prioritizes expansion into parts of the state where maternity deserts are pronounced. There are current reimbursement models for some of the named interventions. Provider and community engagement and training build local capacity that can be maintained beyond the life of the grant. By aligning with established programs such as DPP, DSMES, SMBP, tobacco cessation, and cancer screening initiatives, it supports continuity of care and reduces fragmentation - including with behavioral health. The focus on referral optimization, provider training, and community engagement builds local capacity that can be maintained beyond the life of the grant. There are active reimbursement models for the named interventions.
Initiative 3: Expand and Integrate Behavioral Health and Substance Use Disorder Services
North Carolina will sustain Initiative 3 by embedding relevant projects (e.g., CCBHC expansion, FEP) within enduring Medicaid payment and policy frameworks to ensure continued access to high-quality behavioral health services beyond FY31. These efforts leverage prospective payment mechanisms that maintain operations without reliance on time-limited grants. Infrastructure and capacity-building investments made under the RHTP will require minimal ongoing costs and will be supported through existing quality reporting systems. By taking a regional approach for new programs, such as EMS-Initiated MAT, initiative 2 will help communities integrate work into existing workflows and funding streams, supporting its relevance and durability after the grant. New SBHCs will follow established sustainability models supported by Medicaid reimbursement, partnerships with local education agencies, and philanthropic contributions. State technical assistance will reinforce sound financial and operational practices.
Initiative 4: Build a Robust & Resilient Workforce & Innovative Care Team Models for Rural Communities
Universities will continue rural field placement and internship stipends through partnerships with AHEC and philanthropic organizations such as the Duke Endowment and BCBS NC Foundation. Stipends will be sustained through provider partnerships and Medicaid administrative match (50/50). Training programs and faculty operations will transition into UNC's Behavioral Health Springboard continuing education platform, ensuring ongoing program delivery and statewide access. Curriculum materials developed under the RHTP will be integrated into the NCCCS permanent course catalog, supported by AHEC continuing education modules. QP

projects will continue through NCCCS Workforce Continuing Education streams, sustained by state appropriations and strengthened by partnerships with behavioral health employers. Most residency programs developed under this initiative will transition to long-term sustainability through Medicare Graduate Medical Education (GME) reimbursement, providing a permanent and predictable funding mechanism. Programs that do not qualify for full Medicare support will receive continued backing through the UNC System's Rural Residency and Medical Education Fund and targeted state appropriations. Program administration and evaluation activities will transition to the NCDHHS Behavioral Health Workforce Portal, ensuring continued coordination, data tracking, and performance monitoring.
Initiative 5: Ensure Fiscal Sustainability of Rural Health Providers Through Innovative Financial Models
This initiative invests in infrastructure and capacity-building activities that will not require ongoing funding once established. The infrastructure and practice transformation payments are one-time investments intended to prepare rural providers for participation in capitated VBP models. Once systems are in place, providers will be equipped to operate within existing Medicaid payment structures and future VBP arrangements with multiple payers. Technical assistance will further build capacity within practices, enabling providers to maintain and evolve their VBP participation, while enabling Medicaid managed care strategies and payment reforms alongside multi-payer opportunities that will augment sustainability efforts.
Initiative 6: Modernize Rural Care Delivery Through Digital Forward Solutions
NC Health Connex provides a fee-free data exchange platform for providers across North Carolina. The system is supported by approximately $9 million in annual state appropriations and ongoing federal IAPD resources. This stable funding model ensures long-term operational viability. NCRDHC will achieve sustainability by embedding developed infrastructure and technical assistance into ongoing programs operated by academic and research partners, leveraging existing capacity and funding streams to maintain continuity beyond the RHTP funding period. Digital health literacy sustainability planning is underway, with options to be determined based on pilot outcomes and stakeholder engagement. Finally, as VBP models expand, the integration of AI-driven tools, RPM, and CCM will enhance care quality, close care gaps, and improve performance on quality metrics tied to incentive payments. The resulting gains in quality bonus payments are expected to offset ongoing licensing and operational costs, establishing a self-sustaining model that aligns financial incentives with improved clinical outcomes beyond the NCRHTP.

H. Acronym List

Table 22. List of Acronyms and State Specific Programs

Acronym	Definition
AAP	Adults' Access to Preventive / Ambulatory Health Care
AHEC	Area Health Education Centers
AI	Artificial Intelligence
AMH	Advanced Medical Home
AROC	Academic Regional Obstetrical Collaborative (AROC)
BCBSNC	Blue Cross Blue Shield of North Carolina
BH	Behavioral Health
BRFSS	Behavioral Risk Factor Surveillance System
CAH	Critical Access Hospital
CBO	Community-based Organization
CCBHC	Certified Community Behavioral Health Clinics
CCM	Chronic Care Management
CCNC	Community Care of North Carolina
CD	Sickle cell disease
CDS	Clinical Decision Support
CHC	Community Health Center
CHW	Community Health Worker
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CON	Certificate of Need
CSC	Coordinated Specialty Care
DEA	Drug Enforcement Agency
DHB	North Carolina Division of Health Benefits
DHSR	North Carolina Division of Health Service Regulation
DMH	North Carolina Division of Mental Health
DO	Doctor of Osteopathic Medicine
DPH	North Carolina Division of Public Health
DPP	Diabetes Prevention Program
DSMES	Diabetes Self-Management Education and Support
ECU	Eastern Carolina University
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Services
FFS	Fee-for-service
FORHP	Federal Office of Rural Health Policy
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HRSA	Health Resources and Services Administration
IAPD	Implementation Advance Planning Document
IDD	Intellectual and Developmental Disabilities
IMEC	Interstate Medical Licensure Compact
LHD	Local Health Department
LOCATe	Level of Care Assessment Tool
MAHEC	Mountain Area Health Education Center
MCO	Managed Care Organization
MD	Doctor of Medicine
MORES	Mobile Outreach Response Engagement and Stabilization
MOUD	Medications for Opioid Use Disorder
NC	North Carolina
NC HIEA	NC Health Information Exchange Authority
NC MATTERS	Making Access to Treatment, Evaluation, Resources, and Screening Better
NC ROOTS	NC Rural Organizations Orchestrating Transformation for Sustainability
NCCCS	NC Community College System
NCDHHS	North Carolina Department of Health & Human Services
NCDST	North Carolina Department of State Treasurer
NCGA	NC General Assembly
NCRDHC	NC Rural Digital Health Collaborative
NCRHTP	North Carolina's Rural Health Transformation Program
NCSCHS	North Carolina State Center for Health Statistics
NP	Nurse Practitioners
ORH	North Carolina Office of Rural Health
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PCP	Primary Care Provider
PFT	Presidential Fitness Test
PA	Physician Assistant
PMPM	Per-member-per-month
PY	Program Year
QI	Quality Improvement
QP	Qualified Professional
RHC	Rural Health Clinic
RHIF	Rural Health Innovation Fund
RPM	Remote Patient Monitoring
SBHC	School-based Health Centers
STLDI	Short-Term, Limited-Duration Insurance
SUD	Substance Use Disorder
TAC	Technical Assistance Center
UNC	University of North Carolina
VBC	Value-based care
VBP	Value-based payment

Endnotes

[i] North Carolina defines "rural" using the Health Resources and Services Administration's (HRSA) Rural Health Grants Eligibility Analyzer and the Federal Office of Rural Health Policy (FORHP) designations and for the purposes of this application includes counties of at least one census tract designated as rural.

[ii] NC DHHS Minority Health Statistics; North Carolina Institute of Medicine, "Healthy North Carolina 2030," HNC-REPORT-FINAL-Spread2.pdf; Robeson County Health Department, "Community Health Needs Assessment 2023," https://schs.dph.ncdhhs.gov/units/ldas/cha2023/Robeson-2023-CHA.pdf.

[iii] NC Rural Center, "County Data Profile," https://www.ncruralcenter.org/county-data/; HRSA Shortage Area Maps.

[iv] Health ENC, "Sampson County 2024 Community Health Needs Assessment," https://schs.dph.ncdhhs.gov/units/ldas/cha2024/SAMPSON-2024-CHA.pdf.

[v] UNC The Cecil G. Sheps Center for Health Services Research, "Rural Hospital Closures," https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

[vi] NCDHHS NC Medicaid Division of Health Benefits, "NC Medicaid Policy on Telehealth, Virtual Communications and Remote Patient Monitoring," https://medicaid.ncdhhs.gov/1h-telehealth-virtual-communications-and-remote-patient-monitoring/download?attachment.

[vii] No RHT funds will be used to issue direct student loans or to fund student loan repayment programs. Tuition reimbursement and paid field placements are provided only as part of a structured workforce development pipeline, contingent on a five-year rural service commitment, and are designed to build sustainable systems and infrastructure for rural workforce recruitment and retention—not as direct lending or repayment mechanisms.

[viii] AMHs are North Carolina's tiered vehicle for care management. Under AMH Tiers 1 and 2, Health Plans retain primary responsibility for ensuring that beneficiaries receive appropriate care management services. AMH Tier 3 practices assume primary responsibility for care management, delivered either directly or through a Clinically Integrated Network (CIN) or another partner. The requirements for care management are in addition to the AMH Tier 1 and 2 primary care practice requirements. AMH Tier 3 practices receive an additional Care Management Fee to provide this service to their assigned patients.

[ix] Funding Protections: To preserve the integrity of the VBP strategies, all funding distributed through both strategies must be used to directly support VBP infrastructure development, quality improvement and VBP workforce within designated rural hospitals, practices or communities. Participating health systems must demonstrate that capacity building and capitation payments are allocated to rural-serving sites, including primary care partners, and not diverted to non-rural operations or administrative overhead unrelated to rural care. As a condition of participation, larger health systems applying on behalf of a CAH or rural hospital must submit a rural reinvestment plan outlining how funds will be used to enhance access, quality, and sustainability in rural areas. NCDHHS reserves the right to audit fund use and require corrective action if funds are not used in alignment with rural transformation goals.

[x] Per the NOFO, the RHIF is capped at 10% of the total CMS award $20M in any given budget period.

[xi] North Carolina Department of Health and Human Services, "North Carolina Medicaid and NC Health Choice Draft Section 1115 Waiver Application," effective March 1, 2016, https://www.ncdhhs.gov/draft-section-1115-waiver-2016-03-01/open.

[xii] North Carolina Emergency Management, "Helene Retrospective," accessed October 29, 2025, https://experience.arcgis.com/experience/7892f669bb0e442981b15009c7f2b5f0/page/Helene-Retrospective?views=Home.

[xiii] UNC The Cecil G. Sheps Center for Health Services Research, "NC Rural Health Research Program," accessed October 28, 2025, https://www.shepscenter.unc.edu/programs-projects/rural-health/.