**Rural Health Transformation Program**
**Project Summary**

The Rural Health Transformation (RHT) Program offers a pivotal opportunity for Oregon to strengthen its rural healthcare system, improve access, and support local communities and economies across the state. As the 9th largest state, with 33% of its population living in rural and frontier communities, the state faces ongoing challenges related to healthcare workforce shortages, limited preventative connections, and the financial stability of rural hospitals and clinics.

Oregon envisions healthy rural communities where people, partners, and technology come together to build thriving communities of care – rooted in prevention, strengthened by regional collaboration, sustained by a resilient workforce, and guided by smart data for better health and well-being. To ensure all people and communities in rural Oregon can achieve optimum physical, mental, and social well-being at every life stage, we will anchor our efforts in these goals: improving health access and outcomes; fostering workforce innovation; supporting technological and data-driven solutions; building strategic partnerships; and ushering in a future of financial sustainability.

Through this cooperative agreement, Oregon and our federal partners will build on a strong foundation of community partnerships and practical health reforms to enhance care delivery in rural areas. Oregon will do this through five initiatives: (1) Regional Partnerships & System Transformation (2) Healthy Communities & Prevention (3) Workforce Capacity & Resilience (4) Technology & Data Modernization and (5) Tribal Initiative. These initiatives all align with Oregon's commitment to local and regional control, improving care efficiency, and responsible use of federal resources. The Oregon Health Authority (OHA) will be the lead agency responsible for implementation and administration of the program. OHA is inclusive of the state's Public Health agency, Medicaid agency, Marketplace, and Behavioral Health agency, which allows OHA to be well positioned for cross-sector partnerships and a comprehensive view of the health of rural Oregonians.

OHA proposes a budget of $200 million dollars annually for five years. OHA will provide a set-aside to the Nine Federally Recognized Tribes of Oregon and use funds to make awards to rural health organizations to implement the first four initiatives in two phases. The two-phase approach for fund distribution, within each initiative, allows Oregon to support rural organizations that have been waiting for an opportunity like this and build longer, sustainable approaches to some of rural Oregon's most impacted sectors, such as technology and workforce. In the first phase, Oregon will fund immediate projects and uplift other projects that can be executed within two years. While those projects are occurring, OHA and its regional partners will work together to develop longer-term ventures that will be implemented during the second phase of the program and beyond.

All awards will ensure that investments and initiatives are community-directed and address local and regional needs. With a proven record of innovation and collaboration between federal partners, state agencies, healthcare providers, tribal and rural leaders, Oregon is well-positioned to use RHT Program funding to strengthen rural healthcare, create jobs, and promote self-sufficient, sustainable communities across the state.

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## Rural Health Needs and Target Population

### Rural Demographics

Oregon is the ninth largest U.S. state, covering over 98,000 square miles. It is home to roughly 4.2 million people, 33% of whom live in rural and frontier communities.[i] Oregon is also home to nine Federally Recognized Tribes, and it was the first state to pass a state-tribal government-to-government relations law. Of Oregon's 36 counties, all but two have rural areas or are entirely rural, and 10 are designated as frontier. Half of the state's counties have less than 22 persons per square mile, down to 0.7 persons per square mile in Harney County.[ii] Oregon is deeply familiar with the challenges that often arise from geographic distribution and isolation, whether that be infrastructural constraints impacting economic development in rural areas or the persistent concentration of services in urban areas. These physical and systemic factors contribute to higher rates of poverty, unemployment, and uninsurance, along with lower median household income and lower levels of educational attainment (see Appendix Table 1 and 2).

As one of the most geographically diverse states, spanning two times zones, Oregon also boasts a uniquely varied economy. Its longstanding industries of agriculture, fishing, and lumber production are complemented by an accelerating high-tech manufacturing sector, which holds a greater share of statewide employment than the national average.[iii] Another prominent sector is healthcare and social assistance, to which seven of the 15 fastest-growing occupations in Oregon are related.[iv] Despite strong current and projected demand for workers in this sector, growth is outpacing labor supply, particularly in rural areas where workforce shortages are exacerbated by an aging population, increasing retirements, and lack of new entrants in the field.[v]

**Health Outcomes**

In Oregon, rural and frontier communities experience higher-than-average death rates for the top 10 causes of death in the state (see Table 3). Adults in rural areas are more likely to be diagnosed with chronic conditions such as asthma, diabetes, coronary heart disease, depressive disorder, and hypertension.[vi] The rural-urban difference is also evident in health-related behaviors and risk factors, with rural adults (18.3%) reporting higher rates of alcohol and tobacco use compared to their urban counterparts (13.8%).[vii]

One of Oregon's most pressing healthcare challenges is its high level of behavioral health needs, including mental health and substance use disorder (SUD). Current data shows that Oregon ranks 42nd of 51 states (including the District of Columbia) in a composite measure of behavioral health outcomes and access to care.[viii] While Oregon ranks 7th for overall access to care, this is heavily influenced by urban access which is 1.75 providers to 1000 residents compared to .61 to 1000 in rural areas.[ix] Oregon ranks last for prevalence of behavioral health disorders and 47th for percentage of youth who had a least one major depressive episode in the past year.[x]

Oregon's rural communities have on average double the rates of inadequate access to prenatal care compared to urban areas.[xi] People in Gilliam and Curry counties must travel on average 35 miles to the nearest birthing hospital, on roads that can be treacherous during winter weather or fire season.[xii] Inadequate prenatal care contributes to low birth weight in newborns; in fact, the rate of low birth weight newborns has increased in Oregon in the last fifteen years and is higher on average in rural communities.[xiii] In addition, two hospital obstetric (OB) units in rural Oregon have closed in recent years, and other rural hospitals have indicated that they may need to close their OB units soon without substantial funding or intervention. Evidence indicates that when an

OB unit closes, initiation of prenatal care decreases even if access to prenatal care is maintained in the community.[xiv]

Oregon faces a rapidly growing older adult population. One in four Oregonians will be over the age of 65 by 2035, and much of rural Oregon has already exceeded that proportion (for example 30% of the population is already over 65 in seven Oregon counties).[xv] Older adults face unique medical and social needs; across the state, 9% report cognitive difficulties, 20% struggle with depression, 33% have fallen in the last year, and 43% have multiple chronic conditions.[xvi]

**Healthcare Access**

Primary and behavioral health access remains one of the biggest barriers to care for many rural and frontier Oregonians. These communities are served by a strained patchwork of rural healthcare providers and systems, including 37 rural hospitals, 25 of which are Critical Access Hospitals (CAHs), 108 Rural Health Clinics (RHCs), 98 Federally Qualified Health Center (FQHC) facilities, and 28 rural community mental health centers.[xvii]

Even among rural and frontier communities, geographic barriers express differently depending on transportation availability and the strength of local healthcare infrastructure. For example, Wheeler County, which is larger than the entire state of Rhode Island, has no hospital, with transport to the closest hospital 65.5 miles away – a 1.5-hour drive on secondary roads in good weather.[xviii] Poor cell phone reception can cause delays in emergency calls, impacting the outcome of serious health events and accidents. There is also a shortage of emergency medical services, many of which rely on dedicated volunteers in these rural areas, undermining a system that is intended to be timely, consistent, and the first line of response.[xix]

A recent report from the Oregon Office of Rural Health on Areas of Unmet Health Care Need highlights the increased barriers rural communities experience with health care access:

- The ratio of estimated primary care visits that providers in urban areas of Oregon can accommodate is 1.19 (a ratio of 1.00 signifies a balance between supply and demand). Rural and frontier regions have a lower average ratio of 0.71, indicating a higher demand than supply. 11 primary care service areas, all rural or remote, have zero primary care provider FTE.[xx]
- Rural and remote areas display a higher rate of preventable hospitalizations, with some areas exhibiting rates twice or more than the state average (6.7 per 1,000).

Behavioral health access reflects a similarly troubling picture. In Oregon, 32 of 36 counties lack even one mental health provider per 1,000 residents.[xxi] In a 2022 statewide assessment conducted by Oregon Health & Science University – Portland State University (OHSU-PSU) School of Public Health in collaboration with the Oregon Alcohol and Drug Policy Commission and Oregon Health Authority (OHA), over 50% of the behavioral health service organizations surveyed did not think their capacity met the current demand for services. 64% also reported that travel time and transportation were significant barriers to timely care, particularly for their patients in rural areas. Despite improvements in access and other benefits of telehealth, utilization in rural Oregon communities lags behind. In 2024, 21% of all telehealth visits occurred in rural areas, while the majority (79%) were provided in urban areas. This distribution is disproportionate to the rural-urban population split (33% vs. 67%), highlighting potential gaps in digital access and technology in rural areas.[xxii]

In rural Oregon, healthcare access is marked by incongruities in supply and demand. While a third of Oregonians live in rural and frontier areas, only 15.9% of all providers (including doctors, nurses, physician assistants, dentists, and therapists) are rural based. When broken down

by specialty, the differences become even more apparent: just 9.1% of internal medicine providers and 24.3% of general practice providers serve rural communities.[xxiii]

Oregon faces significant gaps in its training pathways for healthcare providers with just 11.7 primary care (family medicine, internal medicine, geriatrics, and pediatrics) medical residents per 100,000, which is well below the national average of 17 per 100,000.[xxiv] The nursing and dental fields are facing similar trends. For instance, the average annual growth of certified nursing assistants (0.3%) is not keeping pace with Oregon's population growth and the number of clinical nurse specialists decreased annually by 2.7% on average over the past five years. Approximately one million Oregonians across 33 of 36 counties live in a Dental Health Professional Shortage Area.[xxv] Exacerbating workforce shortages is the concentration of postsecondary education training opportunities in urban areas. For instance, 83% of family medicine graduate medical education (GME) slots are found in the Portland Metro area, even though only 46.7% of Oregon's population live in that area.[xxvi]

**Rural Facility Financial Health**

Although Oregon has largely avoided rural hospital closures, many facilities have been forced by shrinking operating margins to cut jobs and divest from critical but costly service lines, including maternity and pediatric intensive care units.[xxvii] 14 of the state's 37 rural hospitals ended 2024 with negative operating margins, and incurred a combined net financial loss of $93 million due to maintaining essential services for the community such as 24-hour emergency and labor and delivery care.[xxviii] One rural hospital recently reduced available emergency room services by stepping down from a Trauma III emergency room to a Trauma IV emergency room because of cost pressures and workforce constraints. This created a 130-mile gap in coverage between it and the next hospital with available 24-hour trauma surgery capacity.

There is greater representation of independent hospitals in rural Oregon than in urban settings. 13 of the 37 rural hospitals are independent of a health system. For instance, Harney District Hospital, which has 25 beds, is the only hospital to serve all of Harney County (the population is 7,623 people). Harney County is 10,226 square miles—larger than six U.S. states. With distances like these, CAHs must work more independently than their urban colleagues. As importantly, rural and frontier areas have higher shares of Medicaid enrollees than urban areas; for example, 54% of residents in Malheur County, which is designated as fully frontier, are enrolled in Medicaid, compared to 36% in Multnomah County, which is completely urban.[xxix] This reality places additional strain on rural safety-net providers when there is more uncompensated or undercompensated care.

Preventable hospitalizations in Oregon have been steadily increasing since the pandemic low point in 2020. While total outpatient visits decreased from 2023 to 2024, total emergency department (ED) utilization and inpatient discharges increased across the state's 60 acute hospitals (A, B, and DRG) with rates consistently higher for rural communities, reaffirming the urgent need to improve timely and effective primary care [xxx].

**Target Population**

In the face of these daunting healthcare challenges, from access gaps to chronic disease burden, Oregon is committed to stewarding RHT program funds effectively by investing it in the most at-risk rural communities. We will target rural and frontier hospitals, health clinics, community health centers, and community-based organizations providing health care services in rural and frontier areas statewide. Rural is defined as any geographic areas in Oregon ten or more miles from the centroid of a population center of 40,000 people or more. Frontier (or "remote")

is any county with six or fewer people per square mile and are included whenever rural populations are referenced.

## Rural Health Transformation Plan

### Vision, Goals, and Strategies

Vision: We envision healthy rural communities where people, partners, and technology come together to build thriving communities of care – rooted in prevention, strengthened by regional collaboration, sustained by a resilient workforce, and guided by smart data for better health and well-being.

Goals: To ensure all people and communities in rural Oregon can achieve optimum physical, mental, and social well-being at every life stage, we will anchor our efforts in 1) improving access and outcomes; 2) workforce innovation; 3) technological and data-driven solutions; 4) strategic partnerships; and 5) financial sustainability.

Anchor Strategies:

*Improving access and outcomes:* Oregon's proposed access activities address many needs identified through Oregon's RHT Program public comment period (see Stakeholder Engagement on page 45). These activities, which span across multiple RHT Program initiatives, will address the higher rates of preventable disease in rural communities, outdated EMS infrastructure, limited access to chronic disease management programs and specialists, and a need for more community-specific solutions that support patient navigation, care coordination, and access to social health services.

Through the RHT Program, Oregon will expand its nurse home-visiting programs to new rural communities, launch rural school nursing access programs in rural/frontier school districts, increase the use of remote patient monitoring (RPM) and health IT tools, and increase self-

management education programs to help patients manage their chronic conditions. Furthermore, Oregon will support rural organizations with developing comprehensive regional school treatment and recovery programs and increasing teletherapy services. Additionally, Oregon will support expanding rural pharmaceutical services through pharmacy lockers, tele-pharmacy and other technologies that enable pharmacist-supervised dispensing, counseling, and medication adherence support. To ensure there are highly skilled care teams to provide ongoing access and care, Oregon will support investment in workforce training programs, non-physician health professional certification to expand the number of allied health professionals in rural areas, and short-term housing solutions for rural healthcare providers for better retention.

Oregon will focus on advanced chronic disease prevention and management through connecting rural residents to preventive care, increasing primary care visits, increasing use of telehealth and RPM, enhancing and creating a stronger rural health care infrastructure, and increasing the number of family medicine, certified nurse midwifery, advanced practice, behavioral health and dentistry residencies in rural areas. To ensure long-term sustainability, Oregon will reinforce and boost strong regional partnerships focused on operational efficiency, continued quality and performance improvement, and the dissemination of best practices and successful models across the state. Additionally, Oregon will direct funds to both ready-to-go innovative projects and longer-term health care infrastructure projects.

*Technology and data driven-solution:* Oregon will invest in and empower rural stakeholders to assess, select, and use data and technology solutions to ensure digital access to and secure sharing of health information. This will support chronic disease prevention and intervention, reduce administrative complexity and burden, and improve communication and coordination across providers, patients, and systems.

Oregon will harness data and technology to furnish high-quality, convenient healthcare services by focusing on supporting remote and digital care tools that give patients the choice receive care outside of traditional health care settings (e.g., at home), reducing travel burdens. The state will also invest in rural community capacity to collect, analyze and disseminate data through community-led data convenings and locally driven projects. These efforts will enable rural communities to leverage their data for informed decision making and targeted investments. Oregon will use new and emerging technologies such as RPM and digital care tools, patient-facing apps, and AI-enabled technology, among others, that emphasize prevention and chronic disease management. These tools will be used by providers and healthcare organizations to monitor vital signs like blood pressure and A1C levels, provide medication titration and monitor medication adherence outside of traditional healthcare settings, and increase patient engagement in managing their own health.

*Workforce innovation:* Oregon is committed to expanding and sustaining its rural healthcare workforce through targeted recruitment, training, and retention strategies that will include "Grow Your Own" models, new residency programs, and provider training and family supports. Achieving this vision requires both immediate and long-term solutions, including tele-mentoring, career pathway development, and financial incentives tied to rural service, to ensure that rural communities are attractive places to train, work, and live. Special focus will be placed on high-need specialties like family medicine, surgery, maternity care, and behavioral health to meet growing demand and ensure access to essential services.

*Strategic partnerships:* The vision for Oregon's rural health transformation is predicated on ensuring our state's rural healthcare system is organized in a way that enables regionally driven approaches to meet the unique and evolving needs of communities by sharing resources,

providers, technology, and more. In years one and two of the RHT Program, Oregon will launch catalyzing efforts to pair region-specific health care needs with transformative resources. In FY28-30, Oregon expects that entities receiving funds through the RHT Program will apply to do so as a regional consortium (e.g., via a lead organization serving as a hub, a shared collaborative, or a similar formal contractual agreement) or in alignment with a shared regional health care plan. In addition, Oregon will bring in trusted partner organizations, such as the state Office of Rural Health, to support distribution of funds, grant management, and targeted technical assistance.

*Financial solvency:* Oregon plans on connecting rural hospitals and other rural providers together through regional partnerships to identify best practices for financial stability and sustainable cost containment. Oregon will support rural organizations to:

- Diversify their revenue streams – including through creative integrated networks with appropriate risk-based models.
- Control costs through shared resources.
- Design and implement alternative payment models, including per-member-per-month (PMPM) payments to support team-based care, and other strategies to drive towards innovative, sustainable, and strategic payment reform.
- Advanced and targeted technical assistance for financial and operational management.
- Right-sizing by aligning services and infrastructure with the needs of Oregon's current and future rural populations by ensuring financial sustainability to support any necessary transitions and maintain access to care.

*Cause identification:* Sparse population in rural communities leads to fewer providers and lower volume of services, which correlates with lower revenue. The median number of annual inpatient

discharges for Oregon's rural hospitals is 474 compared with a median of 4,053 for Oregon's urban hospitals.[xxxi] These low volumes create challenges for rural hospitals to maintain certain services that rely on 24/7 staffing, including maternity services and ED, as well as services for a significantly older population compared to the urban areas of the state. In 2024, 45% of Oregon's hospitals had negative margins, 26% of hospitals had modest margins of 0-5%, and 29% of hospitals had an operating margin above 5%. Operating margins can be a signal of the financial health of a hospital. In Q1 of 2025, Oregon hospitals lost a combined $359 million on operations, the equivalent of a statewide -7.0% operating margin. This is the most significant operating margin deficit for hospitals to date.[xxxii]

One of the most pressing issues facing rural Oregon is the closure of hospital labor and delivery units, and the reduction in maternity services. Oregon's Perinatal Collaborative visited each of Oregon's 47 hospitals that provide labor, birth, and postpartum services in 2024 to understand the specific factors influencing hospital operations, and they all confirmed three major challenges that exacerbate financial issues: 1) staffing challenges, 2) patients who are sicker, and 3) more patients with unmet basic needs.[xxxiii]

**Program Key Performance Objectives**

By the end of the cooperative agreement period in FY 2031, our program will have achieved measurable, transformative improvements in rural health care across Oregon. Through a carefully designed and selected portfolio of initiatives, we aim to expand access, improve outcomes, modernize systems, build a resilient and skilled workforce, and empower local and regional partnerships. Just as our Transformation Plan is informed by CMS's five strategic goals, so too are the program performance objectives, which have been selected for their relevance, feasibility, and alignment with the initiatives.

The overall program performance objectives are:

1. By FY 2031, increase the number of new access points in operation for preventative care and social health services in rural and frontier counties by 15%.
2. By FY 2031, increase the percentage of rural health care providers participating in a value-based payment arrangement. 75% of participating providers will demonstrate improved performance on at least one quality metric.
3. By FY 2031, ensure that at least 75% of rural health care organizations participating in RHT Program report improved workforce stability.
4. By FY 2031, ensure that 75 of rural provider entities participating in the RHT Program report improved health IT capabilities, interoperability and/or cybersecurity.
5. By FY 2031, ensure that at least 75% of rural counties are engaged in formal regional partnerships that support shared infrastructure, governance, and service delivery.

These objectives are supported by a comprehensive and complementary set of initiative milestones and outcome metrics that will ensure operational direction and accountability, as well as continuous performance improvement throughout the cooperative agreement period. Our metrics are designed to track progress towards initiative-specific outcomes and systems-level change. For example, we will measure increase in access to preventative care, growth in the rural health workforce, and expanded interoperability and adoption of health IT. These outcome metrics will help us assess whether rural communities are experiencing improvements in service availability, care coordination, and social health services support.

By aligning initiative-level metrics and milestones with the program performance objectives and the strategic goals of the RHT Program, we are designing a symbiotic program that ensures

that improvements in one area, such as workforce or technology, contribute to broader gains in access, quality, and system transformation.

**Strategic Goal Alignment**

*Make Rural America Healthy Again:* Increasing the proportion of rural residents with access to preventative care, which includes nutrition and dietary counseling, will help support a thriving rural community through innovative new access points. This will include funding and supporting nurse home-visiting programs and projects that improve access to telehealth and tele-pharmacy.

*Sustainable Access:* As part of the first phase, Oregon will reinforce and accelerate regional partnership building to bring stakeholders together and design long-term access points for care. Key to the effort is increasing the percentage of rural health care providers participating in new payment arrangements to ensure long-term financial sustainability.

*Workforce Development:* Building, supporting, and attracting a high-skilled health care workforce is paramount to Oregon's goals and objectives. To ensure a long-term pipeline of healthcare professionals across the state, Oregon will launch new certification programs and residency programs with rural tracks. Strategies will include expanding tele-mentoring opportunities, developing clear career pathways, and offering financial incentives tied to rural service – all designed to make rural practice a viable and rewarding career choice.

*Innovative Care:* Oregon's regional partnership initiative will include robust community discussion and input to bring innovative care models forward. Regional entities are best positioned to identify and implement coordinated care models that improve health outcomes while reducing costs.

*Tech Innovation*: Oregon will support innovative technologies, such as telehealth, wearable monitoring devices, and virtual access points to assist rural residents in managing chronic

diseases and receiving care from their providers when they need it. Tech tools will also be used by providers and healthcare organizations to monitor vital signs like blood pressure and A1C levels, provide care and monitor medication adherence outside of traditional healthcare settings.

**Legislative or Regulatory Action**

Oregon is actively working with the Governor's Office and Legislators to identify future legislative or regulatory actions related to the RHT Program. This includes exploring policy needs that align with the RHT "State policy actions" and support the state's overall participation and success in the program. Oregon will focus its policy actions on the levers that offer the greatest potential to reinforce the outcomes and goals of the state's strategic initiatives.

B.4. Nutrition Continuing Medical Education (CME):

Currently, Oregon does not have nutrition education included in its CME for physicians, nor is there pending state legislation addressing this issue. Oregon recognizes the importance of nutrition in preventive and whole-person care and intends to continue discussions with trusted partners, including the Oregon Medical Board and Oregon Medical Association, to explore the development of a policy that ensures clinical relevance, administrative feasibility, and successful adoption. Oregon will use this opportunity to explore continuing education (CE) policies to include non-physician providers, where appropriate, to support team-based approaches to nutrition and chronic disease prevention, a core component of the State's RHT activities.

By September 30, 2026, Oregon will work with partners and medical boards to identify opportunities for integrating nutrition education into CME and CE and by September 30, 2028, Oregon will pursue all necessary discussions and policy development related to nutrition-focused CME and CE, including assessing the implementation pathways with our partners and identifying the most effective medium for policy action. Based on the outcomes of that planning,

we would work with Legislators and the Governor's office to pursue bill sponsorship for the 2027 or 2028 State Legislative Session. That legislative process would position the state to enact a bill and finalize regulations by December 31, 2028.

D.2. Licensure Compacts

Oregon continues to explore approaches to strengthen and expand its health care workforce, including efforts to reduce barriers to licensure and credentialing. In the most recent legislative session, a draft provision to join the Emergency Medical Services (EMS) Compact had prompted robust dialogue around the need to balance workforce mobility with patient safety, administrative feasibility, and system readiness. Oregon intends to build on these efforts and focus its licensure compact exploration on the EMS Compact as this essential service and workforce are focal points throughout the state's RHT Program initiatives. Compact participation is a strategy that could complement the other EMS activities, particularly those aimed at enhancing workforce training and regional coordination.

Over the next two years, Oregon will pursue all necessary discussions and policy development with the state's Public Health Division, Legislature, and EMS stakeholders to revisit the compact framework and assess regulatory implications. By September 30, 2026, Oregon will have refined the policy option and completed initial legislative engagement, positioning the introduction of a bill for 2027 State Legislative Session with a target enactment by December 31, 2027.

D.3. Scope of Practice

Oregon is committed to exploring further scope of practice expansions for provider types facing significant workforce strain. We intend to focus on pharmacists, who currently have full drug administration authority and partial laboratory testing and independent prescribing

authority.[xxxiv] Exploring this State policy action would complement emerging tele-pharmacy and mobile health care delivery models aimed at expanding pharmacy services found in key activities across several of the initiatives.

Oregon will engage in policy development and discussions in collaboration with the Oregon Board of Pharmacy, the Public Health & Pharmacy Formulary Advisory Committee, and other Pharmacy stakeholders, who will advise on policy actions around pharmacy prescribing and laboratory testing authority. By September 30, 2026, Oregon will have refined the policy option and completed initial legislative engagement, positioning the introduction of a bill for 2027 State Legislative Session, with a target enactment by December 31, 2027.

## Other Required Information

| State Policy Action | Current Status | Proposed Policy Commitment |
|---|---|---|
| B.2. Health and Lifestyle | Oregon currently has a comprehensive policy around Physical Education Standards. These standards include identifying ways to be physically active and developing a variety of motor skills. | Oregon does not plan to pursue a state mandate. |
| B.3. SNAP Waivers | Oregon does not currently have a SNAP Food Restriction Waiver | Oregon does not plan to pursue a SNAP Food Restriction Waiver. |
| B.4. Nutrition Continuing Medical Education | Oregon does not currently have nutrition CME. | Oregon plans to pursue this policy action. See Legislative or Regulatory Action for more detail. |
| C.3. Certificate of Need (CON) | Oregon has moderate CON policies across Cicero facility categories. | Oregon does not plan to pursue any CON eliminations. |
| D.2. Licensure Compacts | Oregon is not a member state of the Interstate Medical Licensure compact, the PSYPACT, the Nurse Licensure Compact, and the EMS compact. | Oregon plans to pursue policy action for the EMS compact. See Legislative or Regulatory Action for more detail. |
| D.3. Scope of Practice | Oregon has full, unrestricted scope of practice policies for Nurse Practitioners and Dental Hygienists. Oregon has advanced scope of practice policies for Physician Assistants and moderate scope of practice policies for Pharmacists. | Oregon plans to pursue policy action for Pharmacists. See Legislative or Regulatory Action for more detail. |
| E.3. Short-term, limited duration insurance (STLDI) | Oregon has some restrictions in place that limit STLDI plans. | Oregon does not plan to pursue amendments to its STLDI plan restrictions. |
| F.1. Remote Care Services | Oregon has optimal Telehealth Laws and Reimbursement Policies across all five CCHP categories. | Not Applicable. |

**For factor A. 2 and A.7:**

A current list of CCBHC entities is provided in Supporting Documentation: All CCBHCs in Oregon.

Oregon has 15 hospitals that met the DSH criteria and are qualified to receive a DSH payments.

## Proposed Initiatives and Use of Funds

Oregon will have five initiatives:

| Initiative | Summary | Main Strategic Goal | Use of Funds | Technical Score Factors |
|---|---|---|---|---|
| Regional Partnerships & System Transformation | Focus on building rural regional hubs to accelerate long-term sustainable strategies. | Sustainable Access, Innovative Care | A, B, F, G, H, I, K | B.1, C.1, C.2, E.1., F.2 |
| Healthy Communities & Prevention | Focus on creating new health access points to rural counties. | Make Rural America Healthy Again, Tech Innovation | A, C, G, B, J, K | B.1, B.2, C.2., E.2, F.1, F.3 |
| Workforce Capacity & Resilience | Focus on developing workforce from training to professional development programs | Workforce Development, Make Rural America Healthy Again, Tech Innovation | E, G, H, K | B.1, B.4, C.2, D.1, D.3 |
| Technology & Data Modernization | Focus on expanding and connecting rural health care to needed technologies. | Tech Innovation, Sustainable Access | D, F, G, K | C.1, F.1, F.2 |
| Tribal | Focus on supporting the Tribes with improving health outcomes. | Make Rural America Healthy Again, Workforce Development, Sustainable Access, and Tech Innovation | A, B, C, D, E, F, G, H, J, K | B.1, C.1, D.1, F.1, F.2, F.3 |

## Regional Partnerships & System Transformation Initiative

**Main strategic goals:** Sustainable Access, Innovative Care

**Uses of funds:** A, B, F, G, H, I, K

**Technical score factors:** B.1, C.1, C.2, E.1., F.2

**Description:** The Regional Partnerships and Systems Transformation initiative intends to:

1. Apply regional solutions to address urgent, immediate needs and enhance Oregon's shared health care infrastructure for rural communities;
2. Scale up planning efforts to pair region-specific health care needs with transformative resources; and
3. Invest in cross-sector collaboration.

*Sharing Infrastructure:* Enhancing rural Oregon's health care infrastructure will require start-up funding to develop shared resources, as well as centralize and streamline back-office functions in order to ensure the financial stability of rural hospitals and clinics and maintain services for rural

residents. Communities and rural health care entities will explore partnerships with larger health care entities to develop targeted and financially sustainable service line expansions while preserving independence of rural providers and keeping care local. Those involved in this work will also intensify efforts around partnerships such as clinically integrated networks (CINs) to better coordinate patient care, collaborate on staff recruitment and retention, share technology, right-size facilities and services, reduce health care entities' administrative costs, and deploy value-based payment arrangements. Projects to expand value-based payment arrangements among rural health care providers will align with current goals expressed by the Oregon Health Policy Board and the Oregon Committee on Health Care Affordability, both of which strive to increase health care quality and value in the state.

*Strategic Planning Activities:* This initiative will fund planning activities that will first focus on at-risk specialty services, such as maternity care. The focus will be on building regional solutions that increase efficiencies in care delivery, thereby improving participants' financial stability and long-term sustainability. A primary component of this work will be exploring new payment structures as a mechanism for reliable revenue streams.

*Cross-sector Collaboration*: Lastly, cross-sector collaboration and investments will ensure that regional efforts build towards financial stability, efficient resource allocation and utilization, and an ongoing collaborative culture that promotes sharing best practices in rural health care delivery. Representatives from the behavioral and medical health care delivery system, social health services, and coordinated care organizations (CCOs)[xxxv] will convene to strategize region-specific priorities and investment opportunities.

All three components – shared infrastructure, regional planning, and cross-sector collaboration – will be achieved through a community hub-and-spoke model, which provides an

efficient means of creating the advanced financial, technical, administrative, and operational infrastructure needed to engage and connect with healthcare partners on behalf of multiple agencies in an organized network delivery model. Hubs can serve multiple functions such as: leadership and governance, strategic business development, network recruitment, engagement and support, contract administration and compliance, centralizing back-office functions and operations, information technology and security.

Uses of funds:

The initiative will solicit local proposals and competitively fund efforts to create and sustain regional partnerships that include health care and social service entities serving rural communities. Targeted technical assistance will be provided to eligible entities, such as organizations serving the AI/AN population, ensuring fair access to applying for the Catalyst Awards and efficient and timely deployment of funds during the first fiscal year (see Implementation Plan for more details). Over the long-term, the goal is to encourage collaboration and strategically invest in these partnerships that have the greatest potential to ensure lasting sustainability. Funds will be used to:

- Accelerate, formalize, and support regional collaboratives. Funds may be used to organize and support the convening of partners as these collaboratives take shape.
- Promote technical assistance on topics such as cycle optimization, workflow and needs assessments, and how to pursue a change in scope for RHCs and CCBHCs.
- Establish and support hub-and-spoke models to further strengthen regional partnerships through centralized infrastructure and operational and administrative functions, including sharing advanced technologies such as surgical robotics.

- Explore and reinforce other partnerships with private sector, business leaders and other sectors to ensure broad engagement and buy-in.
- Support strategic investments in CAHs to ensure sustainable emergency, maternity, and other services.
- Learning collaboratives: Develop and launch learning collaborative opportunities so health care entities both within and across rural areas can support each other.
- Child & Youth focus: Increase regional collaboration for children through partnerships between school districts, early learning hubs, school-based health centers, local systems of care collaboratives, intellectual and developmental disability services, juvenile justice and child welfare to provide physical, and behavioral health supports and resources.
- Data focus: Support for input on program development, structure, and oversight, such as when implementing IT systems, software, or data sharing that supports care coordination or for collaboration and convening to strategize region specific priorities and investments.
- Rural community-led data analysis and governance: Invest in rural community capacity to collect, analyze and disseminate data through community-led data convening and data projects including:
    - Convener(s) to develop community-led data practices for data governance and decision making to leverage their data for investments that improve health outcomes, efficiency, and sustainability.
- Maternity focus: Improve access to perinatal services in rural Oregon by investing in:
    - Rural maternity care coalitions or partnerships to design a sustainable system of maternity care and allows maternity providers to practice at the top of their training and license.

    - FQHCs, RHCs, and birthing centers' abilities to provide perinatal care through partnerships with nearby hospitals.
    - Expansion of Nurture Oregon, a rural integrated care model for pregnant families that includes peer support, prenatal care, substance use and mental health treatment, care coordination, and other services, into three additional communities.
- Emergency Medical Services (EMS) focus: EMS modernization through strengthened regional coordination and formalized coordination agreements. Establish standardized regional advisory structures to coordinate EMS response, hospital triage, and interfacility transfers. Promote data sharing, joint training, and integrated resource planning.

**Key Stakeholders:** See Appendix Table 4 for full list.

**Outcomes:**

1. Reduce operating costs for rural health organizations through shared infrastructure according to regional/local needs
2. Increase access to high-need or at-risk service lines, such as maternity care
3. Increase regional planning efforts focused on shared governance models, including CINs and consortiums by county level
4. Increase participation in value-based care models

Oregon's Metrics and Evaluation Plan (page 49) provides additional details.

**Impacted counties:** This initiative will impact all counties in Oregon. See Appendix Table 5 for the list of FIPS codes.

**Estimated required funding: $40,000,000 - $55,000,000 / year**

### Healthy Communities & Prevention Initiative

**Main strategic goals:** Make Rural America Healthy Again, Tech Innovation

**Uses of funds:** A, C, G, B, J, K

**Technical score factors:** B.1, B.2, C.2., E.2, F.1, F.3

**Key stakeholders:** See Appendix Table 4 for full list.

**Description:** The Healthy Communities & Prevention Initiative focuses on bolstering rural health systems by expanding access to integrated primary care and social health services that promote prevention, healthy nutrition, care coordination, and care management, especially for individuals with complex health statuses. Investments made under this initiative promote whole person health across all facets of life, from prenatal & infancy to end-of-life care.

This initiative responds to these identified challenges with the following aims:

- Ensuring rural Oregonians can easily and affordably access the necessary services, including for behavioral health, maternal and child health, oral health, long-term care, and emergency services, in their community across a variety of settings by leveraging local partnerships and technology-driven solutions.
- Increasing social health services, navigation and outreach capabilities, non-traditional care teams, and population health infrastructure.
- Advancing innovative, community-driven solutions that provide choice and tools to support personal health care management.

Oregon will leverage this funding opportunity to move beyond the status quo of care delivery and coordination by scaling promising programs and adopting innovative solutions, especially those aided by digital tools and remote care access, to address health across the entire lifespan.

*Strong Foundations for Healthy Families:* The Healthy Communities & Prevention initiative reflects Oregon's standing commitment to creating a state where rural families can thrive. Beginning with the health and wellbeing of mothers and babies and continuing to support the optimal development of Oregon's children and youth, this initiative will focus on prevention-focused initiatives that address the root causes of public health.

*Supporting Rural Residents with Special Healthcare Needs* (Those with chronic disease, behavioral health needs, and Dual Eligible Special Needs Plan (D-SNP) members): Building healthy communities also requires targeted solutions for the unique medical and social challenges experienced by individuals during life stages marked by complex, changing, and sometimes stressful roles within families and communities. Without reliable or sufficient access to essential care and social health services, individuals are not being empowered to lead healthy lives. To support rural residents with their complex medical needs, this initiative supports new and innovative ways to connect people to healthcare services and facilities.

*Aging in Place:* This initiative responds to rural older adults' specific challenges accessing care and fostering social cohesion by expanding long-term care and community-based services that support seniors to age safely, healthfully, and independently in their homes and communities.

Uses of funds:

The initiative will dedicate funding to expand proven, evidence-based solutions and solicit proposals for community-driven solutions for each of the three lifespan groups.

*Strong Foundations for Healthy Families:*

- Expand nurse home visiting programs (such as Family Connects Oregon[xxxvi]) to new rural communities.

- Launch a rural school nursing access program to increase access to school nursing in rural/frontier school districts. This program will fund a nurse consultant to support three school districts, providing regional support for the delivery of school nursing services in collaboration with school nurse extenders (including telenursing and partnering with LPHA RNs).

*Supporting Rural Residents with Special Health Care Needs:*

- Improve the ability and capacity of schools to provide resources and respond to co-occurring behavioral health concerns through the development of a comprehensive regional school treatment and recovery program in public schools that have access to community SUD services.
- Increase access for individuals to behavioral health services including teletherapy (individual, group, and peer support), respite, remote and ED/emergency response-initiated medication assisted treatment for SUD and other SUD treatment.
- Strengthen care linkages to EMS services for Buprenorphine initiation to support ongoing engagement of treatment, such as connection to follow up providers or utilization of embedded peer service providers.
- Investments in technical assistance to build capacity for telehealth-based ambulatory detox as well as community-based services that support families through intensive inpatient treatment programs.
- Improve access to integrated care for dually eligible individuals and/or children and youth with complex needs in rural areas through increased outreach and strengthened care coordination and care management.

- Increase access to community naloxone to reduce the number of fatal overdoses, including through local public health department in partnership with schools and other local site to ensure low barrier to access.

*Aging in Place:*

- Expand community health worker outreach models, such as the Connected Care for Older Adults (CCOA) model, to new rural clinics. In the CCOA model, community health workers (CHWs) improve care for frail adults 55 and older through home visits, information, education, coordination with primary care providers to existing community services. The initial pilot successfully reduced ED and hospital utilization, increased Advanced Directive completion, connected over 400 patients and their families to community resources, and improved patient, caregiver, and provider experience.
- Expand brain health and caregiver trainings through online self-management platforms.
- Support for emergency medicine services to establish treat "in place" procedures as part of emergency calls for older adults.

*Interventions Across the Entire Life course:*

- Support for expanded rural pharmaceutical services through pharmacy lockers, tele-pharmacy and other technologies to enable pharmacist-supervised dispensing, counseling, and medication adherence support.
- Support to expand or modify services through non-traditional delivery mechanisms, such as mobile health units, for general health purposes or specialties like maternal health.
- Increase access to nutrition/lifestyle medicine approaches to meet the needs of rural Oregonians by expanding models such as the Heart Healthy Ambassador Program[xxxvii], Walk With Ease[xxxviii], and Chronic Disease Self-Management Education programs.[xxxix]

- Invest in locally developed networks to increase access to social health services, including emergency food services and transportation.
- Increase access to comprehensive oral health services for patients across Oregon through innovative solutions including mobile dental clinics and tele-dentistry.
- Expansion of telehealth and digital health tools, including RPM and self-management education programs to help rural patients with chronic conditions.

**Outcomes**

1. Universal access to home visiting services
2. Increase availability of mental health and substance use disorder treatment
3. Increase patient engagement with new preventative health and/or self-management programs
4. Increase rural populations served by new health care and social health services
5. Increase proportion of telehealth encounters by county

Oregon's Metrics and Evaluation Plan (page 49) provides additional details.

**Impacted counties:** This initiative will impact all counties in Oregon. See Appendix Table 5 for the list of FIPS codes.

**Estimated required funding: $50,000,000 - $75,000,000 / year**

### Workforce Capacity & Resilience Initiative

**Main strategic goals:** Workforce Development, Make Rural America Healthy Again, Tech Innovation

**Uses of funds:** E, G, H, K

**Technical score factors:** B.1, B.4, C.2, D.1, D.3

**Description:** A strong workforce is the backbone to a sustainable, high-quality healthy America. Oregon has long been a leader in empowering providers to practice in team-based settings at the top of their license through advanced scopes of practice. The Workforce Capacity & Resilience Initiative builds on this legacy by addressing the growing shortage of health care professionals, especially in rural communities, through targeted investments and innovative strategies to:

- Expand Oregon's skilled health care workforce, including non-physician providers and allied health professionals
- Create new training opportunities
- Build long-term capacity across rural areas of the state

Through a concerted approach, including recruitment and retention efforts, rural-, maternity-, and behavioral health-focused new residency programs and training, "Grow Your Own" workforce models, upskilling, and alternative staffing models, Oregon will be ready to meet the evolving health care needs of its rural and frontier communities.

In the immediate term, this initiative focuses on the current workforce by enhancing provider wellness and retention. This includes increasing access to peer support and technical assistance, as well as expanding tele-mentoring, e-consultation, mobile simulations units, and continuing education opportunities in areas such as nutrition and lifestyle medicine. These tools ensure rural providers have the ongoing training and support they need to deliver high-quality care. A provider "exchange" program will be explored, allowing rural providers to gain rapid on-the-job training and skills refreshing, while bringing specialists or other high-need providers to the rural areas to meet local needs. Special attention will be given to training and continuing medical education related to maternity care, behavioral health, nutrition, dementia care, and gerontology.

To strengthen recruitment, this initiative will also invest in strategies that attract providers to rural areas. Financial support will be offered to students and recent graduates pursuing health care careers in exchange for five years of service in rural communities, with a focus on high-need specialties such as maternity and behavioral health. Before receiving qualifying workforce benefits, all participants will be asked to sign a service commitment agreement that outlines the expected 5-year service period including anticipated start and end dates. The agreement will be administered by the respective subcontractor or subgrantee and provide clear information about what happens if a participant needs to end their service early or is unable to meet the full commitment. These efforts will be complemented by partnerships with local employers and the private sector to address common barriers to rural practice by providing supports such as community orientation, housing search assistance and stipends, career networking for spouses/partners, and childcare assistance. When paired with the Regional Partnerships & Systems Innovation Initiative, these strategies foster shared resources, professional camaraderie, and collaborative decision-making, making rural practice more sustainable and appealing.

Long-term success depends on building a strong pipeline of future providers. This initiative will support career pathway development beginning in high school, helping students in rural areas envision themselves in health care roles and understand how to get there. Strategic, place-based programs, otherwise known as “Grow Your Own” models, will help to build a sustainable pipeline of local talent by recruiting, training, and retaining community members. Fellowships and residencies with tracks in rural communities will provide early-career providers hands-on training and exposure, increasing the likelihood they will remain in those communities beyond their five-year commitment. Priority areas for these investments include family medicine, obstetrics, behavioral health, and oral health.

Together, these immediate, medium-, and long-term strategies will drive innovative transformation and sustainability in Oregon's rural health care workforce. By investing in a workforce capable of delivering both in-person and virtual care tailored to local needs, this initiative ensures that rural and frontier communities are not only equipped but also empowered to meet their evolving health care needs, now and into the future.

Uses of funds:

- Invest in development of rural track residencies/fellowships in high-demand specialties including but not limited to family medicine, surgery, obstetrics, psychiatry and dentistry.
- Expand workforce training activities. Allocate resources to rural provider training through activities such as virtual education for surgical care and mobile simulation units.
- Expand investment in tele-mentoring through Project ECHO, including continuing education offerings in nutrition and lifestyle medicine, as well as tele-mentoring and provider trainings in areas of critical need (e.g., obstetrical care, behavioral health, dementia, gerontology, and pharmacy dispensing, counseling, and adherence support).
- Establish new or expand provider-to-provider consultation lines to rural regions to provide clinical and prescribing guidance for complex patients, such as 1) obstetric patients in need of SUD treatment to prevent unnecessary transfer to higher level of care; 2) complex pediatric patients for children with special health care needs; or 3) child and adult psychiatric consultation (such as OPAL-K).
- Investment in rural K-12 health care workforce pathway programs through camps, career coaching, internships and job shadowing opportunities to expose and encourage students to pursue health careers in rural communities.

- Support expansion of EMS training, certification pathways, models that incentivize providers, and simulation exercises in rural communities to equip paramedics, EMT's and other first responders.
- Support short-term housing solutions for rural training rotations. Collaborate with partners and the private sector to provide career networking for spouses/partners, housing search assistance, flexible childcare options and other family-based programs to ensure providers can pursue professional and family goals without compromise.
- Invest in training, certification, and integration of non-physician health care providers, non-hospital-based providers, and allied health professionals, such as birth doulas and end-of-life doulas, and develop sustainable payment models for Traditional Health Workers (THWs) across the continuum of care and lifespan.[xl]
- Invest in workforce training programs for rural behavioral health providers, such as qualified professional counselors, marriage and family therapists, and clinical social workers, with supervision practicum opportunities in coordination with local health clinics, hospitals, higher education, technical/career education partners, and community organizations.

**Key Stakeholders:** See Appendix Table 4 for full list.

**Outcomes:**

1. Increase # of rural providers and partner organizations participating in workforce training programs
2. Increase # of rural providers recruited to deliver health care in rural areas through local partnerships and relocation and retention incentives by county
3. Increase health care career pathway programs in rural K-12 schools

4. Increased hiring, training, and use of non-physician, non-hospital, and allied health professionals

Oregon's Metrics and Evaluation Plan (page 49) provides additional details.

**Impacted counties:** This initiative will impact all counties in Oregon. See Appendix Table 5 for the list of FIPS codes.

**Estimated required funding: $30,000,000 - $45,000,000 / year**

### Technology & Data Modernization Initiative

**Main strategic goals:** Tech Innovation, Sustainable Access

**Uses of funds:** D, F, G, K

**Technical score factors:** C.1, F.1, F.2

**Description:** The Technology & Data Modernization Initiative will transform Oregon's rural health communities through investments for enhanced technological approaches and solutions to ensure digital access to and secure sharing of health information, reduced administrative complexity and burden, and better communication and coordination across providers, patients, and systems. Rural entities across the health care ecosystem including providers, hospitals, organizations serving the American Indian/Alaska Native (AI/AN) population, EMS agencies, behavioral health providers, and community-based organizations lack the resources to purchase, upgrade, or replace equipment and technology that is necessary to provide quality care to their patients and community. They also may not have robust health information technology (IT) staff with the expertise to support the selection, implementation, maintenance, and enhancement of technology solutions. This initiative focuses on support for providers and rural communities to invest thoughtfully in technologies that meet their needs and technical assistance to maximize the

value of technology investments. These investments will improve efficiency, have a long-term financial benefit to organizations, and improve patient outcomes.

This initiative emphasizes the use of innovative tech-enabled solutions to improve patient engagement, service delivery, care coordination, population health management, interoperability, and data sharing particularly in high-need areas such as:

- Perinatal and maternal health
- Mental health and SUD treatment
- Referral to social health services and other community-based organizations
- Primary care settings
- Emergency response

Projects prioritized for funding under this initiative aim to bridge data silos, support real-time decision-making, and ensure that rural providers have access to the tools and information needed to deliver high-quality, coordinated care. For patients, these projects will improve their access to their health information through easy-to-use digital tools and to quality care in their communities that promotes preventative health and addresses root causes of disease.

Uses of funds:

- Support the design, deployment, and/or enhancement of IT systems, software, data sharing, or data analytics infrastructure, such as:
    - Remote care infrastructure and technology supporting the provision of remote patient monitoring and telehealth services, such as tablets, audio visual equipment, and kiosks and associated clinical solutions.
    - AI-enabled tech solutions such as clinical AI scribes, clinical decision support tools, and analytics tools for population health management.

- Solutions to streamline admin processes like billing or practitioner credentialing.
- Community information exchange (CIE) and closed-loop referrals technology to streamline care coordination by sharing resources, making referrals, and ensuring the completion of the referral process that help with coordinating amongst stakeholders and/or population health management.
- Enhance cybersecurity capability (e.g., via managed security service provider).
- Tools and/or functionality to facilitate electronic lab ordering and reporting, and electronic case reporting.
- Procurement or modification to IT infrastructure or data platforms to support rural community data capacity, including ASTP/ONC certified electronic health records (EHRs), and connection to standards-based health information exchange in alignment with CMS's Health Technology Ecosystem criteria.

- Centralized strategic technical assistance and training for all phases of health IT technology implementation and operations for rural providers and organizations, including:
  - Supporting the selection, implementation, maintenance, and enhancement of technology solutions (e.g., effectively adopting new tech-enabled solutions).
  - Advancing and maintaining their technology infrastructure.
  - Legal and regulatory issues concerning the implementation of technology projects.
  - Data projects and building rural capacity to collect, analyze, and disseminate data, including technical assistance on procurement or modification of IT infrastructure
  - Rural health IT landscape needs assessments, including cybersecurity and availability of broadband internet service.

**Key Stakeholders:** See Appendix Table 4 for full list.

**Outcomes:**

1. Robust engagement with IT technical assistance
2. Increase health IT adoption and interoperability
3. Reduce administrative burden on providers
4. Improve organizational cybersecurity practices
5. Increased use of remote care services and remote patient monitoring to prevent and manage chronic disease and reduce hospital admittance

Oregon's Metrics and Evaluation Plan (page 49) provides additional details.

**Impacted counties:** This initiative will impact all counties in Oregon. See Appendix Table 5 for the list of FIPS codes.

**Estimated required funding: $7,400,000 - $ 35,000,000 / year**

### Tribal Initiative

**Main strategic goals:** Make Rural America Healthy Again, Workforce Development, Sustainable Access, and Tech Innovation

**Uses of funds:** A, B, C, D, E, F, G, H, J, K

**Technical score factors:** B.1, C.1, D.1, F.1, F.2, F.3

**Description:** The Tribal Initiative supports the Nine Federally Recognized Tribes of Oregon ("the Tribes") to implement and enhance projects that align with both the RHT Program requirements and each individual Tribe's priorities and goals. Some of these goals are also included in the Oregon Tribal Health Strategic Plan, which guides the Oregon Health Authority's (OHA) work with the Tribes. The vision for this initiative is that investments in the Tribes' health

care systems, infrastructure, and community-based projects will create long-lasting, sustainable and measurable impacts on the health of communities throughout rural Oregon.

OHA has engaged in formal Tribal Consultation with the Tribes regarding the RHT Program and their inclusion in Oregon's application. OHA also provided the draft Tribal Initiative narrative to the Tribes for review, and met with them to receive feedback, which has been integrated into Oregon's application. OHA's Office of Tribal Affairs will continue to lead and facilitate ongoing discussions with the Tribes to ensure that implementation of the Tribal Initiative is managed according to the government-to-government relationship with the Tribes and OHA's Tribal Consultation and Urban Indian Health Program Confer Policy.

This initiative honors self-determination, self-governance, and Tribal sovereignty of the Tribes and recognizes the critical role the Tribes play in transforming rural health care in Oregon. All nine of the Tribes' Service Delivery Areas include predominantly rural and/or remote (i.e. frontier) counties of Oregon, and all of the Tribes operate health centers within their service delivery areas. Work implemented under this initiative will be directed to these areas per the requirements of the RHT Program. This initiative follows both state and federal laws in honoring the government-to-government relationship with the Nine Federally Recognized Tribes. It acknowledges the Tribes are best positioned to understand the needs of their communities and to lead the transformation of rural health care for their own Tribal communities, as well as for the broader communities they serve.

Each individual Tribe determines its patient population. Therefore, those impacted by this initiative include enrolled Tribal members; other American Indian/Alaska Native people; often Tribal employees and their families; and the general population.

<u>Potential uses of funds could include:</u>

- Promoting chronic disease management:
    - Integration and support for the Diabetes Prevention Program (DPP) to be expanded to new rural and remote patient populations. DPP is evidence based and demonstrated effective at lowering the risk of diabetes.
- Paying health care providers:
    - Payments to health care providers serving rural and remote patient populations for providing non-reimbursable care aligned with Oregon's RHT Plan. Examples include cases where services related to care coordination, patient navigation, prevention classes, and screening events are not reimbursable.
- Promote consumer-facing tech for chronic disease management:
    - Invest in promotion of and access to apps and personal tech tools for managing diabetes, cardiovascular conditions, and other chronic diseases through remote and personal monitoring, fitness, and other strategies.
- Recruit and retain clinical workforce in rural/remote areas with 5-year service commitments (OHA will require participating Tribes to attest that they will ensure funds will only be used toward providers who state their willingness to remain committed to serving rural and remote communities for five years):
    - Start and/or expand a "Grow Your Own" workforce programs for Certified Nursing Assistants, CHWs, Peers, Tribal THWs and more.
    - Expanded implementation of the Community Health Aide Program (CHAP) to rural and remote areas by creating and supporting training programs for Dental Health Aides, Behavioral Health Aides, and Community Health Aides.

    - Implement relocation grants and short-term housing solutions for students, trainees, and providers in rural and remote areas.
    - Develop a provider rotation plan with the Northwest Native American Center of Excellence at Oregon Health and Sciences University to promote Tribal clinic recruitment.
    - Invest in expanded training programs for Tribal Certified Alcohol and Drug Counselor Cohort, Tribal Certified Prevention Specialist Cohort, and Traditional Health Care Practices serving rural and remote patient populations.
- Provide IT support to improve efficiency, cybersecurity, and patient outcomes:
    - Invest in electronic health record and telehealth upgrades including at rural and remote Tribal health clinics that rely on manual processes.
    - Implement a dedicated telehealth suite to provide remote behavioral health, chronic disease management, and maternal care services.
    - Upgrade clinic systems for secure data sharing with regional hospitals while maintaining Tribal data governance.
    - Invest in IT supports for a withdrawal management service expansion.
- Help rural communities right-size delivery systems:
    - Assess preventive, telehealth and other care needs among rural and remote patient populations to identify additional strategies for addressing needs.
- Expand access to opioid, substance use, and mental health treatment:
    - Implement a mobile Opioid Treatment program unit for rural and remote patients.
    - Expand existing Opioid Treatment Program facilities, inpatient residential treatment, detox, sober living facilities for behavioral health treatment and recovery.

- Invest in rural health care facility infrastructure:
    - Equipment purchases and minor alterations to existing Tribal facilities to expand available services and populations served, including:
        - Updating a small facility to provide counseling in a remote area of a reservation.
        - Facility upgrades to support additional exam rooms, prevention clinics, pharmacy, behavioral health services and Tribal elder care.
    - Purchase vehicle(s) and equipment to launch mobile health services in rural and remote Tribal service areas, including:
        - Mobile counseling unit and/or mobile primary care unit(s).
        - Starlink or wireless hotspot to allow for access to telehealth services from a mobile health unit.
- Foster and strengthen strategic partnerships between local and regional partners:
    - Strengthen regional partnerships to enhance access to primary care, behavioral health, and substance use disorder services for rural and remote patient populations.
- Train and assist rural hospitals in adopting technology-enabled solutions:
    - Providing technology technical assistance and expertise to support rural hospitals serving patients to develop targeted programs for specific health conditions that would use consumer-facing technology.

**Key Partners:** The entities that will carry out this initiative are the Nine Federally Recognized Tribes of Oregon:

- Burns Paiute Tribe
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of Grand Ronde

- Confederated Tribes of Siletz Indians
- Confederated Tribes of the Umatilla Indian Reservation
- Confederated Tribes of Warm Springs
- Coquille Indian Tribe
- Cow Creek Band of Umpqua Tribe of Indians
- Klamath Tribes

The Tribes will collectively determine, through established government-to-government processes, which of the Tribes will participate as subgrantees under the Rural Health Transformation Program. The Tribes may choose to include the Native American Rehabilitation Association of the Northwest (NARA NW) in implementing this initiative.

**Outcomes:**

Oregon is providing the following options for potential outcomes which will be finalized by the point of award through further consultation with the Tribes. This will include finalization of associated metrics and milestones for each outcome/metric. The Tribes may collectively choose from or modify outcomes (and associated metrics) included in this list. This approach honors the Tribes' right to self-determination and self-governance and provides time for OHA's standard Tribal consultation processes around this type of decision that was not allowed for by the short application timeline.

<u>Potential Outcomes List</u>:

1. Increase in healthcare providers recruited to Tribal clinics or access points serving rural and remote service delivery areas.
2. Increase in health care programs serving rural and remote patient populations.
3. Increase in number of primary care visits at rural and remote Tribal clinics/access points.

4. Increase in rate of individuals screened for behavioral health needs at rural and remote Tribal clinics or other access points.
5. Decreased rates of diabetes/hypertension in rural and remote patient populations.
6. Increase in telehealth encounters for rural and remote patient populations.
7. Increase in number of EHR systems that meet the needs of the rural remote patient populations
8. Increase in members of rural and remote patient population participating in chronic disease programs.
9. Increase in provider training sessions held to enhance skillset and services to rural and remote patient populations.
10. Increase in new partnerships established by Tribes to deliver behavioral health services to their rural and remote patient populations.
11. Reduction in social health needs among rural and remote patient populations.
12. Reduction of emergency room referrals from clinics and other access points serving rural and remote patient populations.
13. Increase in number of patients in rural and remote patient populations with access to opioid use disorder treatment.

**Impacted counties:**

This initiative will be carried out by Nine Federally Recognized Tribes of Oregon within their Service Delivery Areas. These service delivery areas adhere to county boundaries, and together represent the following 23 Oregon counties: Benton, Clackamas, Coos, Curry, Deschutes, Douglas, Harney, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Marion,

Multnomah, Polk, Tillamook, Umatilla, Union, Wasco, Washington, and Yamhill. See Appendix Table 5 for the list of FIPS codes.

**Estimated required funding: $20,000,000 / year or 10% of funding**

This honors a formal set-aside request made collectively by the Nine Federally Recognized Tribes of Oregon, as supported by OHA's Tribal Consultation and Urban Indian Confer Policy, following state and federal laws that honor the government-to-government relationship with the Federally Recognized Tribes.

### Implementation Plan and Timeline:

Oregon's RHT Program consists of many different components in different stages of implementation. The Oregon RHT Program Work Plan, available in the Supporting Documents, describes the stages and timing of key operational milestones in detail.

Timeline: Oregon's program will be a two-phase approach to maximize both short- and long-term success.

**PHASE 1 (FY26 – FY27)**: The initial phase of Oregon's Rural Health Transformation Plan focuses on three pathways for fund distribution:

1. Catalyst awards: To ensure that investments and initiatives are community-directed and address local needs, this funding method creates a structured framework that drives the state forward to achieve its goals while offering a specific menu of possible options to potential applicants. All applicants will be expected to apply across initiatives for ready-to-go projects that can be implemented within the first two years of the RHT Program, maximizing impact of the first budget period and ensuring subgrantees have through the following fiscal year to spend awarded funding. Targeted technical assistance will be provided to organizations, including those serving the AI/AN population, to support the development of complete,

aligned, and competitive applications the Catalyst Award. In Phase 1, applicants for Catalyst Awards would be asked to list up to two potential initiative-based projects or activities that are ready-to-go and meet the goals of the program. To further narrow the focus to achieve our goals, the initiatives must serve at least one population of focus: 1) maternal and child health, 2) co-occurring BH conditions (mental health and substance use disorder), 3) individuals aging in place, and 4) chronic disease. These populations experience the greatest challenges related to access and health and wellness outcomes in rural Oregon. (See Budget Narrative and Supporting Document: Work Plan for more info.)

2. Immediate Impact: Simultaneously, the state has identified a select set of aligned opportunities, across the initiatives, that ensure funds go out rapidly for immediate impact. Examples include team-based care PMPMs, funding of new residency programs, and establishing new sites for expansion of successful care delivery models.
3. Regional Sustainability: The state will award a subcontractor(s) to provide facilitation and technical assistance to drive towards regional solutions, including advanced Clinically Integrated Networks, in preparation for Phase 2 funding. In parallel, the state will provide strategic investments to independent rural hospitals and CAHs to stabilize essential services and build readiness for Phase 2 regional models focused on resource optimization and sustainability.

INITIATIVE ACTIVITY + POPULATION OF FOCUS = CATALYST AWARD

**PHASE 2 (FY28 – FY30):** Distribution of funds in Oregon's second phase will mirror the initial phase but will incentivize true transformation with increased expectations related to regional alignment and sustainability.

1. Competitive Catalyst awards*:* Funds will be distributed through a competitive Request for Grant Proposals process that incentivizes organizations to apply collectively (e.g., as a consortium, as part of a formal agreement, a CIN) or demonstrate significant alignment with regional priorities and needs. Those awarded must demonstrate how the funds will enable further transformation and sustainability of health care in the region.
2. Sustained awards: Some Phase 1 projects across all the initiatives that had demonstrated significant success and valuable impact but requires additional years of investment to ensure completion (e.g., investment in new residency programs and state-sponsored Technical Assistance) will continue to be funded.

As part of this work, the program will onboard subcontractors to assist entities with planning and applying for the Phase 2 Request for Proposals (RFPs). Criteria for subcontractors and subgrantees include:

- Experience with rural health community organizations
- Ability to assess organizational capacity to implement the requested tool
- Proven ability to scale up to meet need of project
- Experience with health IT
- TA experience specific to health information technology implementation and strategy (e.g., EHR, HIE, CIE, health information sharing, population health tools, telehealth)
- Experience with facilitation (e.g. community of practice)
- Experience with federal funding mechanisms and compliance with federal requirements
- Demonstrated capacity and intent to execute on a sustainability plan

Oregon will select and fund entities' Phase 2 projects in accordance with the vision outlined in this RHT Program application. We will prioritize scalable projects that create new or accelerate

existing partnerships, reduce overhead, minimize patient travel costs, ensure and expand access to care, and deploy new technologies that align with the vision of CMS's Health Technology Ecosystem initiative. Technical assistance will be provided to ensure the projects succeed and that technologies are appropriate, scalable, and aligned with rural workflows.

Legislative or regulatory action related to committed policy actions will be pursued for completion by the required enactment date (i.e., December 31, 2027, for all but two State policy actions, B.2 and B.4, which have a deadline of December 31, 2028). Please see Supporting Document: Work Plan and Legislative or Regulatory Action (page 14) for more detail.

Governance and Project Management Structure:

The Oregon Health Authority (OHA) will be the lead agency. The statutorily required Rural Health Coordinating Council, which advises the Oregon Office of Rural Health, will serve as the RHT Program advisory group for the state. The new Oregon RHT Program will possess the skills and resources to effectively manage all components of the program. Key personnel will include a Program Director, a Project Manager, grant and contract analysts, operational staff, data analysts, budget analysts, and a communications specialist. The communications specialist will lead efforts to inform the wider community about upcoming funding opportunities, share progress made with media outlets and Legislators, and coordinate with other government offices such as the Oregon Department of Human Services. For a complete list of key personnel and function, see the Budget Narrative.

In order to fully leverage the RHT Program opportunity, the state will both hire new staff and engage external partners to manage components of the program. State staff will ensure all contracting and requests for applications and proposals comply with state procurement requirements. External partners will assist in administering smaller awards to applicants.

External entities will also provide the technical assistance as outlined in other sections of the Project Narrative. State staff will solicit applications from vendors and choose only those who are qualified and experienced in the subject matter.

### Stakeholder Engagement

Rural Oregon partners are eager to engage with this work, by bringing innovative solutions and a commitment to the improvement of their communities. OHA has an ever-growing list of over 100+ statewide partners that we have met with, collaborated, communicated, or intend to work with throughout the entirety of the RHT Program. Please see Supporting Documentation: List of Stakeholders and Engagement Steps for more details.

OHA will manage stakeholder engagement in three ways:

1. Formal agreements with state-wide trusted organizations, such as the state Office of Rural Health, which will provide pathways for ongoing process improvement.
2. Public discussion, review and insight from Oregon's Rural Health Coordinating Council.
3. Direct statewide publications and communications, including surveys, public presentations, and other strategies for soliciting ongoing feedback, input and engagement.

In particular, Oregon will utilize existing pathways for communication and engagement, including websites and meeting forums such as the Oregon Health Policy Board, which is the policymaking and oversight board of the OHA.

Pre-award public comment has occurred from August 2025 – October 2025. This step has involved multiple virtual public forums, meetings with healthcare associations, entities, and rural health experts, robust survey collection, and a presentation at Oregon's Rural Health Conference. Between both public forums and the conference, OHA had over 600+ individuals hear about and

provide feedback on OHA's intended initiatives. From that feedback, OHA has modified the initiatives and Transformation Plan to more directly impact on ready-to-go projects.

Continuous stakeholder engagement will occur during all five years of the program. During this time, OHA will support and act as a conduit for stakeholder engagement in two ways:

1. Continuous Information Sharing – OHA will connect committees/boards/councils, Tribal communities, and program subgrantees/subcontractors. Information will flow from each of these groups to OHA, who will compile and report out on a quarterly basis. This will be through OHA's website, in-Person/Virtual meetings, and quarterly newsletters. All parties will remain up-to-date on subaward process, any major shifts in health, and allow OHA to respond to the most important needs.
2. Rural Health Advisory – OHA will support the continued work of the Rural Health Coordinating Council (RHCC). This group consists of healthcare providers, rural Oregonians, and rural healthcare leaders. They will act as both OHA's accountability board for appropriate use of RHT Program funds and advise on any gaps for rural and frontier communities. The Oregon statute (ORS 442.495) specifies that a number of organizations will be represented on the RHCC. These include: Oregon Medical Association, Oregon Osteopathic Association, Oregon Nurse Association, State Board of Pharmacy, Oregon State EMT Association, Coalition of Local Health Officials, Oregon Association for Home Care, Oregon Health & Science University, Hospital Association of Oregon, Oregon Dental Association, Oregon Association of Optometry, Oregon Association of Physician Associates, and Oregon Association of Naturopathic Physicians.

Nine Federally Recognized Tribes of Oregon:

OHA has engaged in formal Tribal Consultation with the Nine Federally Recognized Tribes of Oregon regarding the Rural Health Transformation Program and the Tribes inclusion in Oregon's application. OHA's Office of Tribal Affairs will continue to lead and facilitate ongoing discussions with the Tribes to ensure that implementation of the Tribal Initiative is managed according to the government-to-government relationship with the Tribes and OHA's Tribal Consultation and Urban Indian Health Program Confer Policy.

The OHA Office of Tribal Affairs maintains regular communication with the Tribes, including monthly meetings with the Tribal Health Directors and staff. OHA will use these existing forums, formal consultation, and other venues as needed, to communicate with the Tribes regarding RHT Program implementation and ensuring progress on the Tribal Initiative.

Stakeholder Letters of Support:

- Please see Additional Attachments for the Governor's Endorsement
- Please see Supporting Documentation: Letters of Support for letters from the Oregon Office of Rural Health, the Oregon Primary Care Association, the Oregon Perinatal Collaborative, and the Hospital Association of Oregon.

Engagement Framework:

OHA will act as a nexus and collect feedback and share out with all major partners and stakeholders. OHA will hold quarterly public forums that coincide with the monthly Rural Health Coordinating Council (RHCC) meetings. The RHCC will have frequent communication and information regarding all RHT developments. OHA will also collaborate and inform with multiple OHA Boards and Committees, State Legislature, Governor's Office, Tribes, and all Oregonians through monthly and quarterly communications, such as electronic newsletters, website updates, and public forums.

***Collect → Assess → Communicate*** – OHA will collect continuous feedback on the progress of the program via email, forums, meetings, and surveys. The agency will then assess the feedback, ensuring any gaps in care are noted and addressed. Finally, the agency will have frequent modalities to communicate progress, milestones and metrics. Through the communications, OHA will be able to continue collecting feedback, questions and information and ensure the cycle of engagement remains. With some rural and frontier counties having over 50% of their population enrolled on Medicaid, OHA will continually work with the Medicaid Advisory Committee, the Beneficiary Advisory Committee and the OHP Bridge Advisory Committee. These three committees represent multiple patient perspectives. Furthermore, OHA will provide quarterly updates to Hospital Association of Oregon, it's Medicaid Provider Connects newsletters, and establish continuing communication and information sharing through the public website and virtual public forums.


Table A: Specific Stakeholder Engagement:

| Stakeholder Group | RHT Program Communication & Engagement Approach |
|---|---|
| State health agency or department of health | OHA Director and Leadership will receive weekly updates via reports, meetings, and internal newsletters. |
| State Medicaid agency | Medicaid Director will be informed through OHA leadership updates, meetings, and internal newsletters. |
| State Office of Rural Health | Will oversee and lead the advisory committee; closely involved in all program work. |
| State tribal affairs office or tribal liaison | OHA's Office of Tribal Affairs and Tribal Affairs Director will receive weekly meetings, reports, or written updates. |

| Stakeholder Group | RHT Program Communication & Engagement Approach |
|---|---|
| Indian health care providers | Communication through existing forums, formal consultation, and other venues to support program implementation and Tribal Initiative. |

## Metrics and Evaluation Plan

Oregon's RHT Program Performance Metrics and Outcomes Plan

For each initiative, there are at least four specific metrics and outcomes designed to track progress in a meaningful manner. These metrics are selected based on their relevance to the initiative's long-term outcomes, as well as on the feasibility of timely data collection and analysis. As specified in Table B, at least one metric for each initiative will be measured at the county level, or similar community level of granularity. For claims-based and state-specific metrics, existing databases and infrastructure will be leveraged, supplemented with additional reporting mechanisms to ensure comprehensive tracking. For participant-reported metrics, we will work with subgrantees and subcontractors to maintain a secure tracking system with appropriate data fields and require subgrantees to submit regular data to support monitoring and evaluation efforts.

In addition to initiative-level metrics and outcomes, we have established a global target to achieve stronger engagement with primary care in rural areas. This target not only aligns with CMS's five strategic goals but also with the specific aims of each initiative. The global target is intended to anchor the initiatives in Oregon's RHT vision – that people and communities in rural Oregon can achieve optimum physical, mental, and social well-being at every life stage. These initiatives are far more impactful when braided together, tackling rural health care challenges from multiple angles to ensure both short term success and long-term sustainability. As such, it is important to identify a shared outcome that formally unifies our efforts and reinforces accountability across the whole program.

Table B: Initiative Outcomes, Metrics, and Milestones

| **Initiative: Regional Partnerships & Systems Transformation** |
|---|
| **Outcome 1:** Reduce operating costs for rural health organizations through shared infrastructure according to regional/local needs<br>**Metric**: Operating margins for CAHs<br>**Data Source and Timing**: State-specific, Oregon Hospital Financial and Utilization Data, quarterly |
| **Targets:**<br>Yr 1: By September 30, 2026, staff will have identified interested partners and defined the regions for regional planning discussions to explore the types of shared infrastructure that will have the most transformative impact for their communities.<br>Yr 2: By September 30, 2027, program staff will launch technical assistance project, which will provide rural health care entities with tools to target how best to share infrastructure.<br>Yr 3: By September 30, 2028, at least two partnerships will launch and begin sharing infrastructure, services, technology, or other resource as identified in the planning efforts.<br>Yr 4: By September 30, 2029, at least three additional partnerships will launch and begin sharing infrastructure, services, technology, or other resource as identified in the planning efforts.<br>Yr 5: By September 30, 2030, at least two additional partnerships will launch and begin sharing infrastructure, services, technology, or other resource as identified in the planning efforts. |
| **Outcome 2:** Increase access to high-need or at-risk service lines, such as maternity care<br>**Metric**: # of patients receiving care from shared resources for at-risk service<br>**Data Source and Timing**: State-specific, participant-reported, annual |
| **Targets**:<br>Yr 1: By September 30, 2026, program staff will allocate a specific dollar amount for strategic investments and will possess a rubric by which funds will be awarded.<br>Yr 2: By September 30, 2027, a full 12 months of strategic investments will conclude, and staff will re-assess the allocated dollar amount and rubric to ensure funds are optimally targeting the desired outcomes.<br>Yr 3: By September 30, 2028, and after two years of strategic investments, program staff will launch additional technical assistance focusing on sustainability and maintaining or expanding services.<br>Yr 4: By September 30, 2029, entities will finalize and begin implementing their sustainability plans.<br>Yr 5: By September 30, 2030, at least two entities in different regions will expand access to what was previously considered an at-risk service. |
| **Outcome 3:** Increase regional planning efforts focused on shared governance models, including CINs and consortiums<br>**Metric**: # of organizations participating in regional partnerships<br>**Data Source and Timing**: State-specific, participant-reported, annual |
| **Targets**:<br>Yr 1: By September 30, 2026, staff will have identified and engaged at least 50 entities.<br>Yr 2: By September 30, 2027, the program will have at least four partnerships identified with either memorandums of agreements or terms sheets outlining commitments of the partners involved.<br>Yr 3: By September 30, 2028, at least three potential partnerships will be identified, and planning will begin.<br>Yr 4: By September 30, 2029, at least three more potential partnerships will be identified, and planning will begin.<br>Yr 5: By September 30, 2030, at least seven shared governance models, including CINs and consortiums, are active and have realized economies of scale or increased profitability. |
| **Outcome 4:** Increase participation in value-based care models<br>**Metric**: # of organizations participating in value-based care models<br>**Data Source and Timing**: State-specific, participant-reported, annual |
| **Targets**:<br>Yr 1: By September 30, 2026, survey will be administered to partners to assess interest in participating in a VBP.<br>Yr 2: By September 30, 2027, interested parties will establish a cross-sector, cross-regional learning collaborative, to which VBP-specific technical assistance is provided.<br>Yr 3: By September 30, 2028, at least five entities will begin discussions with commercial, CCOs, or other payers about launching a new or expanding an existing VBP.<br>Yr 4: By September 30, 2029, at least five more entities will begin discussions with commercial, CCOs, or other payers about launching a new or expanding an existing VBP<br>Yr 5: By September 30, 2030, at least ten entities will be operating under a new or expanded VBP. |

| **Initiative: Healthy Communities & Prevention** |
|---|
| **Outcome 1:** Universal access to home visiting services<br>**Metric**: # of families receiving home visits<br>**Data Source and Timing**: County-specific, Oregon Family Care Connects data, annual |
| **Targets:**<br>Yr 1: By September 30, 2026, launch new home visiting programs in 5 rural counties; integrate CHW outreach and care coordination models into 10 rural clinics.<br>Yr 2: By September 30, 2027, launch new home visiting programs in 4 rural counties; integrate CHW outreach and care coordination models into 25 new rural clinics.<br>Yr 3: By September 30, 2028, launch new or expand home visiting programs in 4 counties; integrate CHW outreach and care coordination models into 25 new rural clinics; evaluate program impact, test sustainable funding models.<br>Yr 4: By September 30, 2029, launch new or expand existing home visiting programs in 4 counties; integrate CHW outreach and care coordination models into 20 new rural clinics; evaluate program impact, implement sustainable funding models.<br>Yr 5: By September 30, 2030, ensure there is access to home visiting programs in every Oregon county; integrate CHW outreach and care coordination models in 20 new rural clinics for total of 100 clinics; evaluate program impact, implement sustainable funding models. |
| **Outcome 2:** Increase availability of mental health and substance use disorder treatment<br>**Metric**: Follow up after ED visit for MH & SUD (7-day and 30-day rates)<br>**Data Source and Timing**: State-specific, Oregon Medicaid data for CMS Core (NCQA), annual |
| **Targets:**<br>Yr 1: By September 30, 2026, integrate SUD and MH standardized screening tool(s) and early intervention protocol into at least 3 schools; increase access to community naloxone in at least 5 rural counties; identify 2-3 EMS providers to pilot overdose reversal and buprenorphine initiation in the field for 2027 and 2028 implementation; identify strategic investments for improving access to integrated care for dually eligible individuals and/or child and youth with complex needs.<br>Yr 2: By September 30, 2027, integrate SUD and MH standardized screening tool(s) and early intervention protocol into at least 3 additional schools; assess feasibility for telehealth-based ambulatory detox and identify at least 3 sites for FY2028; increase access to community naloxone in at least 10 additional rural counties.<br>Yr 3: By September 30, 2028, integrate SUD and MH standardized screening tool(s) and early intervention protocol into at least 3 additional schools; implement at least 3 telehealth-based ambulatory detox programs; increased availability of remote medication assisted treatment in 3 counties and ensure connection to local emergency departments; 1-2 EMS providers are piloting initiation of buprenorphine in the field post overdose reversal; invest in innovative integrated care models for dually eligible individuals and/or children and youth with complex needs in at least 3 rural communities.<br>Yr 4: By September 30, 2029, implement at least 3 additional telehealth-based ambulatory detox programs; increased availability of remote medication assisted treatment in 5 additional counties.<br>Yr 5: By September 30, 2030, finalize expanded partnerships and sustainable funding mechanisms for expanded services. |
| **Outcome 3:** Increase patient engagement with new preventative health and/or self-management programs<br>**Metric**: # of new preventative health or self-management programs in rural Oregon<br>**Data Source and Timing**: State-specific, participant-reported, annual |
| **Targets:**<br>Yr 1: By September 30, 2026, conduct at least 3 chronic disease management trainings for CHWs; launch at least one caregiver training through an online self-management platform; launch Brain Health Promotion initiative.<br>Yr 2: By September 30, 2027, conduct at least 3 additional chronic disease management trainings for CHWs; Partner with at least 5 CBOs or clinics to provide patient facing technology enabled programs to their eligible patients/participants; Launch Dementia Care Navigation initiative and/or nutrition and lifestyle medicine programs in at least 4 rural community settings.<br>Yr 3: By September 30, 2028, Partner with at least 5 additional CBOs or clinics to provide patient facing technology enabled programs to their eligible patients/participants; Launch Dementia Care Navigation initiative and/or nutrition and lifestyle medicine programs in at least 5 additional rural community settings. |

| **Initiative: Healthy Communities & Prevention** |
|---|
| Yr 4: By September 30, 2029, Partner with at least 5 additional CBOs or clinics to provide patient facing technology enabled programs to their eligible patients/participants; Launch Dementia Care Navigation initiative and/or nutrition and lifestyle medicine programs in at least 5 additional rural community settings.<br>Yr 5: By September 30, 2030, Partnerships established with a total of 20 CBOs or clinics to provide patient facing technology programs to their eligible patients/participants; New care navigation and/or nutrition and lifestyle medicine programs are operating in at least 20 rural community settings. |
| **Outcome 4:** Increase rural populations served by new health care and social health services (i.e., health services)<br>**Metric**: # of new access points to care<br>**Data Source and Timing**: State-specific, participant-reported, annual |
| **Targets**:<br>Yr 1: By September 30, 2026, increase access to health services in school settings in 3 school districts; identify at least 3 clinics that can participate in a mobile care clinic expansion initiative (including oral, perinatal, and/or optometry services); direct 15 awards to regional health coalitions in rural and frontier counties for social health service projects, including emergency food services and transportation supports.<br>Yr 2: By September 30, 2027, increase access to health services in school settings in 4 school districts; provide school health service planning and assessment support to at least 3 school districts; support at least 5 critical access pharmacies to launch expanded services through lockers, tele-pharmacy, and other technologies; launch mobile clinic expansion initiative, including implementation of at least 3 new mobile clinics.<br>Yr 3: By September 30, 2028, fund at least one initiative that expands access to care; identified by regional partner convenings, in each region; increase access to health services in school settings in at least 3 school districts; support at least 10 additional critical access pharmacies to launch expanded services through lockers, tele-pharmacy, and other technologies; provide ongoing TA and support for at least 5 mobile clinics.<br>Yr 4: By September 30, 2029; assess funded programs and initiatives for effectiveness and potential improvement; provide ongoing TA and support for at least 5 mobile clinics; confirm sustainability plans for all currently funded initiatives.<br>Yr 5: By September 30, 2030, finalize expanded partnerships and funding mechanisms for new health services. |
| **Outcome 5:** Expanded access to health care services, including chronic disease management, through increased availability of telehealth<br>**Metric**: Increased proportion of telehealth encounters<br>**Data Source and Timing**: County-specific, Claims and encounter data, annual |
| **Target:**<br>Yr 1: By September 30, 2026, update telehealth billing guidance and documentation templates; explore expansion of additional telehealth service lines for new specialty care types that have limited rural provider networks.<br>Yr 2: By September 30, 2027, launch telehealth training for navigators and existing CHWs to be able to support patients with limited digital literacy; launch TA and quality improvement learning collaboratives for rural providers who are initiating or expanding telehealth services; 4 assessments of internet availability and strength within communities (outside of hospitals and schools) are conducted and locations with weak and strong internet access are mapped; tele-pharmacy guidelines and regulations mapped and necessary updates determined.<br>Yr 3: By September 30, 2028, rural providers and organizations have agreements in place with telehealth service providers for provision of critical services such as teletherapy and medication assisted treatment; education on telehealth is developed and provided to patients; tele-pharmacy agreements in place.<br>Yr 4: By September 30, 2029, appropriate locations for telehealth access points withing communities are selected and implementation started; necessary additional agreements to provide rural telehealth services at telehealth access points, including physical, behavioral, and oral health, are negotiated with vendors; expanded tele-pharmacy provision implemented.<br>Yr 5: By September 30, 2030, location for telehealth access points within communities are implemented; 10% increase in telehealth visits. |

| **Initiative: Workforce Capacity & Resilience** |
|---|
| **Outcome 1:** Increase # of rural providers/partner organizations participating in workforce training programs<br>**Metric**: # of provider trainings held<br>**Data Source and Timing**: State-specific, participant-reported, annual |
| **Targets**: |

| **Initiative: Workforce Capacity & Resilience** |
|---|
| Yr 1: By September 30, 2026, conduct 15 simulation trainings for at least two specialties; launch one new project ECHO or comparable education programs designed for rural providers; establish one additional peer-to-peer e-consultation line for rural providers.<br>Yr 2: By September 30, 2027, conduct 20 simulation trainings for at least two specialties; launch three new project ECHO or comparable education program for rural providers; expand hours of access to peer-to-peer e-consultation line for rural providers and promote consult line to increase access and availability of resource.<br>Yr 3: By September 30, 2028, maintain at least 20 simulation trainings across two specialties; add additional consultation capacity and incorporate more regional expertise.<br>Yr 4: By September 30, 2029, maintain at least 20 simulation trainings across two specialties; begin transitioning to non RHT Program funding for sustainability of provider consultation service.<br>Yr 5: By September 30, 2030, secure sustainable funding to maintain and expand workforce training programs as needed by communities. |
| **Outcome 2:** Increase # of providers recruited to deliver health care in rural areas through local partnerships and relocation and retention incentives<br>**Metric**: Provider-to-population ratio (direct patient care FTE per 100,000 population) in rural areas.<br>**Data Source and Timing**: County-specific, Oregon Health Care Workforce Reporting Program data, annual |
| **Targets**:<br>Yr 1: By September 30, 2026, at least three partners identified to implement rural provider incentive programs; identify sponsoring institution for new family medicine residency.<br>Yr 2: By September 30, 2027, identified partners distribute provider incentive programs and recruit more providers; continue residency program development and apply for accreditation.<br>Yr 3: By September 30, 2028, identify at least three additional partners to implement second round of provider incentive programs; add core faculty for residency program to aid in recruitment and selection of participants.<br>Yr 4: By September 30, 2029, identify three additional partners to distribute provider incentive programs to recruit rural providers; first class of residents begin.<br>Yr 5: By September 30, 2030, secure sustainable funding to continue workforce training programs as identified by community needs; second class of residents begin. |
| **Outcome 3:** Increase health care career pathway programs in rural K-12 schools<br>**Metric**: # of K-12 health career pathway programs launched<br>**Data Source and Timing**: State-specific, participant-reported, annual |
| **Targets**:<br>Yr 1: By September 30, 2026, establish partnerships between K-12 schools, higher education institutions and health care settings such as hospital or clinics; develop project plan and implementation strategy; identify 1 initial sites for health care career exploration programs.<br>Yr 2: By September 30, 2027, develop one initial K-12 health care career pathway programs in rural community; identify 1 additional site for program expansion.<br>Yr 3: By September 30, 2028, open one additional K-12 health care career pathway programs in rural communities; assess initial program for effectiveness and potential improvement; identify one additional site for program expansion and begin identifying long-term sustainable funding through partnerships.<br>Yr 4: By September 30, 2029, have a total of at least three K-12 health care career pathway programs with plans to scale the program for additional sites as communities need; secure sustainable funding for program continuation and expansion.<br>Yr 5: By September 30, 2030, have at least three sustainable K-12 health care career pathway programs in rural communities. |
| **Outcome 4:** Increased hiring, training, and use of non-physician, non-hospital, and allied health professionals<br>**Metric**: # of non-physician, non-hospital and allied health professionals recruited to rural areas<br>**Data Source and Timing**: State-specific, participant-reported, annual |
| **Targets**:<br>Yr 1: By September 30, 2026, identify at least 2 partners to coordinate training for non-physician, non-hospital and allied health profession in rural areas such as dental hygienists, pharmacy technicians, and traditional health workers such as peer support specialists.<br>Yr 2: By September 30, 2027, identify at least 2 additional partners to coordinate and administer training for non-physician, non-hospital and allied health professionals in rural areas. |

| **Initiative: Workforce Capacity & Resilience** |
|---|
| Yr 3: By September 30, 2028, expand partnerships to integrate and provide continuing education of non-physician, non-hospital and allied health professionals in FQHC's, RHC's and other primary care initiatives.<br>Yr 4: By September 30, 2029, continued expansion of partnerships to integrate and provide continuing education; assess success of initial training programs for effectiveness and potential improvement.<br>Yr 5: By September 30, 2030, have sustainable funding for additional trainings and partnerships for long-term workforce retention of non-physician, non-hospital and allied health professionals in rural communities. |

| **Initiative: Technology & Data Modernization** |
|---|
| **Outcome 1:** Robust engagement in IT technical assistance<br>**Metric**: % organizations requesting health IT technical assistance that complete health IT and cybersecurity self-assessment<br>**Data Source and Timing**: State-specific, participant-reported, annual |
| **Targets**:<br>Yr 1: By September 30, 2026, guidelines and procedure developed for TA deployment and self-assessment support.<br>Yr 2: By September 30, 2027, 30% of organizations requesting health IT technical assistance that complete health IT and cybersecurity self-assessment.<br>Yr 3: By September 30, 2028, 40% of organizations requesting health IT technical assistance that complete health IT and cybersecurity self-assessment.<br>Yr 4: By September 30, 2029, 60% of organizations requesting health IT technical assistance that complete health IT and cybersecurity self-assessment.<br>Yr 5: By September 30, 2030, 75% of organizations requesting health IT technical assistance that complete health IT and cybersecurity self-assessment. |
| **Outcome 2:** Increase health IT adoption and interoperability<br>**Metric**: # of tools/capabilities adopted by awardees<br>**Data Source and Timing**: County-specific, participant-reported, annual<br>**Note**: Tools/capabilities are counted at the organization level |
| **Targets**:<br>Yr 1: By September 30, 2026, guidelines developed for tool selection.<br>Yr 2: By September 30, 2027, 5 tools and capabilities adopted.<br>Yr 3: By September 30, 2028, 20 additional tools and capabilities adopted.<br>Yr 4: By September 30, 2029, 25 additional tools and capabilities adopted.<br>Yr 5: By September 30, 2030, 70 total tools and capabilities adopted. |
| **Outcome 3:** Reduce administrative burden on providers<br>**Metric**: % of organizations adopting a new health IT tool/capability that self<br>**Data Source and Timing**: State-specific, participant-reported, annual |
| **Targets**:<br>Yr 1: By September 30, 2026, develop assessment for self-report and begin baseline data gathering.<br>Yr 2: By September 30, 2027, continue baseline data gathering, develop follow-up data gathering protocol.<br>Yr 3: By September 30, 2028, 15% of organizations adopt a new health IT tool/capability that self-report administrative burden reduction.<br>Yr 4: By September 30, 2029, 30% of organizations adopt a new health IT tool/capability that self-report administrative burden reduction.<br>Yr 5: By September 30, 2030, 40% of organizations adopt a new health IT tool/capability that self-report administrative burden reduction. |
| **Outcome 4:** Improve organizational cybersecurity practices<br>**Metric**: % of organizations completing a cybersecurity self-assessment implementing measures to improve cybersecurity<br>**Data Source and Timing**: State-specific, participant-reported, annual |
| **Targets**:<br>Yr 1: By September 30, 2026, develop cybersecurity educational materials, including expectations for cybersecurity performance goals. |

| **Initiative: Technology & Data Modernization** |
|---|
| Yr 2: By September 30, 2027, distribute cybersecurity educational materials and provide TA to support implementation.<br>Yr 3: By September 30, 2028, 10% of organizations completing a cybersecurity self-assessment implementing measures to improve cybersecurity.<br>Yr 4: By September 30, 2029, 20% of organizations completing a cybersecurity self-assessment implementing measures to improve cybersecurity.<br>Yr 5: By September 30, 2030, 40% of organizations completing a cybersecurity self-assessment implementing measures to improve cybersecurity. |
| **Outcome 5:** Increased use of remote care services and remote patient monitoring to prevent and manage chronic disease and reduce hospital admittance<br>**Metric**: % increase in providers using remote patient monitoring<br>**Data Source and Timing**: State-specific, claims data, annual |
| **Targets**:<br>Yr 1: By September 30, 2026, assess current utilization of remote patient monitoring.<br>Yr 2: By September 30, 2027, provide technical assistance for providers on the use of remote patient monitoring.<br>Yr 3: By September 30, 2028, 20% increase in providers using remote patient monitoring.<br>Yr 4: By September 30, 2029, 30% increase in providers using remote patient monitoring.<br>Yr 5: By September 30, 2030, 40% increase in providers using remote patient monitoring. |

For the Tribal Initiative, Oregon has a list of options for potential metrics that will be finalized prior to Notice of Award through further consultation with the Tribes. This will include finalization of proposed annual milestones and confirmation of data sources/systems for each selected metric as well as baseline data when available. The Tribes may collectively choose from or modify metrics included in this list, which align with the potential outcomes identified in the Tribal Initiative. This approach honors the Tribes' right to self-determination and self-governance and provides time for OHA's standard Tribal consultation processes.

Evaluation Plan

To ensure the integrity, effectiveness, and accountability of our RHT Program, we are committed to a sound and collaborative evaluation strategy that ensures the success of all five initiatives. This includes leveraging evaluation experts at OHA and coordinating with trusted partners that have proven track records of supporting the state in previous program implementation and evaluations.

Our phased approach is intentionally designed to support early, active monitoring while identifying preliminary successes and opportunities to support continuous improvement. We will

work closely with partners to develop a rigorous and tailored evaluation plan for each initiative focused on measuring the impact of initiative activities based on all identified milestones and metrics. Robust reporting will be required of subgrantees and subcontractors to collect and analyze data that ensures fidelity in program activities. Phase 2 would build on Phase 1 by implementing the evaluation plan and by continuing to assess progress not only with the program's milestones but towards its intended long-term outcomes.

We affirm our full cooperation with any CMS-led evaluation or monitoring activities. We recognize the importance of aligning with federal oversight and contributing to the broader learning and evidence-base for rural health care transformation.

### Sustainability Plan

Oregon is committed to the health of its rural communities and ensuring that the investments made through this initiative will lead to lasting, self-sustaining improvements in rural health care delivery, access, and health outcomes.

Through strategic investments and cross-sector partnerships, the primary focus of the Regional Partnerships & Systems Transformation Initiative, we will enhance care coordination and referral pathways, reduce administrative overhead, and improve operational efficiency. These strategies will lower operating costs, expand access to preventive services, and drive long-term improvements in health outcomes. Regional planning efforts will strengthen relationships among rural providers, hospital systems, and clinics, fostering a network built on shared accountability and success. Increased participation in value-based payment models will provide reimbursement that is tied to high-quality and low-cost care, producing returns on investment over the long-haul. Finally, implementing shared delivery strategies that include next generation

technology and pooling resources will expand access to high-quality care and drive greater efficiency, ultimately reducing the total cost of care.

By incentivizing preventive care, health promotion, and community-based chronic disease management programs in the Healthy Communities & Prevention Initiative, Oregon will improve population health outcomes and reduce expensive costs associated with unnecessary hospital utilization. Mobile health units, mobile simulation units, and investment in allied health professionals and CHWs will increase the capacity and skills of local care teams, preventing high-cost transfers and traveling long distances for care.

Through the Workforce Capacity & Resilience Initiative, we will grow rural residency and fellowship programs by continuing collaboration with state agencies, higher education institutions, and leveraging state policy to sustain long-term investments in Oregon's healthcare workforce. There is immense value generation in building rural residency programs that are eligible for Medicare reimbursement; not only do they create a stable pipeline of providers, but they also lead to transformation of local health systems, making them more self-sufficient and resilient. Similarly, ongoing investments in rural K-12 health care pathway programs will support the economic vitality of these communities and create generative conditions for a locally sourced workforce. Training and retention structures that allow local Tribal members to fill permanent health workforce roles at Tribal clinics and other access points will reduce reliance on short term contracts and support a more stable, culturally responsive healthcare system.

Workforce retention and recruitment initiatives will be supported through investments in advanced tech-enabled solutions, including telehealth, RPM, cloud-based EHRs, tele-mentoring, and emerging applications of AI. These technologies will transform the way care is delivered, increasing timeliness, reducing costs, expanding access, and improving patient outcomes. These

technologies are selected not only for their immediate impact but also for their ability to generate operational efficiencies and lower costs with improved data collection, billing and coding, population health management, and more – ultimately strengthening the effectiveness of rural health systems in providing affordable, high-quality care.

To achieve sustainability, projects will be required by year four to collaborate with Oregon's RHT Program to develop a comprehensive sustainability plan and identify additional funding sources. By coupling transformative investments with clear accountability, this approach creates both a strong program on-ramp and a sound financial off-ramp, focused on reinvesting generated savings to support continued operations before and beyond the conclusion of the RHT Program.

Key sustainability strategies will include building payment capacity for Medicaid billing and cost-based reimbursement (without supplanting existing funding streams), advancing value-based arrangements, and investing in staff training and development to effectuate these efforts. Additional system improvements, including payer enrollment and credentialing, EHR configurations for claims, and optimized revenue-cycle workflows, will help cement durable revenue pathways over the long haul. These strategies closely align with the Technology & Data Modernization Initiative, reinforcing the program's emphasis on IT modernization, interoperability, and workforce training as foundational to healthcare transformation.

By embedding sustainability into every aspect of our proposal—from workforce and technology to prevention and reimbursement—we are building a model that will sustain healthy communities in rural areas long after the Rural Health Transformation Program concludes.

## Appendix

### Table 1: Select Social Characteristics in Oregon by Geography, avg 2018-2022

| | Rural | Urban |
|---|---|---|
| Population below Poverty Level ($24,526 per year for 2 adults/1 child <18 in 2023) | 12.6% | 11.6% |
| Population below 200% of Poverty Level | 31.90% | 26.2% |
| Population 16+ Unemployed | 5.8% | 5.4% |
| Population with no health insurance coverage | 7% | 6.3% |
| Adults aged ≥ 25 years with any postsecondary credential | 43% | 57% |

Source: American Community Survey, U.S. Census, avg 2018-2022

### Table 2: Median Household Income in Oregon by County, 2023

| **Urban Counties Tend to Have Higher Household Income, 2023 Oregon = $80,061** | | | | | |
|---|---|---|---|---|---|
| **County** | **Median Household Income** | **County** | **Median Household Income** | **County** | **Median Household Income** |
| Washington County | $103,486 | Marion County | $73,210 | Josephine County | $61,575 |
| Clackamas County | $100,376 | Sherman County | $73,123 | Coos County | $61,386 |
| Deschutes County | $95,414 | Jackson County | $71,030 | Wallowa County | $61,173 |
| Yamhill County | $86,887 | Linn County | $70,242 | Grant County | $61,024 |
| Multnomah County | $83,290 | Lane County | $70,065 | Douglas County | $60,296 |
| Columbia County | $81,463 | Tillamook County | $68,717 | Baker County | $59,123 |
| Morrow County | $80,508 | Jefferson County | $68,419 | Harney County | $56,649 |
| Polk County | $79,970 | Wasco County | $65,701 | Lake County | $56,518 |
| Hood River County | $79,092 | Clatsop County | $65,160 | Curry County | $55,238 |
| Benton County | $74,800 | Union County | $63,524 | Klamath County | $54,630 |
| Gilliam County | $74,010 | Umatilla County | $62,890 | Malheur County | $53,762 |
| Crook County | $73,421 | Lincoln County | $61,603 | Wheeler County | $46,315 |
| | | = denotes Urban County | | | |
| *Source: Oregon Employment Department, U.S. Census Bureau, Small Area Income and Poverty Estimates* | | | | | |

### Table 3: Causes of Death Rates per 100,000 by Geography, avg. 2018-2022

| | Frontier | Rural | Urban | Oregon |
|---|---|---|---|---|
| Cancer | 242.4 | 244.7 | 167.5 | 193.5 |
| Heart Disease | 265.5 | 222.1 | 146.9 | 173.4 |
| Unintended Injuries | 76.7 | 71.2 | 54.1 | 61 |
| Cerebrovascular Disease | 62.9 | 62.7 | 47.6 | 52.8 |
| Alzheimer's | 47.2 | 48.4 | 45.2 | 46.3 |
| Chronic Lower Resp. Disease | 75.1 | 66.7 | 35.5 | 46.1 |
| Diabetes | 39 | 39.3 | 27.3 | 31.4 |
| Alcohol Induced | 24.3 | 32.3 | 22.3 | 25.7 |
| Suicide | 25 | 24.7 | 17.8 | 20.3 |
| Hypertension | 21.9 | 19.4 | 13.7 | 15.7 |

Source: Oregon Office of Rural Health and OHA Public Health Division (2018-2022 average per year)

## Table 4: List of Stakeholders

| Initiative | Key Stakeholders |
|---|---|
| Regional Partnerships & System Transformation Initiative | Rural health systems, rural hospitals, and rural health clinics; Critical Access Hospitals (CAHs); Federally Qualified Health Centers (FQHCs); Organizations providing emergency medical services (EMS); Certified Community Behavioral Centers (CCBHCs); Local Mental Health Authority/Community MH Program; County public health departments; Community based organizations; Statewide Perinatal Quality Collaborative; Education service districts (ESDs); Early Learning hubs; Oregon Office of Rural Health (ORH); Coordinated Care Organizations; Organizations serving the American Indian /Alaska Native population; Rural educational entities such as high schools, community colleges and more |
| Healthy Communities & Prevention Initiative | Community clinics: FQHCs, RHCs, SBHCs; Local Public Health Authorities; Education Service Districts; Schools; Faith communities; Community Based Organizations; Residential Treatment Facilities; CCBHCs; Pharmacies; Oregon Department of Human Services: Aging & Disability Services; Child Welfare; Intellectual & Developmental Disabilities |
| Workforce Capacity & Resilience Initiative | FQHCs; Primary Care Clinics and RHCs; Organizations serving the AI/AN population; CAHs (specifically, but not limited to, those with residency programs, preceptor programs/staff); ORH; Oregon Primary Care Association (OPCA); Hospital Association of Oregon (HAO); Education institutions (specifically, but not limited to, those with rural residency programs); Oregon Nurses Association (ONA); Oregon Dental Association (ODA); Area Health Education Centers (AHEC); Oregon Community Health Worker Association (ORCHWA); Oregon Council for Behavioral Health; Higher Education Coordinating Commission (HECC); Oregon Perinatal Collaborative (OPC); Oregon Health Sciences University (OHSU); Association of Community Mental Health Programs (AOCMHP); Oregon Workforce Partnerships |
| Technology & Data Modernization Initiative | ORH; local health departments; school districts and ESDs; Tribal clinics; RHCs and hospitals, including FQHCs and CAHs; emergency service agencies; oral health providers and payers; community-based service organizations; and public-private partnerships (HIT Commons). |

## Table 5: Oregon Counties and FIPS codes

| Name | FIPS code | Name | FIPS code | Name | FIPS code | Name | FIPS code |
|---|---|---|---|---|---|---|---|
| Baker | 01135845 | Douglas | 01135849 | Lake | 01135854 | Sherman | 01135863 |
| Benton | 01155126 | Gilliam | 01135850 | Lane | 01135855 | Tillamook | 01135864 |
| Clackamas | 01155127 | Grant | 01135851 | Lincoln | 01135856 | Umatilla | 01156673 |
| Clatsop | 01135846 | Harney | 01135852 | Linn | 01135857 | Union | 01164165 |
| Columbia | 01135847 | Hood River | 01155131 | Malheur | 01135858 | Wallowa | 01155135 |
| Coos | 01135848 | Jackson | 01135853 | Marion | 01135859 | Wasco | 01155136 |
| Crook | 01155128 | Jefferson | 01155132 | Morrow | 01135860 | Washington | 01155137 |
| Curry | 01155129 | Josephine | 01155133 | Multnomah | 01135861 | Wheeler | 01135865 |
| Deschutes | 01155130 | Klamath | 01155134 | Polk | 01135862 | Yamhill | 01135866 |

## Endnotes

[i] The Oregon Office of Rural Health (ORH) defines rural as any geographic area that is ten miles or more from a population center of 40,000 people or more. Frontier counties are those with six or fewer people per square mile; https://www.ohsu.edu/sites/default/files/2025-02/ORH_2024YearEndReport%20-%20FINAL.pdf
[ii] The Oregon Office of Rural Health
[iii] https://oregonbusinessplan.org/about-the-plan/about-oregons-industry-clusters/; https://www.qualityinfo.org/-/made-in-oregon-a-profile-of-the-state-s-manufacturing-sector
[iv] https://www.qualityinfo.org/documents/d/guest/growing-demand-and-workforce-needs-in-oregon-s-health-care-and-social-assistance-sector
[v] https://www.oregon.gov/oha/HPA/HP-HCW/Documents/2025-Health-Care-Workforce-Need-Assessment-report-final.pdf
[vi] Oregon Behavioral Risk Factors Surveillance System
[vii] Ibid
[viii] https://mhanational.org/wp-content/uploads/2025/09/State-of-Mental-Health-2025.pdf
[ix] https://mhanational.org/wp-content/uploads/2025/09/State-of-Mental-Health-2025.pdf; Oregon Areas of Unmet Health Care Needs Report 2025
[x] https://mhanational.org/wp-content/uploads/2025/09/State-of-Mental-Health-2025.pdf
[xi] Oregon Areas of Unmet Health Care Needs Report defines inadequate prenatal care as care that did not begin until the third trimester or consisted of fewer than five prenatal visits.
[xii] https://www.marchofdimes.org/peristats/reports/oregon/maternity-care-deserts
[xiii] Oregon Annual Trends in Birth & Pregnancy Dashboard
[xiv] Radke, S et al (2023) Closure of Labor & Delivery units in rural counties is associated with reduced adequacy of prenatal care, even when prenatal care remains available. https://onlinelibrary.wiley.com/doi/full/10.1111/jrh.12758
[xv] "Forecasts of Oregon's County Populations by Age and Sex, 2010 - 2050." Office of Economic Analysis, Department of Administrative Services.
[xvi] America's Health Rankings® 2025 Senior Report, United Health Foundation, 2025
[xvii] https://www.ohsu.edu/sites/default/files/2025-02/ORH_2024YearEndReport%20-%20FINAL.pdf; https://www.oregon.gov/oha/hsd/amh/pages/cmh-programs.aspx
[xviii] https://www.ohsu.edu/sites/default/files/2025-02/ORH_2024YearEndReport%20-%20FINAL.pdf
[xix] https://oregoncounties.org/road-resources/
[xx] Primary Care Services Areas are sub-county units defined by factors such as travel time, ZIP codes, population, and community needs and used by the Oregon Office of Rural Health to more accurately measure and represent access and use of health care services.
[xxi] Oregon 2025 Behavioral Health Talent Assessment Report
[xxii] The Oregon All Payers All Claims (APAC) Reporting Program
[xxiii] https://www.stroudwater.com/services/rural-health-insights-for-each-state-and-congressional-district/
[xxiv] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-primary-care-workforce-report-2024.pdf; https://www.milbank.org/primary-care-scorecard/
[xxv] Oregon 2025 Health Care Workforce Need Assessment Report
[xxvi] Oregon's Health care Workforce Committee GME Educational Webinar (April 2025)
[xxvii] https://www.opb.org/article/2025/08/19/providence-seaside-hospital-closes-maternity-unit/; https://www.opb.org/article/2025/09/16/providence-st-vincent-pediatric-icu-close/
[xxviii] Oregon Community Benefit Data (2025) Oregon Health Authority Hospital Reporting Program
[xxix] Oregon Medicaid Enrollment Report
[xxx] OHA categorizes hospitals by size, distance from another hospital, and reimbursement level. OHA's Hospital Reporting Program primarily uses three hospital type designations: DRG, Type A, and Type B. Type B hospitals are small hospitals with 50 or fewer beds that are located within 30 miles of another hospital. Type A are small hospitals with 50 or fewer beds that are located more than 30 miles from another hospital. DRG are typically urban hospitals that receive standard Medicare Diagnostic Related Group based reimbursement; https://visual-data.dhsoha.state.or.us/t/OHA/views/databankdashboardappendix/UtilizationDashboard
[xxxi] Oregon Community Benefit Data (2025) Oregon Health Authority Hospital Reporting Program
[xxxii] Oregon Community Benefit Data (2025) Oregon Health Authority Hospital Reporting Program

[xxxiii] https://oregonperinatalcollaborative.org/wp-content/uploads/2024/Hospital-Report-FINAL-Map-Added-5.1.25.pdf
[xxxiv] https://ciceroinstitute.org/research/2025-policy-strategies-for-full-practice-authority/
[xxxv] Coordinated care organizations (CCOs) are local health plans that serve individuals with the Oregon Health Plan, Oregon's Medicaid program.
[xxxvi] Family Connects is an evidence-based model that offers 1-3 home visits from a registered nurse to all families with newborns.
[xxxvii] https://pmc.ncbi.nlm.nih.gov/articles/PMC11414079/
[xxxviii] https://www.arthritis.org/health-wellness/healthy-living/physical-activity/walking/walk-with-ease/wwe-about-the-program
[xxxix] https://www.ruralhealthinfo.org/toolkits/chronic-disease/2/self-management
[xl] In Oregon, Traditional Health Workers are trusted and trained community members who serve as a bridge between health systems and communities. They provide health education, care coordination, advocacy, and social support. Birth doulas provide emotional, physical, and informational support before, during and after childbirth. End-of-life doulas are non-medical companions who support individuals and families through the dying process offering emotional, spiritual, and practical care.