Utah Department of Health & Human Services

Utah's Rural Health Transformation Plan

November 2025

Note: This document varies from the formatting requirements specified in the CMS RHTP NOFO and used in Utah's official application submission. This version is designed for ease of public reading and reference.

Project summary

Utah geographically is the 13th largest state and 77% rural. Rural residents in Utah face persistent healthcare barriers including geographic isolation, provider shortages, aging infrastructure, and economic hardships. These challenges contribute to higher rates of chronic disease, behavioral health issues, and poor maternal and child health outcomes. Addressing these challenges requires building a sustainable, patient-centered system of care to improve outcomes and ensure the long-term viability of rural healthcare in Utah.

Utah's Rural Health Transformation Program (RHTP) is a bold, multi-faceted innovative effort aimed at generational investments to build resilient, sustainable rural health systems. This outcome-focused program will be guided by four strategic pillars—Making Rural Utahns Healthy, Workforce Development, Innovation and Access, and Technology Innovation. Within these strategic pillars, Utah will implement seven integrated initiatives in collaboration with state, local, tribal, and community partners to create a rural health ecosystem designed to improve health outcomes: PATH (Preventive Action and Transformation for Health); RISE (Rural Incentive and Skill Expansion): SHIFT (Sustaining Health Infrastructure for Transformation); FAST (Financial Approaches for Sustainable Transformation); LIFT (Leveraging Innovation for Facilitated Telehealth): SUPPORT (Shared Utilities for Partnered Provider Operational Resources and Technology); and LINCS (Leveraging Interoperability Networks to Connect Services).

Combined, these initiatives will create financially sustainable health systems while supporting healthy lifestyles for rural Utahns, beginning in childhood and extending across the lifespan. PATH fosters lifelong wellness through improved nutrition, physical activity, and healthy environments. RISE strengthens the rural workforce through early and alternative career pathways, education, training, and structured provider incentives. SHIFT strategically invests in preventive care infrastructure to advance proactive, community-based health delivery systems, while strengthening public health capacity. FAST drives high-quality care, cost efficiency, and financial stability in rural health systems. LIFT expands access to care through telehealth to

overcome geographic barriers. SUPPORT modernizes digital and administrative systems to enhance operational efficiency. And LINCS improves and optimizes data sharing across clinics, hospitals, behavioral health providers, and community organizations to enable coordinated care.

Created through robust stakeholder engagement, these initiatives aim to unite rural providers, community partners, and public health entities to transform healthcare delivery, strengthen patient-centered care, and drive measurable improvements in health, coordination, and financial sustainability across rural Utah. Utah's RHTP framework ascribes to a core Utah financing principle: to use one-time funding to convert short-term investments into lasting operational efficiencies and policy reforms. By aligning financial incentives, modernizing infrastructure, expanding telehealth capacity, and addressing workforce shortages, Utah is positioned to cultivate a data-driven, patient-centered rural health system that supports providers to thrive and ensures rural Utahns have consistent access to high-quality care for generations to come.

Lead organization: Utah Department of Health and Human Services

Subrecipients/sub-awardees: Post Notice of Award, the state will select subrecipients.

Total budget amount requested: $1,000,000,000

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I. Rural health needs and target population

Rural demographics

The vast rural areas in Utah make up 77% of the state's land.[i] Despite having most of its population concentrated in urban areas, Utah is an overwhelmingly rural state.[ii] Utah is the 13th largest state in the U.S. by area but ranks 30th among states in population. Utah's population primarily resides in a 4-county region known as the Wasatch Front. The urban areas in this north-central portion of the state are home to approximately nine of every 10 Utahns and make up just 1.1% of the land mass. This places Utah 40th among all states in population density.[iii] Of Utah's 25 non-urban counties, 13 are classified as rural and 12 meet the federal definition of frontier, characterized by extremely low population density and limited access to services. According to Utah Code, a "rural county" is defined as "a county of the fourth, fifth, or sixth class; or a county of the third class, if the county of the third class has no municipality with a population of 100,000 or more."[iv] Under this definition, 25 of 29 counties are rural. Roughly 64% of Utah's land is owned by the federal government, 21% is private land, 10% is state-owned, and 5% is tribal land. See Table 1.

Table 1: Utah urban and rural demographics.[v]

Utah demographics	Urban	Rural
Population size	3,000,000	338,080
Density	90%	10%
Income level per capita	$72,332	$54,006
Unemployment rates	3.5%	3.5%
Bachelor's degree educational attainment	38.5%	32.5%
Uninsured rate	10.2%	12.3% rural/14.5% frontier
Seasonal/recreational housing units	1.5%	20.9%

Utah's rural residents are more likely to work in agriculture, forestry, fishing and hunting, mining, construction, public administration, transportation and warehousing, and utilities.[vi] Rural workers have lower median earnings than their urban counterparts. On a per capita income basis, Utah's urban workers earn approximately 33% more than rural Utahns ($72,332 vs $54,006). Unemployment rates are also significantly higher and more volatile in rural counties. For example, rural counties like Piute and Garfield have the state's highest unemployment, 5.4% and 5.1%, respectively. These are significantly higher rates relative to Utah's general unemployment rate of around 3.5%.

Educational attainment is a challenge, with the rural population holding fewer college and advanced degrees (only 32.5% have a college degree compared to 38.5% in urban areas). This educational gap correlates with poorer health outcomes and higher rates of uninsurance. Adults in Utah's frontier counties have the highest uninsured rate (approximately 14.5%), followed by rural counties (approximately 12.3%); both are higher than the urban uninsured rate of 10.2%. Utah also ranks 36th in the rate of insured children.[vii]

Health outcomes

Preventive care

Preventive care and screenings play a vital role in overall health and well-being. However, Utahns who live in rural areas do not receive the preventive care needed. Almost one-in-three Utah adults living in rural counties (28.2% rural, 30.4% frontier) did not have a routine check-up in the past year.[viii] Most recent data show that one-in-five children in Utah (20.3%) did not receive a preventive check-up in the past year.[ix] Preventive visits for oral healthcare remain low in Utah. Among adults in rural Utah, 26.1% in rural counties and 32.7% in frontier counties, had no routine dental visit in the past year.[x] Many Utah children were eligible for Early and Periodic Screening, Diagnostic, and Treatment Medicaid dental coverage in 2024. Despite this coverage, fewer than half of children aged 1 to 18 enrolled in Medicaid (48%) received a preventive dental visit that year. Additionally, many Utahns living in rural counties do not receive recommended screening tests. Utah is 35th among states in the non-metro percentage of adults ages 45-75 who reported receiving one or more of the recommended colorectal cancer screening tests within the recommended time interval.[xi] More than one-in five adults who live in rural Utah (22.9% rural, 21.1% frontier) have not had a cholesterol screening test in the past five years.[xii] Many women in rural Utah do not receive recommended screenings. Utah ranks 32nd and below the national average on the percentage of non-metro women ages 40-74 (34.49% rural, 43.57% frontier) who reported they did not receive a mammogram in the past two years.[xiii,xiv] Rates for Utah women not receiving a pap smear in the past three years (40.12% rural, 39.97% frontier) is also alarmingly high.[xv,xvi]

Chronic disease

Chronic disease and related risk factors pose significant health challenges in Utah. Heart disease, linked to diabetes, obesity, and hypertension, is the leading cause of death in Utah. Utah adults who live in frontier counties have the highest rates of diabetes (10.1%) and high blood pressure (30.1%) in the state. While rates of obesity are fairly consistent regardless of geography (31.4% overall), Utah adults living in frontier counties have the highest rates of being overweight (38%). Healthy eating and physical activity are important behaviors to delay or even prevent

chronic disease. A majority of adults living in rural Utah do not meet recommendations for physical activity (66.4% rural, 72.6% frontier) or fruit and vegetable consumption (86.8% rural, 90.6% frontier).[xvii,xviii] There is a similar trend among adolescents in Utah, with a majority living in rural counties (80.4%) who do not meet physical activity recommendations.[xix] Food security is also an issue in rural Utah, with one-in-five adults in frontier counties (21.2%) who report being worried or stressed about having enough money to buy nutritious meals.[xx]

Behavioral health

Utah, like the rest of the nation, is experiencing high rates of behavioral health disorders, including suicide and substance use disorders. Utah had the 7th-highest age-adjusted suicide rate in the U.S. in 2022.[xxi] In 2023, the suicide death rate in Utah's rural counties hit its highest level in a decade and was 40% higher than the urban rate.[xxii] That year, suicide was the second leading cause of death for Utahns ages 10 to 44. From 2021 to 2023, four of Utah's rural health districts had significantly higher age-adjusted suicide rates compared to the state rate.[xxiii] One in five rural Utahns (21% in 2024) have been diagnosed with depression in their lifetimes, and a similar number report poor mental health in the past 30 days (22%).[xxiv] The percentage of rural and frontier Utahns who report having poor mental health in the past 30 days has increased by 47% from 2015 (14.8%) to 2024 (21.7%).[xxv] Utah has also been hit hard by the opioid epidemic. Substance use disorders, compounded by limited access to treatment and stigma are elevated in rural Utah.[xxvi] From 2014 and 2023, there was a 1,160.9% increase in Utah deaths involving fentanyl.[xxvii] This epidemic disproportionately impacts rural areas. Utah's eastern rural counties have the highest rates of overdose in the state, with rates as high as 34 deaths per 100,000 people in 2022.[xxviii]

Maternal and child health

The health and well-being of mothers, infants, and children are vital to shaping the next generation of Utahns.[xxix] While Utah has long been known for large families and a high birth rate, Utah fertility rates are following declining national trends. The total fertility rate for Utah declined by 2.8% and dropped from fourth to tenth highest in the country in 2023.[xxx] However, maternal and child health remains a top concern for the state. Women of reproductive age in rural

Utah face significant barriers to quality preconception, pregnancy, and postpartum care, largely due to shortages of primary care providers and obstetrician-gynecologists. Over three-fourths of Utah's births in 2023 occurred to mothers residing in a county designated as a primary care workforce shortage area. Utah has one of the lowest rates in the nation of preventive medical visits for women aged 18 to 44 (65.7% vs. 71.2% nationally).[xxxi] Only half of Utah women (52%) had a regular health care checkup in the 12 months before pregnancy. The percentage of pregnant women living in rural Utah counties that received prenatal care in the first trimester is alarmingly low (62.83% rural, 66.47% frontier). Another major issue in Utah's rural counties is access to birthing hospitals. In five rural Utah counties, the average travel time to a birthing hospital is over 60 minutes.[xxxii] These issues increase the likelihood of severe maternal morbidity and adverse birth outcomes.

Healthcare access

Utah's rural areas experience chronic workforce shortages for both primary care and specialty services. Utah ranks the lowest (50th) among states in the number of primary care physicians per 100,000 population (60.2 versus 83.8 nationally).[xxxiii] These workforce shortages exacerbate existing barriers to access due to long travel distances, challenging terrain, and inclement weather. Utahns living in rural counties may travel more than one hour to receive care at a hospital and up to four to six hours one-way to see a specialty provider.[xxxiv] The average 911 emergency transport time is twice as long in rural counties (60.8 minutes) compared to urban counties (35.2 minutes).[xxxv] These limitations in access to care may delay important medical care, which can result in severe and even life threatening complications. The majority of Utah's hospitals statewide are managed by two healthcare systems, Intermountain Health and University of Utah Health, with a smaller number operated by CommonSpirit Health, Lifepoint Health, and MountainStar Healthcare. Utah is home to 21 rural and Critical Access Hospitals (CAHs); nine of these are independent facilities that serve the seven counties in which they are located, as well as four adjacent counties without hospitals. Additionally, Utah has 21 rural health clinics (RHCs) and 35 rural community health center clinics.

Rural facility financial health

Since 2005, Utah has had no hospital closures and is one of few states with no hospitals at immediate risk of closure. Even so, five rural hospitals had a negative margin (loss) on patient services.[xxxvi] Rural hospitals face higher average costs per service due to low patient volume and the need to maintain staff and equipment regardless of utilization. In the past year, Utah's overall inpatient hospitalizations have used between 44% and 73.5% of beds.[xxxvii] See Table 2.

Utah's rural hospitals have a harder time securing a high share of revenue from private payers because patients often travel to larger urban centers for specialty care.

This inability to capture the higher-paying private patient revenue stream, combined with the losses often incurred on uninsured and Medicaid patients, limits the ability of rural hospitals to invest in new services and technology for long-term sustainability. Utah's Rural Health Transformation (RHT) plan aims to help Utah's rural hospitals and CAHs provide more of these services locally by expanding service lines, allowing patients to seek care in their communities, and avoid the added costs from time off work and associated travel expenses.

Table 2. Utilization of rural hospitals.[xxxviii]

Service type	Annual patient volume range (rural hospitals)
Emergency department visits	500 to over 16,000 per year
Inpatient stays	46 to 3,000
Outpatient visits	5,550 to over 53,000

Target population

Utah's RHT plan will focus on improving health outcomes in the state's 25 rural counties; however, its impact will extend across the entire healthcare delivery system. The plan includes generational investments that will benefit rural hospitals, rural health clinics, and community health centers statewide—ensuring residents in these communities receive more coordinated, accessible, and high-quality care. Particular attention is being paid to children, students, and individuals who are dually eligible for Medicaid and Medicare, a group that represents 12.6% of Utah's dual-eligible population.[xxxix] These efforts are designed to create a seamless healthcare delivery model that supports both publicly insured and uninsured individuals, bridging gaps across programs and providers. Given that 12% of Utah's Medicaid members and 10% of the state's population live in rural areas, the RHT plan is not only a rural initiative—it is a strategic blueprint for statewide health and system-wide transformation.

II. Rural health transformation plan:

A. Goals and strategies

Utah's vision is to transform rural health through sustainable, generational investments to increase opportunities for all rural Utahns to live safe and healthy lives. This is built on a strong foundation of positive health outcomes as demonstrated by our state's consistent ranking as one of the nation's healthiest states. Utah's RHT plan is grounded in the principles recently adopted by the Utah State Legislature, including sustainable financial outcomes, prioritization of one-time projects, leveraging non-state resources**,** inspiring innovation in healthcare delivery, and improving health outcomes. In addition to these guiding principles, the plan repeatedly reflects and emphasizes the required elements of improving access; improving outcomes; utilizing technology; leveraging regional partnerships; and the development of a sustainable rural healthcare workforce. The plan is built to ensure Utah's rural health systems continue to be financially solvent with strategies that are data-driven and outcome focused.

Through extensive planning for this funding opportunity, Utah's rural health stakeholders identified four strategic goals, aligned with the CMS RHT Program's strategic goals, that now guide this plan.

- **Making rural Utahns healthy:** Support upstream projects that promote healthy lifestyles beginning in childhood; prevent illness; manage chronic disease; improve maternal and child health outcomes, and address behavioral health.
- **Workforce development:** Support rural communities in growing, attracting, and retaining skilled healthcare providers to deliver high-quality, comprehensive care.
- **Innovation and access:** Support rural providers to strengthen infrastructure, share resources, and adopt innovative, data-driven care approaches to maintain long-term, reliable care that is financially sustainable.
- **Technology innovation:** Support rural providers and patients to use modern technology to make care easier, faster, and more secure.

Collectively, these goals will drive progress for rural communities and result in tangible results for Utah through four overarching outcomes.

A. **Improving outcomes:** Improved health outcomes and healthy behaviors in chronic disease, behavioral health, and maternal and child health across rural Utah.

B. **Improving access:** Expanded access to healthcare and essential health services, ensuring rural Utahns receive the care they need, when and where they need it.

C. **Improving quality:** Strengthened systems that support high-quality care and services with improved coordination, standards, and continuous quality improvement to prevent any rural hospital from closing.

D. **Strengthening workforce:** Strengthened workforce stability to ensure rural communities have skilled and reliable healthcare professionals.

Utah plans to drive progress on these outcomes through seven broad initiatives in partnership with state, local, tribal, and community stakeholders across rural Utah.

1. Making Rural Utahns Healthy: Preventive Action and Transformation for Health (PATH)
2. Rural Incentive and Skill Expansion (RISE)
3. Sustaining Health Infrastructure for Transformation (SHIFT)
4. Financial Approaches for Sustainable Transformation (FAST)
5. Leveraging Innovation for Facilitated Telehealth (LIFT)
6. Shared Utilities for Partnered Provider Operational Resources and Technology (SUPPORT)
7. Leveraging Interoperability Networks to Connect Services (LINCS)

Within each of the seven initiatives, Utah will implement targeted core activities directly aligned with key performance objectives to be achieved by the end of FY2030. The key performance objectives are outlined in the initiative sections below.

Legislative or regulatory action

The Utah State Legislature has been the nation's leader in addressing many legislative and regulatory priorities outlined in this funding opportunity. It has recently banned fluoride in Utah drinking water; required the removal of additives in school lunches; and prohibited the use of SNAP funds to purchase beverages with sugar.[xl, xli,xlii] Below addresses the status of the state policy actions requested within this funding opportunity.

Status of and commitment to "State policy actions" technical score factors

- B.2 Health and lifestyle (None): The state had a comparable, locally-developed school program called *Gold Medal Schools* (GMS) that coincided with the 2002 Utah Olympics and the Presidential Fitness Test. The state is proposing to re-establish GMS. Utah will pursue requiring schools to reestablish the Presidential Fitness Test by December 31, 2028, in a way that is aligned with federal guidance associated with Executive Order 14327. This

legislative action will help rural communities benefit from initiatives promoting prevention through physical activity, which can reduce overall cost of care burden and improve health outcomes.

- B.3 SNAP waivers (Enacted): The state has a USDA SNAP Food Restriction Waiver that prohibits the purchase of non-nutritious items. SNAP Benefits Waiver: Utah Code § 35A-17-P1.
- B.4. Nutrition Continuing Medical Education (None): Utah has a robust medical education system through which physicians receive adequate nutrition training.
- C.3 Certificate of Need (Enacted): The state has no CONs across facility categories.
- D.2 Licensure compacts (Enacted): The state is a member of all identified interstate licensure compacts. Interstate Medical Licensure Compact: Utah Code § 58-67b; Nurse Licensure Compact: Utah Code § 58-31e-102; EMS Compact: Utah Code § 53-2e-101; Psychology Interjurisdictional Compact: Utah Code § 58-61b; PA Licensure Compact: Utah Code § 58-70c-P1.
- D.3 Scope of practice (Partial): Utah Physician Assistant Act enables full practice authority: Utah Code § 58-70a-501; Nurse Practice Act enables full practice authority: Utah Code § 58-31b. The state will review expanding scope of practice for dental hygienists and pharmacists in 2026 and 2027.
- E.3 Short-term, limited-duration insurance (Enacted): The state follows federal CMS direction on the non-enforcement of the 2024 final rule, Short-Term, Limited-Duration Insurance (STLDI) and Independent, Noncoordinated Excepted Benefits Coverage. The state's maximum allowable initial contract term for STLDI is less than 12 months and allowable total coverage period for STLDI is no more than 36 months.
- F.1 Remote care services (Partial): The state Medicaid program provides reimbursement for live video: R414-42. Telehealth. The state allows out-of-state, licensed physicians in good standing to provide telehealth services without a Utah license, and the state does not require a special license for telehealth: Utah Code § 26B-4-704.

Other policy actions Utah plans to pursue

Additionally, Utah is committed to pursuing complementary policy actions that would support the successful implementation of the planned initiatives in rural Utah.

- Exploring policy changes that would allow pharmacists to distribute medication through mobile pharmacy kiosks in rural communities. This legislative change would improve population health by bringing medication and preventive screenings to communities that might otherwise face barriers to accessing a pharmacy.
- Exploring policy to improve the timely credentialing of providers by insurers. This regulatory change would streamline the credentialing process, reduce administrative delays, allow providers to begin billing sooner, and improve timely access to care in rural facilities while supporting financial sustainability and operational efficiency.

Other required information

As required by Section 71401 of Public Law 119-21, Utah's initiatives address the statutory elements and align with the CMS RHT Program's five strategic goals. More detailed information is included throughout the project narrative and in the attachments. Additionally, Utah is reporting on request information related to factors A.2 and A.7.

For factor A.2: Utah does not have any Certified Community Behavioral Health Clinics (CCBHC) entities in the state as of September 1, 2025.

For factor A.7: The following nine hospitals in the state received a Medicaid Disproportionate Share Hospital (DSH) payment from Utah for the most recent State plan rate year (SPRY): Beaver Valley Hospital, Garfield Memorial Hospital, Gunnison Valley Hospital, Kane County Hospital, Milford Valley Memorial Hospital, Moab Regional Hospital, San Juan Hospital, University of Utah Hospital, and Utah State Hospital.

B. Proposed initiatives and use of funds

Utah's comprehensive RHT plan represents a strategic, generational investment in building a sustainable rural health system that will improve health outcomes for Utahns living in rural communities. Each of the seven outcome-driven initiatives includes specific activities with measurable objectives, allowing progress to be monitored and evaluated with data. These initiatives, activities, and estimated funding amounts were informed by a rigorous stakeholder engagement process—detailed later in this application—that generated more than 210 proposed projects with itemized budgets totaling approximately $2.97 billion in funding requests, which were then consolidated into the $1 billion hypothetical budget submitted for this application. Utah's RHT plan activities are described below by initiative.

1. Making Rural Utahns Healthy: Preventive Action and Transformation for Health (PATH)

Description

The PATH initiative advances rural health through innovations in nutrition, physical activity, and built environments, establishing lifelong healthy behaviors to promote health, improve maternal and behavioral health, and reduce the overall burden of chronic disease in rural communities.

Increasing access to healthy foods and opportunities for physical activity, access to care, and reducing limitations in the built environment reduces the risk of chronic disease.[xliii] Nearly 11% of Utahns lack reliable access to nutritious food, with rates in some rural counties approaching as much as 20%.[xliv,xlv] Access to healthy, whole foods is necessary for good health and to prevent and manage chronic diseases, including obesity, type 2 diabetes, cardiovascular disease, and certain cancers, which are prevalent in rural counties.[xlvi]

In addition to access to nutritious food, physical activity is a recognized contributor to improved health outcomes. Nearly 1 in 5 adults in rural Utah are physically inactive and nearly half of youth in Utah do not meet weekly physical activity recommendations.[xlvii] Utah's rural areas often lack safe and accessible places to be physically active. This lack of access and engagement in physical activity contributes to chronic disease and mental health challenges.[xlviii]

The PATH initiative also uses regional stakeholder groups to create community care hubs to create integrated models that support improved health outcomes. PATH is a comprehensive strategy to prevent chronic disease, support maternal health, and address the root causes of poor physical and mental health across the lifespan for rural Utahns.

Key actions

1.1. Strengthen rural food infrastructure

1.A. Fund innovative approaches to strengthen local producers' capacity to supply rural communities with fresh, nutritious whole food. Approaches should contribute to a resilient food system to decrease the reliance on ultra-processed food by increasing access to and consumption of nutritious foods and place rural farmers and ranchers at the center of good health. Funded activities may include, but are not limited to:

- Components of an efficient and resilient supply chain, including storage, transportation, and processing facilities.
- Providing start-up costs to rural producers to remove barriers in food systems.
- Educating producers on innovative techniques to boost productivity, reduce waste, and extend the growing season, as well as educating consumers (including children) about shopping for and cooking locally-sourced, healthy foods.
- Support centrally located facilities, like food hubs, that are an innovative and sustainable way to provide the structure to store, sort, process, package, and distribute regionally-produced nutritious food products.

1.2. Strengthen physical activity and nutrition in schools

1.B. Re-establish and implement *Gold Medal Schools* in rural communities. *Gold Medal Schools* (GMS) is a locally-developed program that will incorporate the Presidential Fitness Test and support schools in providing physical activity, healthy nutrition choices and nutrition education, and wellness policies within rural local education agencies (LEAs).[xlix] Created for the 2002 Olympic games held in Utah, GMS will be re-established to coincide with the 2034 Olympic games to be held in Utah.

1.3. Support unique rural built environment needs

1.C. Fund innovative approaches and regional partnerships to improve the walkability, physical safety, and recreation of rural communities in support of regular physical activity and active transportation. Funded activities may include the following:

- Bike lane improvements to improve access to biking safely.
- Improve wayfinding on trail systems and expand trail connection.
- Update and improve existing infrastructure, such as adding missing sidewalk connections or bike lanes, and landscaping to create gathering areas and promote activity and recreation.

1.4. Improve coordinated care for prevention and disease management

1.D. Pilot Utah's first community care hub (CCH) for rural communities. CCHs are an effective way to coordinate care across rural settings to address health and social needs.[l] CCHs help small rural clinics, community-based organizations, local health departments, and others that participate in service delivery. The CCH serves as a connector in rural communities to support organizations and individuals to improve health by facilitating referrals, implementing sustainable reimbursement models, supporting dual-eligible enrollment in integrated plans, and working with agencies that provide community-based social care services. Services may include evidence-based chronic disease prevention and management, behavioral health, and maternal and child health programs, as well as services to address health-related social needs.

1.E. Select the CCH model through strategic, informative activities like conducting a landscape analysis to understand existing resources and infrastructure, establishing a community advisory council and determine framework, and contracting with local organizations to deliver or coordinate services.

1.F. Scale up the model to additional rural communities.

1.5. Support integrated behavioral health and primary care services

1.G. Assist rural sites in behavioral health and primary care services integration using a stepped-care approach. The lowest necessary intervention will be provided first, outcomes tracked, and care is "stepped up" as needed. Sites may implement the Collaborative Care Model (CoCM) according to their capacity. CoCM is an evidence-based approach to integrate behavioral health care into primary care settings. CoCM includes a patient-centered care team, population-based care, measurement-based treatment to target, evidence-based care, and accountable care. CoCM can be implemented across multiple care settings, to support individuals with mild to moderate behavioral health conditions including dual-eligible beneficiaries.

1.H. Provide technical assistance for screening and referral.

Table 3: PATH initiative summary of funding, goals, and measures.

Main strategic goal: Make rural America healthy again

Use of funds: A, H, K

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

Key performance objectives: By 2031, Utah will (1.1) increase the % of rural Utahns with access to locally-sourced fresh, whole foods (baseline pending; targets to follow); (1.2) support the Presidential Fitness Test statewide by increasing participation in the *Gold Medal Schools* program among rural school districts to 50%; (1.3) expand regional partnerships and built environment projects in 50% of rural counties to enhance opportunities for physical activity and active transportation; (1.4) increase the # of county- or region-based linkages between healthcare and social service providers (baseline pending; targets to follow) to strengthen rural care coordination; (1.5) expand integrated care by increasing the % of rural Utahns with access to facilities with increased behavioral health and primary care integration by 50%.

Outcomes and measures: A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, C.1, C.3, C.4, C.5, D.3, 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 1.10 (Tables 11 and 12)

Key stakeholders: State and local health programs, rural food producers and suppliers, Federally Qualified Health Centers (FQHCs), primary care and RHCs, community-based organizations (CBOs), faith-based organizations, state and local health departments, healthcare consulting organizations, health professions organizations, healthcare systems, tribal governments and tribal organizations, civic and community leaders, healthcare providers, local businesses, state and local education agencies, state and local transportation organizations, rural and CAHs, health organizations, state legislative and regulatory bodies, local mental health authorities (LMHAs), local public works departments, Utah Department of Agriculture and Food (UDAF), Utah Indian Health Advisory Board, Association for Utah Community Health (AUCH), Indian Health System (I/T/U) partners.

Impacted counties: All rural counties in Utah: 01448015, 01448017–19, 01448021–30, 01448032–37, 01448039–41, 01455158, 01455966

Estimated required funding: $155,000,000

2. Rural Incentive and Skill Expansion (RISE)

Description

The RISE initiative strategically invests in building a sustainable rural healthcare workforce by investing in career pathways beginning in grade school, expanding training, connecting education to local needs, and supporting recruitment and retention. Evidence shows that providers are significantly more likely to practice where they train—making local education and training essential.[li] This initiative aligns with Governor Cox's goal of improving access to high-quality, affordable healthcare for rural Utahns with a measurable target to increase the number of primary care providers in rural counties by 5%.[lii]

Utah currently has the lowest number of primary care physicians per capita in the nation and these physician shortages are even more severe in the rural areas.[liii] A significant barrier is the current structure of medical residency training, known as graduate medical education (GME), which does not exist outside Utah's urban Wasatch Front. As a result, current residency programs struggle to address rural physician shortages. Utah also ranks poorly, having the fourth lowest number of primary care GME positions per capita, and faces unique barriers in obtaining federal GME funding for rural primary care training.[liv] The high-volume, high-acuity hospitals necessary to produce high-quality physicians are often located at inconvenient distances from the rural training sites that are foundational to developing future rural, primary care physicians. Without an intentional, strategic, and sustainable plan for GME expansion into rural areas, these rural physician shortages are anticipated to worsen.

Rural communities in Utah face persistent, interconnected challenges in recruiting and retaining healthcare professionals. Financial barriers are significant: rural areas often offer lower salaries and limited sign-on and relocation incentives.[lv] Many rural residents cannot afford healthcare training, impeding the development of a local pipeline. Moreover, current challenges with housing affordability create a major hurdle, preventing professionals from being able to train and work in these areas.[lvi]

Clinical preceptors—experienced, licensed clinicians who provide one-on-one supervision, instruction, and evaluation to a student or a newly hired professional in a clinical setting—are essential to bridge the gap between theoretical knowledge and practical application, acting as role models and mentors to safely guide students into competent, professional practice. A recent study initiated by Utah's Health Workforce Advisory Council (HWAC), found Utah also faces a severe and rapidly growing clinical training crisis, requiring an estimated 3,000 additional preceptorships annually by 2031—a 57% increase from 2023 levels.[lvii] According to the study, the primary barrier to meeting this demand is financial strain, as only 24% of current preceptors receive compensation, and these crucial trainers carry significantly higher educational debt than their non-precepting colleagues. The study concluded that a clear solution pathway exists, making targeted financial incentives the most effective intervention to expand the state's preceptor pool, and RISE will address that through preceptor stipends.

The RISE initiative prioritizes activities that cultivate and retain healthcare professionals within rural communities by (1) addressing rural physician workforce needs, healthcare capacity to deliver rural GME, and patient mix and volumes for a high-quality educational experience; (2) expanding infrastructure and educational support for rural clinical rotations and finding the appropriate financial incentives to support rural precepting; (3) growing healthcare talent locally through structured educational pathway programs; (4) expanding industry-driven training programs for non-GME workforce; and (5) designing and implementing a provider incentive strategies that align with Utah's ongoing investment to support providers in practicing at the top of their licensure.

Key actions

2.1. Develop GME training in rural healthcare facilities

2.A. Create and implement a comprehensive strategic plan to sustainably develop and expand GME opportunities in rural facilities with Utah's medical schools.

2.B. Build capacity and attain accreditation within rural hospitals and clinics to allow students to focus their residency or internship programs in rural hospitals and rural community outpatient settings.

2.2. Expand rural clinical preceptor capacity program

2.C. Design and implement an incentive program to support rural clinical preceptors for a range of providers, including nurses, physician assistants, and physicians.

2.3. Increase health career pathways through the creation of "grow our own" high school to certification programs

2.D. Develop multidisciplinary local training programs for rural high school students or recent graduates pursuing healthcare careers including distance-learning options so students can stay in their communities. The certification types that will be the focus of this "grow our own" initiative may include the following, based on community need: paramedic, nursing assistant, behavioral health technician, community health worker, behavioral health technician, behavioral health coach, master addiction counselor, prescribing psychologist, other clinical or non-clinical community, behavioral health, and health professionals.

2.E. Provide support that may include stipends, internships, apprenticeships, clinical supervision, or career coaching.

2.4. Optimize public-private partnerships to expand non-GME pipeline development

2.F. Partner with education and employers across industries for public-private partnerships to expand rural-based, non-GME health workforce career training programs in targeted occupations with regional demand. This could include community health aides, behavioral health aides, dental health aide therapists, peer behavioral health specialists, care coordinators and navigators, doulas, and community paramedicine. Providing these opportunities addresses healthcare workforce gaps across various careers and strengthens local economies by fostering a skilled and employable labor force.

2.G. Expand opportunities for apprenticeships and internships for individuals seeking non-degree or alternative pathways into healthcare careers.

2.H. Leverage existing health sciences higher education partnerships and the Utah Health Scholars program to create career ladders with regional needs, ensuring locally accessible pathways to health workforce careers.[lviii,lix]

2.5. Recruit and retain rural workforce

2.I. Offer structured incentives to recruit and retain rural workforce. The amount of these incentives will be benchmarked to the cost of living in the rural community in which the professional is employed and will include a commitment from the provider to serve a minimum of five years in the rural community. These awards will target those in high-need professions such as nursing, dentistry, midwifery, and behavioral health. Additional incentives will be available to trainees completing short-term rotations; providers offering short-term coverage to local staff; and awards supporting upskilling and professional development.

2.J. Align with Utah's ongoing investment in systems, resources, policies, and collaborative models to support providers in practicing at the top of their licensure.

Table 4: RISE initiative summary of funding, goals, and measures.

Main strategic goal: Workforce development

Use of funds: E, G, H, K

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

Key performance objectives: By 2031, Utah will (2.1) improve workforce recruitment and retention by increasing the # of providers with 5-year service commitments in rural communities by 45; (2.2) improve workforce capacity by increasing the # of primary care providers (MD, DO, APRN, PA) practicing in rural counties by 5%; (2.3) expand healthcare career opportunities by increasing the # of recognized healthcare career pathways available to rural students in school districts across 50% of rural counties.

Outcomes and measures: A.3, A.4, A.5, A.6, A.7, A.8 B.1, B.2, B.3, B.4, C.4, C.5, D.1, D.2, D.3, D.4, 2.1, 2.2, 2.3, 2.4 (Tables 11 and 12)

Key stakeholders: State and local education agencies, medical schools, healthcare systems, primary care and RHCs, rural EMS agencies, health career students, CBOs, nonprofit organizations, state agencies, state trade associations, health professions organizations, philanthropic organizations, HWAC, Governor's Office of Economic Opportunity, Talent Ready Utah, Utah Department of Workforce Services.

Impacted counties: All rural counties in Utah: 01448015, 01448017–19, 01448021–30, 01448032–37, 01448039–41, 01455158, 01455966

Estimated required funding: $187,000,000

3. Sustaining Health Infrastructure for Transformation (SHIFT)

Description

The SHIFT initiative seeks to transform preventive care through enhancements to local service delivery that improves health outcomes. Recognizing that rural communities face disproportionately poorer health outcomes compared to urban populations due to interconnected economic, infrastructure, and workforce barriers, SHIFT aims to build a resilient, interconnected system centered on proactive wellness and early intervention.[lx]

A key component of this transformation is the development of integrated rural health provider networks such as rural health clinics, pediatric trauma, and

community health worker networks that expand services, pool resources, and reduce duplication. By establishing shared services, SHIFT will support coordinated care, lower administrative costs, and strengthen the capacity of rural systems to meet community needs. Infrastructure modernization and physical capacity expansion are crucial to achieve sustainable change through one-time funding projects. By funding vital improvements to ensure healthcare settings are structurally and technologically equipped for the future, such as repurposing existing space and acquiring specialized equipment, Utah is creating new local service points for behavioral health, maternal care, and chronic disease management.

For efficiency, these strategic capital investments will establish essential 24/7 crisis stabilization centers and upgrade community assets into multi-functional facilities that can deliver a broader array of preventive and specialist care services closer to home.

A central challenge the SHIFT initiative addresses is the human capital resource gap, which severely limits access to local, essential services and contributes to poor patient outcomes. Many EMS agencies rely heavily on volunteers and operate with constrained resources which limit their ability to invest in updated equipment or expand services beyond emergency response.[lxi] SHIFT responds by strategically expanding EMS to deliver care closer to home and reduce emergency department dependence. This involves evolving the role of EMTs and paramedics into community paramedicine hubs, equipped with modern technology to deliver non-emergency, preventive services directly to patients' homes.

Finally, the program capitalizes on the development of new models of care that incorporate community health workers (CHWs), peer support specialists, and other paraprofessionals within healthcare delivery systems to alleviate provider strain and improve care coordination. In addition to expanding the workforce in these often underutilized extender certifications, the SHIFT plan incorporates the exploration of diverse funding models (including Medicaid reimbursement and value-based care integration), and capitalizing on the opportunity to upskill professionals like EMTs and doulas through dual certification.[lxii] By funding these new models of care and empowering community-embedded individuals, SHIFT ensures that preventive, chronic disease, maternal and child health, and behavioral

health management services are accessible, mobile, and anchored in the very communities they serve.

The SHIFT initiative responds by: (1) funding capital improvements for expanded local services and modern equipment; (2) integrating innovative EMS and CHW community-based models in rural healthcare; and (3) establishing rural health provider networks to share resources and coordinate preventive care.

Key actions

3.1. Support capital infrastructure improvements

3.A. Fund capital infrastructure improvement projects to improve care delivery, keep care local, and improve the quality of care in rural Utah, which may include:

- Minor building alterations or renovations to repurpose existing space and add new services; expand existing services such as pharmacy services, dialysis, behavioral health, cancer care, maternal health; and physical spaces for telehealth capabilities.
- Purchase new equipment or upgrade older equipment to ensure quality and safety standards of care are achieved.
- Facility master planning, feasibility studies, and service line analysis (new service line exploration, growth opportunities, outmigration analysis).
- Improvements to infrastructure to ensure access to safe food and drinking water in rural communities.
- Establishing and expanding rural receiving centers staffed by therapists, nurses, and peer counselors that offer 24/7 crisis stabilization.

3.2. Expand services and resources through rural health provider networks

3.B. Expand and establish integrated rural health provider networks such as a rural health clinic network, pediatric trauma network, or community health worker network.

3.C. Develop a resource directory of physical and behavioral healthcare services in rural Utah, detailing capacity, access, and availability to support patients and providers by pooling resources, reducing duplication, and lowering administrative costs.[lxiii]

3.3. Strengthen EMS

3.D. Establish community paramedicine programs that provide non-emergency healthcare services in rural areas. These programs could expand access to preventive and post-discharge care in rural areas and help reduce unnecessary emergency department visits and hospital readmissions.

3.E. Invest in technology components to support the delivery of services key to community paramedicine programs. This may include equipping ambulances with broadband connection and devices capable of video conferencing, mobile network devices, and remote medical direction/consultation services.

3.F. Facilitate the delivery of low-cost initial, continuing, and specialty EMS education for providers and agencies in rural communities. This may include the use of mobile simulation trailers that travel to rural areas to provide initial training and ongoing CME.

3.4. Build new models for innovative care

3.G. Fund innovative approaches to new models of care that expand access to mobile services, enhance transportation for medical appointments, and support prevention and management of chronic diseases, cancer, behavioral health, and maternal and child health in rural communities.[lxiv]

3.H. Assist rural employers to embed CHWs within their healthcare delivery model. Support activities may include guidance and technical assistance, recruitment and retention strategies, and payment sustainability models, as well as supporting sustainable training, certification, and continuing education that meets the needs of rural Utah.

Table 5: SHIFT initiative summary of funding, goals, and measures.

Main strategic goal: Innovative care

Use of funds: A, C, D, E, F, G, H, I, J, K

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

Key performance objectives: By 2031, Utah will (3.1) increase the # of new services or expand existing services in rural facilities by 10–12 services; (3.2) strengthen care coordination and shared services by expanding or establishing 2–4 rural health provider networks; (3.3) enhance rural emergency and preventive care by increasing the # of rural EMS units implementing community paramedicine programs across 40% of rural counties.

Outcomes and measures: A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, B.1, B.2, B.2, B.4, C.1, C.4, C.5, D.1, D.2, D.3, D.4, 3.1, 3.2, 3.3, 2.4 (Tables 11 and 12)

Key stakeholders: Rural and CAHs, FQHCs, primary care and RHCs, health professions organizations, healthcare systems, community leaders, rural EMS agencies, state and local health departments, CBOs, health career pathway programs, state and local health programs, healthcare providers, academic medical centers, state agencies, tribal governments and tribal organizations, Utah Indian Health Advisory Board, Indian Health System (I/T/U) partners.

Impacted counties: All rural counties in Utah: 01448015, 01448017–19, 01448021–30, 01448032–37, 01448039–41, 01455158, 01455966

Estimated required funding: $247,000,000

4. Financial Approaches for Sustainable Transformation (FAST)

Description

The FAST initiative addresses core financial and care delivery challenges that hinder rural healthcare viability in Utah by transitioning providers to value-based payment and proactive care, streamlining revenue cycles for efficiency, and piloting alternative models to fund specialist access for rural communities.

Rural providers face significant obstacles in shifting to value-based care models, which demand robust data systems, population health analytics, and

specialized care teams.[lxv] Low patient volumes prevent the rapid achievement of shared savings and economies of scale, while thin financial margins restrict a provider's ability to absorb the financial risk common in value-based care contracts. This disadvantage is compounded by limited local access to specialists and behavioral health services, which are critical for effective care coordination and demonstrating successful patient outcomes. Initiatives will identify and implement incentives for value-based care approaches that are structured to reward better patient outcomes.

Additionally, rural hospitals face difficulties in optimizing their revenue cycles. Reduced operating margins mean small disruptions, such as claim denials or processing delays, severely impact cash flow and financial stability. Structural issues, including a high mix of underinsured and Medicaid patients, reduce overall reimbursement potential. Furthermore, many facilities lack the specialized workforce, updated billing technology, or data analytics capabilities required to efficiently manage operations.

In addition to challenges with the financial sustainability of rural health systems, another driver of financial and care coordination is the severe lack of local specialist access in rural Utah counties, covering fields like urology, cardiology, and orthopedics.[lxvi] One approach to addressing this shortage is leveraging urban specialists to travel to rural counties. However, these specialists often incur financial loss when traveling to, and treating patients at a rural site, given current payment structures which fail to compensate for travel time or the reduced volume of procedures in rural communities. It is the rural patient population who bears the burden of this gap requiring them to travel long distances for care, lost wages, directly hindering local revenue generation and complicating the coordination necessary for value-based care and strong revenue cycles.[lxvii] The exploration of alternative payment models will accelerate sustainable, economically viable solutions in accessing specialty care in rural communities.

The FAST initiative seeks to further Utah's rural healthcare financial stability and sustainability by: (1) building the data and operational maturity needed to capture sustainable revenue from new payment models; (2) streamlining operations and leveraging technology to capture all allowable revenue; and (3)

resolving critical workforce and specialty access gaps by establishing alternative payment models to allow patients to receive care in their communities.

Key actions

4.1. Support rural providers in transitioning to value-based care models

4.A. Provide needs assessment, training, and education around value-based care models and contracts with payers.

4.B. Develop data infrastructure for quality reporting to prepare for value-based payment.

4.C. Expand technical capabilities for interoperability and data sharing.

4.D. Work with insurers and the state insurance commission on timely data availability.

4.E. Operationalize and expand a clinically integrated network (CIN), that supports centralized billing, IT, credentialing, and advanced care coordination.

4.F. Pilot and evaluate value-based payment model with two payers.

4.2. Develop infrastructure for revenue cycle optimization

4.G. Provide denials management support, coding and billing training, and certification.

4.H. Improve patient engagement to reduce missed appointments and increase revenue by implementing a system to improve patient registration and scheduling.

4.I. Support payer negotiations, patient portal development, and AI/Chatbot technology.

4.3. Implement a pilot for alternative payment model to increase specialty care access

4.J. Provide per diem payments for specialists to provide on-site specialty care in rural hospitals and clinics. The alternative payment model stabilizes specialist earnings during the initial start-up phase, directly compensating for barriers like travel time and the lack of sufficient patient volume. This support is vital to mitigate financial risk and allows specialists to build consistent patient loads so the on-site practice can successfully transition to a financially self-sustainable model that provides a reliable, long-term pathway to specialty care for rural residents.

Table 6: FAST initiative summary of funding, goals, and measures.

Main strategic goal: Innovative care

Use of funds: A, B, C, D, F, H, I, K

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

Key performance objectives: By 2031, Utah will (4.1) strengthen financial sustainability by increasing the # of rural health systems equipped to implement value-based payment models by two; (4.2) improve financial sustainability in rural healthcare by increasing the % of rural facilities optimizing revenue cycle management (baseline pending; targets to follow).

Outcomes and measures: A.3, A.4, A.5, A.6, B.1, B.2, B.3, B.6, 4.1, 4.2, 4.3 (Tables 11 and 12)

Key stakeholders: Primary care and RHCs, rural EMS agencies, rural and CAHs, FQHCs, state and local health departments, LMHAs, CBOs, payers, technology providers, tribal governments and tribal organizations, Utah Indian Health Advisory Board, Indian Health System (I/T/U) partners.

Impacted counties: All rural counties in Utah: 01448015, 01448017–19, 01448021–30, 01448032–37, 01448039–41, 01455158, 01455966

Estimated required funding: $65,000,000

5. Leveraging Innovation for Facilitated Telehealth (LIFT)

Description

The LIFT initiative aims to improve sustainable physical and behavioral healthcare access and outcomes in Utah's rural communities through scalable, data-informed, telehealth strategies, reinforced by training and technical assistance to facilitate effective implementation and lasting impact. Access issues which plague rural Utah lead to negative health outcomes including lower survival rates for cancers, higher rates of death by suicide, and limited access for treatment for myriad behavioral health challenges.[lxviii] Together, these challenges highlight an urgent need to expand access to timely, high-quality care in rural communities through telehealth.

Additionally, this RHT plan's extensive focus on workforce emphasizes the serious concerns around healthcare workforce shortages across primary care, behavioral health, maternity, dental, and both adult and pediatric specialty services. As previously highlighted, many counties are designated as Health Professional Shortage Areas (HPSA). While attracting the workforce to rural communities is a critical strategy to improve access to healthcare for those who live in Utah's rural and frontier counties, additional innovative strategies are required given that there will never be enough healthcare providers to meet the needs of Utah's rural population.

The LIFT initiative attempts to enhance Utah's RHT plan's focus on workforce as a strategy to access and implement innovative additional strategies that address systemic barriers, including limited broadband service, fragmented electronic health records, telehealth integration gaps, reimbursement restrictions, cybersecurity constraints, and insufficient digital literacy among both patients and providers.[lxix,lxx] The removal of these systemic barriers will allow Utah's rural communities to embed a wide array of telehealth services and in-home medical care, thereby ensuring improved health outcomes for patients who require healthcare from the most minor of issues to the most serious such as cancer.

Telehealth offers a strategic solution to expand access to care, improve outcomes, and support workforce efficiency. By leveraging remote consultations, virtual monitoring, and integrated care platforms, rural providers can deliver timely,

preventive, and specialty services closer to patients' homes. Telehealth also enables point-of-care medication access, reduces delays in treatment, and supports chronic disease management, behavioral health, and maternal care.[lxxi] While the COVID-19 pandemic introduced Utah to the value of telehealth and remote healthcare delivery, limited funding and barriers impeded the opportunity to fully integrate telehealth in Utah's healthcare delivery models. The LIFT initiative provides the opportunity to expand access to healthcare through telehealth while also addressing broadband gaps and interoperability challenges; providing training to medical professionals; leadership engagement; and digital literacy to patients.

The LIFT initiative will employ a multi-stakeholder approach to supporting new and existing innovative, data-informed, and scalable projects across rural Utah that take into consideration: (1) the healthcare and telehealth needs in rural communities; and (2) existing telehealth resources and gaps, including those in policy, education, training, technical assistance, and technology capabilities.

Key actions

5.1. Expand access care through telehealth services and support implementation

5.A. Establish a multi-stakeholder consortium with representatives from rural and urban healthcare sub-specialty providers, community health organizations, network and security providers, nutrition and wellness specialists, vendors, and other key community partners to guide activities.

5.B. Conduct a telehealth needs assessment, including a community survey, to assess the landscape and develop actionable recommendations. Potential activities may include a community education campaign to telehealth utilization, telehealth access points (TAPs) mapping, and supportive training and technical assistance.

5.C. Fund scalable, sustainable projects to meet needs that align with telehealth consortium recommendations. Projects may be related to preventive and primary care; chronic disease and cancer care; behavioral healthcare; acute, emergency and in-patient care, emergency services; maternal and infant health; medication access and adherence; and oral health. These may include virtual visits, nurse triage, health coaching, collaborative care

management, mobile screening, virtual scribes/AI documentation, school-based telehealth, tele-ophthalmology, remote monitoring, crisis intervention, virtual therapy, tele-psychiatry, tele-wound care, EMS tele-triage, tele-stroke, en-route telemonitoring. wellness and nutrition virtual education, virtual perinatal care, lactation support, tele-pharmacy, remote medication counseling, point of care (POC) automated dispensing, tele-dentistry, and remote dental exams.

5.D. Support onsite and virtual training and technical assistance for project implementation, management, and sustainability. This may include offering digital literacy education for providers, patients, and community members to ensure effective use.

Table 7: LIFT initiative summary of funding, goals, and measures.

Main strategic goal: Sustainable access

Use of funds: A, B, C, D, E, F, G, H, I, J, K

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

Key performance objectives: By 20231, Utah will (5.1) increase the % of patients in rural counties with access to telehealth services by 50%; (5.2) increase the # of specialties available via telehealth (baseline pending; targets to follow).

Outcomes and measures: A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, B.1, B.2, B.3, B.4, C.1, C.2, C.4, C.5, D.1, D.2, D.3, 5.1, 5.2, 5.3 (Tables 11 and 12)

Key stakeholders: State and local health departments, rural and CAHs, FQHCs, health systems, technology providers, health professions organizations, CBOs, state and local education agencies, correction facilities, academic medical centers, Utah Education and Telehealth Network (UETN), Northwest Regional Telehealth Resource Center, tribal governments and tribal organizations, Utah Indian Health Advisory Board, Indian Health System (I/T/U) partners.

Impacted counties: All rural counties in Utah: 01448015, 01448017–19, 01448021–30, 01448032–37, 01448039–41, 01455158, 01455966

Estimated required funding: $125,000,000

6. Shared Utilities for Partnered Provider Operational Resources and Technology (SUPPORT)

Description

The SUPPORT initiative partners with rural facilities to build critical digital, technological, and administrative infrastructure offering collaboration and pooled or shared resources that leverage economies of scale while preserving operational autonomy.

Rural Utah healthcare facilities operate on limited budget flexibility.[lxxii] Their low patient volume prevents them from achieving economies of scale that larger, from which urban systems benefit from. This results in high, fixed costs per patient, purchasing disadvantage, revenue cycle complexity, and inadequate cyber-resiliency. The unique challenges faced by rural facilities, which may be small and independent, and CAHs, can be effectively alleviated through the strategic implementation of shared services.[lxxiii] Although these facilities may individually serve fewer patients and be geographically or organizationally isolated, they can pool and leverage shared resources to achieve economies of scale. Administrative services that are common across most facilities, but require specialized, costly talent or technology, are especially well-suited for collaboration. The functions well-suited for collaboration and shared services include shared systems for information technology and cybersecurity, centralized human resource recruiting, and other administrative or operational functions.

One of the largest drivers of provider burnout is the time spent on administrative and non-clinical tasks, which takes time away from direct patient interaction.[lxxiv] Providers often spend excessive hours inputting data into complex electronic health records (EHRs) and managing documentation requirements. Providers also lack immediate, shared access to specialists for real-time consultation, diagnosis, and monitoring which makes it more difficult to safely manage the care of patients with complex medical conditions. Also, fewer resources committed to cybersecurity leave patients' most sensitive protected health information (PHI) vulnerable to breaches and ransomware attacks. Cyber events also threaten a system's ability to remain operational, keeping essential

clinical services available and preventing mass appointment cancellations and delays in care.

Shared services offer rural healthcare facilities a lifeline by providing the scale and sophistication needed to operate in the modern healthcare environment. The SUPPORT initiative seeks to advance data and administrative infrastructure in rural health by helping providers to invest in, and pool resources to modernize EHRs, enhance patient access, strengthen cybersecurity capabilities and training, and implement consumer-facing tech and AI solutions.

Key actions

6.1. Support investments in EHR upgrades and improved patient access

6.A. Fund rural sites to upgrade, enhance, and modernize their EHR systems, with consideration given and options available for shared and pooled platforms and services.

6.B. Support sharing of EHR platforms where feasible under the federal EHR Donation Safe Harbor and Stark Law exceptions, ensuring that there is interoperability among systems and data is accessible at the individual and community level.

6.C. Work with rural sites to evaluate levels of patient access to their own healthcare data and implement solutions that increase patient access to this data.

6.2. Defend rural facilities from cyberattacks

6.D. Deploy multi-factor authentication (MFA) for users to defend against compromised user credentials, not broadly implemented in rural facilities due to resource constraints.

6.E. License and deploy endpoint detection and response (EDR) software to detect, investigate, and respond to advanced threats that bypass traditional security measures to servers, workstations, and connected medical devices.

6.F. Purchase and manage tools and software for threat intelligence and patch management to identify vulnerabilities and push urgent security patches and software updates to connected devices simultaneously.

6.3. Equip rural providers through shared cybersecurity expertise and training

6.G. Conduct annual, standardized risk assessments and vulnerability scanning across all participating facilities, which will also fulfill regulatory requirements (e.g., HIPAA) and identify unique gaps for participating clinics or hospitals.

6.H. Provide high-quality, continuous security awareness training for all staff (clinical and administrative), focusing on current cyber threats and attacks.

6.I. Offer fractional access to a qualified chief information security officer (CISO) who advises leadership at each rural hospital on governance, risk management, business continuity, and strategic security planning, a role otherwise completely inaccessible to a standalone facility.

6.4. Deploy consumer-facing tech and AI solutions

6.J. Identify and make available solutions that automate routine tasks like appointment booking, prescription refill requests, and general practice inquiries to improve patient access and frees up the limited staff in rural clinics to focus on direct patient care.

6.K. Identify and make available AI-powered remote patient monitoring (RPM) tools to analyze data from vendor-provided or consumer-owned devices (smartphones, wearables) to track vital signs, fetal monitoring, or chronic conditions.

6.L. Identify and deliver tailored information and personalized wellness plans based on a patient's health data, promoting self-management of chronic conditions, supporting prenatal and maternal care, and improving overall adherence to treatment.[lxxv]

6.5. Facilitate clinical technology and AI solutions

6.M. Identify and make available clinical AI agents or similar technologies to assist with note generation, chart summarization, diagnosis history, ordering, and/or treatment recommendations.

6.N. Identify and make available a charge and coding AI agent or similar technologies to review documentation for recommended charge levels (CPT codes) and assist with updating diagnosis/problem lists (HCC codes).

Table 8: SUPPORT initiative summary of funding, goals, and measures.

Main strategic goal: Tech innovation

Use of funds: C, D, F, K

Technical score factors: C.1, F.1, F.2, F.3

Key performance objectives: By 2031, Utah will (6.1) increase the # of rural healthcare facilities using new and emerging technologies (baseline pending; targets to follow); (6.2) increase the # of rural healthcare facilities participating in shared services models (baseline pending; targets to follow).

Outcomes and measures: A.7, B.1, B.2, B.3, C.1, C.2, C.3, 6.1, 6.2 (Tables 11 and 12)

Key stakeholders: FQHCs, primary care and RHCs, CBOs, rural and CAHs, state and local health departments, nonprofit organizations, health systems, technology providers.

Impacted counties: All rural counties in Utah: 01448015, 01448017–19, 01448021–30, 01448032–37, 01448039–41, 01455158, 01455966

Estimated required funding: $80,000,000

7. Leveraging Interoperability Networks to Connect Services (LINCS)

Description

The LINCS initiative aims to create a connected health ecosystem for rural Utah communities by modernizing the interoperability and secure exchange of health data among clinics, hospitals, public health and behavioral health entities, as well as community-based organizations. As an innovation leader, Utah's approach aligns directly with the CMS Interoperability Framework, advancing open, standards-based data exchange and positioning the state at the forefront of using interoperability to transform rural health care. This initiative will enable Utah to

create a digital ecosystem where data sharing leads to real-time, secure, and seamless care coordination.

Rural healthcare organizations often operate on isolated EHR platforms with limited ability to share patient data across systems.[lxxvi] The lack of interoperability also limits participation in value-based payment models, population health management, and chronic disease monitoring. Many federal and state programs require accurate, shareable data to measure quality and outcomes. Rural providers without interoperable systems struggle to report performance metrics or qualify for incentive payments, which puts them at a financial disadvantage.[lxxvii]

Many rural residents live with chronic diseases such as diabetes, COPD, or heart disease. Managing these conditions requires collaboration among primary care providers, specialists, pharmacists, and social workers. Limited health data exchange between systems creates a high likelihood of missing pertinent data at the point of care and costly duplication of diagnostic services. The management of paper records, access to multiple portals, and communication with payers is problematic. Without direct access and interoperability, patients must either request records from time-strapped rural clinics or manually carry incomplete information between local and specialty providers. By giving patients' control, they become active partners in their care. They can ensure their record is complete, supplement it with information from other sources, and seamlessly coordinate their own care.[lxxviii]

Utah lacks a timely and comprehensive statewide chronic disease monitoring system which hinders effective public health action. This deficit prevents the implementation of targeted, data-driven public health actions and interventions aimed at improving patient outcomes. Additionally, the absence of comprehensive, statewide chronic disease data differentiated by geographic area impacts accuracy in assessing needs, allocating resources, and evaluating the effectiveness of public health interventions in rural and urban areas of the state.

Utah's early success in modernizing health data exchange through statewide collaboration provides a strong foundation for this effort and a model for expanding innovation to rural communities.[lxxix] The LINCS initiative will further help rural providers modernize healthcare interoperability and expand patient data

access by enabling secure viewing and sharing of health records. The initiative also includes developing and applying a cloud-based semantic data platform that harmonizes data from multiple sources—including EHRs and claims—into a single, computable structure using open-source frameworks.[lxxx]

Key actions

7.1. Support rural providers to modernize interoperability capabilities

7.A. Understand rural providers' current interoperability capabilities to identify technical gaps, readiness, barriers, and data quality of information sharing.

7.B. Facilitate rural site connectivity to exchange data electronically via recognized data exchange standards such as HL7® FHIR® APIs, directly and through a modernized state interoperability platform, such as the state's Health Information Exchange (HIE), by providing technical assistance, potential funding to offset EHR vendor connectivity costs, and ongoing training for key stakeholders.

7.C. Evaluate the quality of data being exchanged against established standards and support providers to bring data feeds up to completeness and quality requirements.

7.D. Support the acquisition of modules or solutions that improve exchange between electronic medical records (EMRs) and community partners by enhancing consent management capabilities to improve and enable exchange of non-medical drivers of health information with community-based organizations, and organizations with laws more restrictive than HIPAA (e.g., 42 CFR Part 2 facilities).

7.E. Streamline electronic submission to state public health registries—directly or through statewide interoperability networks—and improve onboarding and validation.

7.F. Provide education, recruitment, and training for analytics and informatics staff.

7.2. Expand patient access to health information

7.G. Increase options for patients in rural areas to meet their healthcare needs by enabling them to securely view, download, and share their health information through applications or portals. Patient access may be enabled through the state HIE, individual providers' patient portals, or through participating providers that adopt recognized data exchange standards, such as HL7® FHIR® APIs, ensuring flexibility and alignment with federal goals for patient-centered interoperability.

7.H. Support targeted provider outreach to help rural clinics understand how patient-directed access reduces their record request burden and improves patient engagement.

7.3. Build a cloud-based and semantically interoperable open data model

7.I. Establish a statewide, cloud-based, semantically interoperable data platform that harmonizes information from EHRs, claims, and public health systems into a consistent, computable structure using open-source frameworks.[lxxxi] This platform will enable real-time data exchange, and create a foundation for analytics, clinical decision support, AI innovation, and other applications of interest to rural hospitals. It will also expose standardized data through HL7® FHIR® APIs, enabling interoperability with the HIE, integration with clinical and operational partners, and secure, direct access for patients—advancing both exchange and patient participation.

7.J. Translate heterogeneous data from multiple EHR vendors into a shared semantic model. Enable rural providers to participate in a unified ecosystem where data is accurate, comparable, and ready for reuse in clinical and administrative workflows.

7.4. Support applications of the semantic data model

7.K. Leverage the semantic data model to explore the potential of a wide range of clinical, operational, and public health applications that can be rapidly deployed. Below are early use cases that may be enabled by this platform: enable public health and rural hospitals to monitor and respond to chronic

conditions through real-time, population-level insights; automate payer-provider workflows to reduce administrative burden and speed up prior authorization, claims adjudication, and payments; reduce duplicate tests and procedures by making readily available patient history including lab and imaging results across different providers and facilities; seamlessly integrate data generated during a telehealth visit (e.g., e-visits, remote monitoring) into the patient's EHR and accessible to all treating providers; support value-based care models through the use of accurate, aggregated patient data which is essential for success in value-based care arrangements; simplify Healthcare Effectiveness Data and Information Set (HEDIS) quality reporting, reduce manual effort, and support value-based care.

Table 9: LINCS initiative summary of funding, goals, and measures.

Main strategic goal: Tech innovation

Use of funds: A, C, D, F, I, K

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

Key performance objectives: By 2031, Utah will (7.1) improve interoperability capabilities in rural healthcare facilities, as measured by annual assessment of readiness, data exchange, and usability (baseline pending; targets to follow).

Outcomes and measures: B.1, B.2, B.3, C.1, C.2, C.3, 7.1, 7.2, 7.3 (Tables 11 and 12)

Key stakeholders: Rural and CAHs, payers, primary care and RHCs, healthcare providers, care facilities, LMHAs, state and local health departments, CBOs, technology providers, One Utah Health Collaborative.

Impacted counties: All rural counties in Utah: 01448015, 01448017–19, 01448021–30, 01448032–37, 01448039–41, 01455158, 01455966

Estimated required funding: $110,000,000

C. Implementation plan and timeline

The following overarching implementation plan and timeline provides current best estimates for key milestones and activities, with updates to be provided in annual reporting. More detailed initiative and activity implementation plans and timelines are included in the attachments.

Ongoing activities FY2026–FY2031

- Stakeholder engagement
- Public communications on project updates
- Regular site visit and contract monitoring
- Outcomes/outputs reporting and monitoring
- Monthly CMS calls and ongoing communications
- Quarterly and annual CMS reporting

State policy actions FY2026–FY2028

- Engage state legislators on policy actions Q2 FY2026–Q2 FY2027.
- State legislative action B.2 enacted by Q1 FY2028.

Stage 0—Project planning is underway. Q2 FY2026–Q2 FY2027

- State legislative appropriations by Q2 2026.
- Establish stakeholder engagement and governance structures by Q1 2027.
- Strategic planning and final adjustments per legislative appropriations by Q3 2026.
- Identify internal project staff and recruitment preparation by Q3 2026.

Stage 1—Initial work on implementing the initiative has begun. Q2 FY2026–Q2 FY2027

- Onboard and train new staff and provide orientation for existing staff by Q4 2026.
- Subaward/subcontract preparation and release by Q1 2027.

- Establish partner reporting requirements and tools by Q2 2027.
- Select and finalize contracts and agreements by Q2 2027.
- Sub-recipients/awardees/contractors' kick off meetings and training by Q2 2027.

Stage 2—Implementation is underway. Q2 FY2027–Q4 FY2027

- With sub-recipients, align implementation with rural community needs by Q4 2027.
- Develop initiative project criteria, eligibility, and processes by Q4 2027.
- Select and finalize subcontracts and sub agreements to support initiative partners in securing platforms, devices, equipment, and/or products and services by Q4 2027.
- Initiative projects are launched and operational by Q4 2027.

Stage 3—Implementation is halfway complete. Q1 FY2028–Q1 FY2029

- Midway through implementation; initiative project activities and goals are actively being executed, monitored, and refined. Partially developed ecosystems, infrastructure developed, necessary services/products and procedures by Q1 FY2029.
- Conduct interim evaluation of initiative activities and outcomes to inform mid-course adjustments by Q1 FY2029.

Stage 4—Deliverables and proposed goals are nearly achieved. Q2FY2029–Q2 FY2030

- Finalize implementation; initiative project activities and goals are being realized. Developed ecosystems, infrastructure developed, necessary services/products and procedures in place by Q2 FY2030.

Stage 5—Fully implemented, goals achieved, and measurable outcomes. Q2–Q4 FY2030

- Finalize implementation; initiative project activities and goals realized by Q4 FY2030.

- Conduct outcome evaluation and identify impactful, scalable, and sustainable initiative projects by Q4 FY2030.
- Leverage evaluation findings for expansion and sustainability efforts by Q4 FY2030.
- Disseminate lessons learned, best practices, and project findings through reports, webinars, and community forums to promote replication, scalability, and broader implementation by Q4 FY2030.

Governance and project management structure

Utah's Rural Health Transformation Program (RHTP) will operate under a robust governance and project management structure with the Utah Department of Health and Human Services (DHHS) as designated by Governor Cox as the lead agency, demonstrating commitment at the highest executive level. This framework ensures effective coordination, strong financial accountability, and alignment with state health priorities through frequent communication and defined decision-making processes. An organization chart is available in the attachments.

Key personnel for program administration (executive oversight)

Senior leaders will provide continuous strategic guidance, policy direction, and executive sponsorship for the RHTP. Their roles, agency/office, and primary function are as follows:

- **Executive director**, DHHS executive director: Provides executive oversight and guidance for the RHTP.
- **Sponsor**, DHHS executive director's office: Provides executive endorsement, removes high-level bureaucratic barriers, and ensures strategic alignment with the DHHS mission.
- **Assistant director,** Division of Population Health: Provides direct oversight and guides initiatives related to improving health outcomes and health access in rural areas.
- **Medical director,** Utah Medicaid Program: Provides clinical and policy expertise, ensuring initiatives are integrated seamlessly within Medicaid systems and standards.

- **Director,** State Office of Rural Health: Contributes expertise on the unique needs and infrastructure of rural healthcare providers and communities.

Dedicated RHTP team headcount and functions

DHHS will dedicate 24.8 full time equivalent (FTE) to this program, including: One office director (1.0 FTE); two management support leadership positions (0.75 FTE); three program coordinators (one for project management, one for workforce development subject matter expert (SME), one for innovation and access and technology innovation; 1.8 FTE); one program manager for food infrastructure (1.0 FTE); one program administrator for behavioral health (1.0 FTE); 11 program specialists (five for make rural Utahns healthy; three for workforce development, one for innovation and access and technology innovation; one for maternal and child health SME, one for project assistance; 10.5 FTE); four finance support staff (one financial manager and three financial analysts; 3.5 FTE); three data specialists (2.25 FTE); one contract monitoring auditor (1.0 FTE); one evaluation manager (0.5 FTE); and two administrative support staff (1.5 FTE). This will ensure sufficient capacity for rigorous management, financial oversight, program execution, and continuous evaluation. Additional personnel information is provided in the budget narrative, with resumes available upon request.

Coordination among state agencies and external stakeholders

Coordination will be executed through a formal structure that prioritizes existing, effective communication channels. At the strategic level, the RHTP Steering Committee will meet at least quarterly to provide policy approval, budgetary oversight, interagency conflict resolution, and strategic direction. For operational issues, weekly dedicated RHTP team meetings will guide day-to-day project management and status reporting. Several specialized stakeholder groups will ensure effective coordination of RHTP activities. This includes quarterly HWAC, Utah Medical Education Council (UMEC), and Utah Behavioral Health Commission (UBHC) meetings to review and advise on specialized initiatives (workforce, GME and behavioral health, respectively), ensuring buy-in and alignment with statutory mandates. The One Utah Health Collaborative's Digital Health Interoperability workgroup meets regularly to advance interoperability frameworks that drive healthcare innovation and efficiency statewide. The Utah Indian Health Advisory

Board (UIHAB) meets monthly to discuss health concerns, policies, and programs with DHHS. Progress reports will be presented at Utah Hospital Association (UHA) Rural Hospital Council semi-annual meetings to ensure feedback from 21 rural hospitals and CAHs and guide program adjustment. This multi-tiered coordination plan ensures that decision-making is defined and appropriate to the scope of the change.

D. Stakeholder engagement

Between July and October 2025, the DHHS executed a comprehensive and multi-layered stakeholder engagement strategy to develop Utah's RHT plan. This effort was grounded in the principle that meaningful transformation in rural health systems must be co-designed with the communities served, including patients, providers, tribal representatives, and local leaders.

The engagement process began in July with internal alignment, including the submission of a situation-background-assessment-recommendation (SBAR) to the executive director's office and the appointment of program two co-leads from DHHS Medicaid and DHHS Population Health, reporting to the executive director. The co-lead from Population Health is responsible for the State Office of Rural Health. Early meetings with DHHS leadership laid the foundation for cross-agency collaboration. On July 25, DHHS initiated external outreach by inviting community stakeholders to join the RHTP contact list via its newly established email, signaling the program's commitment to transparency and inclusion from the outset. This process generated an initial list of more than 130 individuals representing a broad range of rural stakeholders—a number that continues to grow.

August marked a surge in strategic consultations. DHHS met with the legislative fiscal analyst, the Office of Legislative Research and General Counsel, the Governor's Office of Planning and Budget, appropriations committees, and individual legislators to align policy and budgetary frameworks. DHHS invited 135 people to the first RHTP Stakeholder Webinar, which included 94 participants. During that webinar, DHHS provided a public-facing overview of the funding opportunity and opened the door to broader dialogue. Engagements with UHA and the Utah Health Improvement Plan's Low-Income Populations working group helped tailor the program to high-need populations.[lxxxii] Additional meetings with

rural providers, provider networks, appropriations committees, and UBHC ensured extensive input. On August 26, DHHS launched the RHTP webpage,[lxxxiii] providing a centralized hub for updates, resources, and a stakeholder survey. This survey garnered 106 responses, a strong signal of community interest and investment.

In September, DHHS transitioned from outreach to activation, establishing four thematic workgroups based on survey results: making rural Utahns healthy, workforce development, innovation and access, and technology innovation. These groups were co-led by an internal and external lead, staffed with subject matter experts, and designed to channel stakeholder expertise into actionable recommendations. Three regional listening sessions were held in rural communities across the state–Cedar City (southwest), Brigham City (north), and Moab (southeast)—drawing close to 40 attendees in each session. These sessions featured structured agendas, transcripts, and meeting minutes, and served as forums for community feedback.

DHHS also deepened its engagement with tribal, local public health, and healthcare entities. Presentations were delivered to UIHAB, the DHHS/local health department coordinating meeting, the governor's rural health workforce strategic planning workgroup, HWAC, UMEC, and UHA's Rural Hospital Council. September 24 marked the second stakeholder webinar to introduce the launch of a solicitation process that garnered more than 200 project proposal ideas and budgets, which further expanded the program's reach and operational readiness.

October culminated in high-level policy integration. DHHS conducted check-ins with the Governor's Office of Planning and Budget and held multiple meetings with legislators, including joint leadership from both chambers. During this time, DHHS engaged in formal consultation with tribal representatives. Efforts culminated in the Utah State Legislature's commitment to rural health transformation through House Joint Resolution 101 (2025), authorizing the state to participate in the RHTP.

October also included workgroup participation at the One Utah Summit, a premier rural event for rural leadership agenda setting. The Summit featured a panel discussion on RHTP, reinforcing the program's visibility and strategic importance. A 2-day virtual open session provided a statewide platform for

dialogue on project proposals and initiatives, followed by final presentations to legislative committees. Finally, RHTP workgroups reviewed project proposals, synthesized ideas, and submitted activities that shaped the development of Utah's seven initiatives and funding allocations, ensuring efforts were grounded in feasible, realistic, and community-driven strategies.

Utah's robust stakeholder engagement reflects a commitment to participatory governance to ensure stakeholder engagement is not a one-time event but a continuous, embedded process that drives decision-making and accountability throughout the program lifecycle. Letters of support are included in attachments.

Table 10: List of stakeholders consulted.

Utah Department of Health and Human Services (DHHS), which includes the involvement of the following divisions: Medicaid; Office of Primary Care and Rural Health (Utah's State Office of Rural Health); Office of Substance Use and Mental Health; Data, Systems, & Evaluation; American Indian/Alaska Native Health & Family Services; Division of Population Health. Additional stakeholders include: Governor's Office of Planning and Budget; Utah state legislators, leadership, and legislative committees; Office of the Legislative Fiscal Analyst (LFA); Office Of Legislative Research and General Counsel; One Utah Health Collaborative; local health departments (LHDs); University of Utah Healthcare; Intermountain Healthcare; Rural 9 Hospital Network; Utah Hospital Association Rural Hospital Council; Utah Behavioral Health Commission; Utah Medical Education Council; Utah Health Workforce Advisory Council; Built Here rural health workforce workgroup; Utah Indian Health Advisory Board (UIHAB); Utah tribal representatives; Indian healthcare providers; FQHCs; Association for Utah Community Health (AUCH); Department of Public Safety, Division of Emergency Management Services; community leaders (e.g., local attendees at listening sessions); patients and providers (via public listening sessions and survey); and local and national vendors (via project proposal submission).

Ongoing stakeholder engagement strategy

Continued and strategic stakeholder engagement is paramount for a seamless transition into the implementation phase. Continuing with the robust process developed to inform the application, DHHS will employ a tiered stakeholder engagement strategy to ensure that decisions continue to be informed, innovative ideas are captured, and expertise, particularly lived experience, is fully leveraged. This is specifically designed to meaningfully involve all partners who contribute to and support initiatives benefiting rural Utahns.

Tiered engagement approach

- **Steering committee:** Composed of senior decision-makers, this committee will provide essential high-level oversight and executive support for programmatic implementation. It will continue the commitment established by leaders across healthcare, state agencies, and rural legislators during the planning phase, ensuring continuous support. Proposed members to include: representatives from DHHS, the Governor's Office of Planning and Budget, the legislature, relevant executive branch agencies, and appropriate tribal and local government entities. Membership will be strategically expanded or adjusted to incorporate expertise as specific areas of interest or implementation needs arise.
- **Implementation partners:** This structure represents a direct continuation of the foundational workgroups—Making Rural Utahns Healthy, Workforce, Innovation and Access, and Technology and Innovation—responsible for initial project proposal review and initiative design. Composed of industry leaders and experts who will be executing the projects, this group is uniquely positioned to deliver the critical, operational input and practical perspective required to guarantee the relevance, efficacy, and successful deployment of all RHTP efforts. It will include engagement building on existing advisory workgroups, ensuring continuity, alignment, and informed decision-making.
- **Patients and rural community feedback**: This engagement mechanism is vital to obtain direct, critical feedback from patients and family members who receive RHTP-supported services. It will gather community-level information regarding the broader impact of services on individuals and

communities. This grassroots-level structure will regularly interface with the steering committee and implementation partners, ensuring a continuous feedback loop that drives the sustained quality and responsiveness of services.

- **Sovereign tribal partners**: Facilitated through existing state and tribal entity policy and infrastructure, DHHS will regularly consult with tribal leadership to inform and align efforts in rural Utah. FQHCs and other community clinics dedicated and specialized in tribal health services, take part in the implementation partners' tier. This ensures that providers serving all rural communities, including tribal members, are contributors and beneficiaries of the RHTP initiatives.
- **Public transparency:** DHHS is committed to maintaining ongoing stakeholder engagement and transparency with interested partners and with all rural Utah communities through dedicated webpage updates, email notifications, webinars, listening sessions, open meetings, and additional communication outlets of the state of Utah.

This tiered framework will include recurring and formal coordination at various levels with key state entities including DHHS and its following divisions: Medicaid, Office of Primary Care and Rural Health (Utah's State Office of Rural Health) , Office of Substance Use and Mental Health, Data, Systems, and Evaluation, and Office of American Indian/Alaska Native Health and Family Services. Governance structures are designed to reflect the communities served, with mechanisms for continuous feedback, milestone tracking, and impact assessment.

E. Metrics and evaluation plan

Key program outcomes and measures anticipated to evaluate success for each initiative are outlined in Table 11. All initiatives contribute toward achieving the key outcomes. Together, the seven initiatives are designed to function as an integrated system of improvement—each reinforcing the others to collectively advance Utah's overarching outcomes of improved health, access, quality, and workforce stability in rural communities. By aligning shared metrics across initiatives and analyzing data at the county and community level, Utah commits to

achieving a greater cumulative impact—demonstrating broader, measurable improvements in rural health outcomes and system performance than any single initiative could achieve independently. Table 12 outlines additional outcomes and performance measures specific to each of the seven initiatives. Table 13 is a key for Tables 11 and 12. Data sources, baselines, and targets have also been outlined, as available. These proposed metrics are preliminary and subject to change according to initiative and activity development based on awarded funding. Further statistical analysis specific to rural data to more accurately determine true baselines and targets will be completed post award. Data sources will include survey data such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Utah Student Health and Risk Prevention (SHARP) survey, state data systems, and progress reports from contracted partners. Staff overseeing data collection and analysis have several years of experience collecting, analyzing, managing, and reporting data for federal grants. Processes to ensure timely and complete data collection and reporting will be built into contracts with health facilities, key partners, and other contractors. Data will be collected and analyzed annually for annual progress reporting.

Table 11: Key program outcomes and measures.

Outcome measure (related initiatives)	Data source	Baseline	Target
A. Improving outcomes: Improved healthy behaviors and health outcomes in chronic disease, behavioral health, and maternal and infant care across rural Utah.			
A.1. % of Utah adults living in rural counties with obesity (BMI 30+) (1, 3, 5)	BRFSS	29.6%*	-5%
A.2. % of Utah children with obesity in grades 6–12 living in rural counties (1, 3, 5)	SHARP	10.5%	-5%
A.3. % of Utahns who report poor mental health living in each rural county (1, 2, 3, 4, 5)	BRFSS	21%**	-10%

A.4. Rate of suicide deaths per 100,000 population in rural counties (1, 2, 3, 4, 5)	Death certificates	20.6	-10%
A.5. % of women in rural counties with first trimester prenatal visit (1, 2, 3, 4, 5)	Birth certificates	63.3%	+10%
A.6. % of women in rural counties with a postpartum visit (1, 2, 3, 4, 5)	PRAMS	92.9%	+5%
A.7. % of people in rural counties with a routine check-up in past year (1, 2, 3, 5, 6)	Contractor reports, BRFSS	71%*	+10%
A.8. % of women ages 18-44 in rural counties with a routine check-up in past year (1, 2, 3, 4, 5)	BRFSS	65%*	+10%
B. Improving access: Expanded access to healthcare and essential health services so people in rural areas can get the care they need, when and where they need it.			
B.1. # of rural hospitals and facilities at risk of service reduction or closure (2, 3, 4, 5, 6, 7)	Contractor reports	0	0
B.2. % of Utahns living in rural counties who report having to wait more than 3 months for a healthcare appointment (2, 3, 4, 5, 6, 7)	BRFSS	–	-10%
B.3. % of Utahns living in each rural county that report waiting more than 3 months for a specialty visit (2, 3, 4, 5, 6, 7)	BRFSS	–	-10%
B.4. % of Utahns living in rural counties who drive more than 30 minutes to receive routine care (2, 3, 5)	HWIC	TBD	-TBD

C. Improving quality: Strengthened systems that support high-quality care and services with improved coordination, standards, and continuous quality improvement.			
C.1. % of clinics in rural counties with improved primary care clinical quality measures (1, 3, 5, 6, 7)	Contractor reports, HEDIS	TBD	+TBD
C.2. % of rural facilities utilizing interoperable capabilities (5, 6, 7)	Contractor reports	TBD	+TBD
C.3. % of rural facilities reporting increased patient healthcare data access and utilization (1, 6, 7)	Contractor reports	TBD	+TBD
C.4. % of preventable hospitalizations in rural facilities (1, 2, 3, 5)	Contractor reports	TBD	-TBD
C.5. % of hospital readmissions in rural facilities (1, 2, 3, 5)	Contractor reports	TBD	-TBD
D. Strengthening workforce: Strengthened workforce stability to ensure rural communities have a skilled and reliable healthcare team.			
D.1. # of rural counties with at least 1 primary care provider per 1,000 people (2, 3, 5)	HWIC	TBD	+TBD
D.2. # of healthcare providers recruited in rural Utah (2, 3, 5)	Contractor reports	–	+5%
D.3. % of rural counties with at least 1 mental health provider per 1000 people (1, 2, 3, 5)	HWIC	TBD	+TBD
D.4. % of EMS provider retention in rural agencies (2, 3)	HWIC	TBD	+TBD

Table 12: Performance measures and outcomes.

Outcome measure (Initiative; strategic goal)	Data source	Baseline	Target
Initiative 1: *PATH* (Preventive Action and Transformation for Health; Making Rural Utahns Healthy)			
1.1 % of Utah adults living in rural counties that meet fruit and vegetable consumption recommendations	BRFSS	11%*	+15%
1.2 % of rural counties with increased access to fresh whole foods	Contractor reports	–	+25%
1.3 % of students at each rural LEA implementing *Gold Medal Schools* that meet fruit and vegetable consumption recommendations	SHARP	TBD	+TBD
1.4 % of students at each rural LEA implementing *Gold Medal Schools* that meet physical activity recommendations	SHARP	19.6%**	+15%
1.5% of Utahns living in rural counties that report using active transportation	BRFSS	35%*	+5%
1.6 % of Utahns living in rural counties that report no leisure physical activity	BRFSS	17%*	-10%
1.7 % of referrals for follow-up clinical services completed through CCH	Contractor reports	–	+TBD

1.8 % of referrals for follow-up social services completed through CCH	Contractor reports	–	+TBD
1.9 % of patients in rural counties screened for depression, anxiety, and SUD in primary care	Contractor reports	TBD	+TBD
1.10 % of BHI/CoCM patients with an improved score on validated tools	Contractor reports	TBD	+TBD
Initiative 2: *RISE* (Rural Incentive and Skill Expansion; Workforce development)			
2.1 # of primary care providers (MD, DO, APRN, PA) in rural counties	NPI	1,189	+5%
2.2 # of new providers trained in each rural county	Contractor reports	–	+1/year
2.3 % of providers retained in each rural county after 1, 2, and 3 years	Contractor reports	–	+50%
2.4 # and type of improvements to workforce shortages	Contractor reports	–	+TBD

Initiative 3: *SHIFT* (Sustaining Health Infrastructure for Transformation; Innovation and acces			
3.1 # and type of improvements to rural health facilities that increase capacity to deliver quality healthcare	Contractor reports	–	+TBD
3.2 # of EMS preventive and post-discharge visits in rural areas	EMS	TBD	+TBD
3.3 % of non-emergent EMS transports in each rural Utah county	Contractor reports	TBD	-TBD
3.4 # of repeat EMS/911 calls by patients with chronic conditions in rural counties	EMS	TBD	-TBD
Initiative 4: *FAST* (Financial Approaches for Sustainable Transformation; Innovation and access)			
4.1 % of rural health facilities in each rural county with data infrastructure in place for value-based payment	Contractor reports	–	+TBD
4.2 # and type of improvements to revenue cycle	Contractor reports	–	+TBD
4.3 % of rural health facilities with improved revenue cycle (denial rate, clean claim rate, etc.)	Contractor reports	–	+TBD

Initiative 5: *LIFT* (Leveraging Innovation for Facilitated Telehealth; Innovation and access)			
5.1 # and type of improvements to increase capacity to deliver quality healthcare via telehealth	Contractor reports	–	+TBD
5.2 % of patients in each rural county using telehealth services	Contractor reports, BRFSS	24.5%*	+50%
5.3 # and type of specialties provided via telehealth in rural counties	Contractor reports	–	+TBD
Initiative 6: *SUPPORT* (Shared Utilities for Partnered Provider Operational Resources and Technology; Technology innovation)			
6.1 % of participating facilities in each rural county with MFA and EDR fully implemented and deployed	Contractor reports	TBD	+TBD
6.2 % of physicians at participating facilities in each rural county reporting decreased documentation and charting time	Contractor reports	TBD	+TBD

Initiative 7: *LINCS* (Leveraging Interoperability Networks to Connect Services; Technology innovation)			
7.1 % of rural facilities in each rural county that report complete and timely data to public health	DHHS reports	TBD	+TBD
7.2 # of manual prior authorization submissions and corresponding electronic approvals	DHHS reports	TBD	+TBD
7.3 % improvement in each category of an annual interoperability assessment across participating facilities (e.g., technical readiness, data completeness, data usability, and clinician experience, etc.)	Contractor reports	–	+TBD

Table 13: Key to Tables 11 and 12.

– Baselines unavailable; TBD: Baselines and targets to be established; *Baselines estimated for rates combined across counties designated as rural and frontier; **Baselines reflect a total for all rural counties or LEAs. Baselines for each county or LEA will be reported post award.
Acronyms: body mass index (BMI); Behavioral Risk Factor Surveillance System (BRFSS); Student Health and Risk Prevention survey (SHARP); emergency department (ED); Pregnancy Risk Assessment Monitoring System (PRAMS); Healthcare Workforce Information Center (HWIC); Healthcare Effectiveness Data and Information Set (HEDIS); local education agency (LEA); community care hub (CCH); substance use disorder (SUD); behavioral health integration (BHI); collaborative care model (CoCM); National Provider Identifier (NPI); Emergency Medical Services (EMS); multi-factor authentication (MFA); endpoint detection and response (EDR); electronic prior authorization (ePA)

Program evaluation

Utah confirms it will cooperate with any CMS-led evaluation or monitoring. Formal evaluations will be contracted out to evaluate the effectiveness and impact of innovative pilot projects as funding is available. These may include projects related to interoperability, telehealth, EMS, new models of care, workforce pathways programs, food infrastructure, and the community care hub. Evaluation efforts requiring subject matter expertise will be built into initiative contracts. These may include semantic data modeling, value-based care, graduate medical education (GME), non-GME programs, and shared services. We will incorporate basic evaluation metrics into contractor reporting for other initiatives.

F. Sustainability plan

Utah is recognized as among the best managed states due to its adoption of a key government financing principle to utilize one-time funds for one-time expenses. The Utah State Legislature embedded that principle when it endorsed its support of Utah's application for RHTP funding by adopting language stating "initiatives should seek to create sustainable positive financial outcomes without creating future financial obligations for the state."[lxxxiv] As a result, Utah's strategy for the RHTP is designed to generate permanent, systemic, and generational change, not temporary reliance on federal infusions. This aligns with the intent of the RHTP encouraging states to reject investments for projects that will not be sustainable upon completion of the program. The plan prioritizes one-time projects or upgrades and focuses on establishing models that are self-sustaining and shifting payment models to reward value and efficiency. Where appropriate, a phased approach will be employed to scaling back funding, while contractors find ways for self-sustainability over the course of the funding cycle.

Key Initiatives:

1. **Making rural Utahns healthy: Preventive Action and Transformation for Health (PATH)**

    - **Financial and operational viability:** Establish payment streams for high-value preventive services (Medicare, Medicaid, private payers). Build administrative systems within the CCH to contract with health plans and

Accountable Care Organizations (ACOs), ensuring reliable revenue. Diversify funding for CCH infrastructure.

- **Community and programmatic sustainability:** Strengthen grassroots infrastructure like local food hubs for permanent market opportunities. Transfer built environment improvements (bike lanes, trails) to local government for long-term maintenance. Institutionalize wellness efforts through the Utah *Gold Medal Schools* program to formalize policies in rural education agencies.

2. **Workforce initiative: Rural Incentive and Skill Expansion (RISE)**

- **Financial and operational viability:** Secure long-term viability through state appropriations, tax credits, and GME subsidies. The preceptor model requires a one-time startup investment, with sustainability through a 10% surcharge on biennial license renewal fees for participating professions. Explore cost-sharing models for rural GME.
- **Community and programmatic sustainability:** Rural GME sites will function as permanent teaching clinics, generating revenue through patient billing. The "Grow our own" initiative will integrate high school-to-certification programs into the Utah System of Higher Education. Evaluate Medicaid as a financing mechanism for rural GME.

3. **Building clinical and operational models that are structurally and financially resilient: Sustaining Health Infrastructure for Transformation (SHIFT)**

- **Financial and operational viability:** Evaluate options for sustainable payment models. One-time capital improvement costs will enable rural facilities to offer new and billable services. Diversify funding through Medicaid reimbursements for paramedicine visits, ACO partnerships, and taxes embedded in rural EMS plans.
- **Community and programmatic sustainability:** Rural health network members will pay dues after funding ends. Payments for new care models will be sustained by savings from reduced hospital readmissions and emergency department reliance. Consider policy for premium payments for

rural coordinated care, leverage Medicare funds, invest shared savings in community workforce, and dual certification of paraprofessionals.

4. **Financial sustainability: Financial Approaches for Sustainable Transformation (FAST)**

    - **Financial and operational viability:** Pilot and stabilize innovative payment models that shift rural providers from fee-for-service toward value-based care. Initial RHTP support will create infrastructure for revenue cycle optimization to boost operating cash flow and profitability. Diversify funding by proving these models generate shared savings.
    - **Community and programmatic sustainability:** Having specialists in the community performing procedures will allow for sustainability. Facilities that want to continue the program will absorb expenses after RHTP ends.

5. **Telehealth: Leveraging Innovation for Facilitated Telehealth (LIFT)**

    - **Financial and operational viability** Collect data on the cost effectiveness of telehealth modalities to transition services into permanent, parity-reimbursed Medicaid benefits. One-time capital investments will be transferred to rural facility ownership.
    - **Community and programmatic sustainability:** Virtual specialty consultations will reduce patient bypass to urban specialists and keep revenue local. Regional partnerships with maternal-fetal medicine specialists provide sustainable access to high-risk expertise. Collaborative care management, telepsychiatry, and virtual therapy will create sustainable mental and behavioral health capacity within primary care practices.

6. **Shared services: Shared Utilities for Partnered Provider Operational Resources and Technology (SUPPORT)**

    - **Financial and operational viability:** The creation of a shared service organization (SSO) will be sustained by the facilities, with combined costs less than individual operational costs. RHTP funds will establish joint purchasing and back-office services, creating a permanent SSO for administrative functions.

- **Community and programmatic sustainability:** Successful clinical AI tools will be bundled with core telehealth offerings, reducing provider burnout and administrative time, making rural practice more attractive and reducing turnover costs.

7. **Interoperability: Leveraging Interoperability Networks to Connect Services (LINCS)**

- **Financial and operational viability:** A single, cloud-based data model will replace costly vendor interfaces and manual data entry, with sustainability driven by eliminating administrative costs and complexity. RHTP will cover the primary cost of initial programming, with few resources needed for maintenance.
- **Community and programmatic sustainability:** Connecting to a Health Information Network will allow rural facilities broader interoperability. Investments in IT infrastructure and data exchange enable data sharing and cybersecurity resilience, institutionalizing multi-factor authentication and endpoint detection and response.

Integrating lessons into ongoing policy

Utah anticipates there will be many lessons learned throughout the course of the RHTP funding period, much of which cannot be anticipated. The ongoing engagement with the Steering Committee and other stakeholders will support the identification of issues that will need to be addressed through statute, administrative rule, and even procedure. At this point, Utah anticipates it will incorporate the following into state-level policy instruments to ensure permanence:

- **DHHS State-level plans:** DHHS will consider formally incorporating successful RHTP measurable rural health transformation goals (e.g., rural access metrics, specialty coverage rates, behavioral health integration in primary care) into strategic plan revisions. This makes rural transformation a core component of statewide public health planning.
- **Medicaid managed care contracting:** Utah Medicaid, with the Utah State Legislature will explore the integration of successful alternative payment models and new services such as mobile health, paramedicine, and

telehealth, will be integrated as mandatory requirements or incentive targets within Medicaid. This may include leveraging managed care organization (MCO) contracts and establishing a fee structure within Utah's fee-for-service model. The need to incorporate these new payment structures and services lines within Utah Medicaid will be determined upon evaluation of the effectiveness of these new models in terms of cost savings and improved patient outcomes.

Transitioning from phased-out financing

The RHTP directly addresses the challenge posed by recent reductions in federal funding mechanisms, specifically the elimination of certain supplemental payments.

- **Addressing DSH/supplemental payment reductions:** Utah's 2024 legislative actions eliminated "DSH add-on" payments. The RHTP is designed to fill this fiscal vacuum by:
    1. Creating financial viability**:** Help CAHs and providers enhance efficiency, right-size their service offerings, and stabilize financial statements.
    2. Shifting revenue**:** Accelerate the transition to alternative payment models and two-sided risk models, replacing fee-for-service with performance-based revenue that rewards quality and value.
    3. IT investment**:** Upgrading IT systems to ensure rural providers can accurately track and report quality measures necessary to maximize reimbursement under value-based care and Medicare's quality improvement programs.

Utah's RHTP strategy aims for permanent, systemic, and generational change in healthcare by prioritizing one-time projects and self-sustaining models, shifting toward value and efficiency. Key initiatives like PATH (preventive health), RISE (workforce development), SHIFT (resilient infrastructure), FAST (financial sustainability), LIFT (telehealth), SUPPORT (shared services), and LINCS (interoperability) focus on financial viability and community sustainability. The plan also integrates lessons into ongoing policy, including DHHS state-level plans and

Medicaid managed care contracting, and addresses DSH and supplemental payment reductions by creating financial viability, shifting revenue models, and investing in IT. By aligning financial incentives, modernizing infrastructure, expanding telehealth capacity, and addressing workforce shortages, Utah is positioned to cultivate a data-driven, patient-centered rural health system that supports providers to thrive and ensures rural Utahns have consistent access to high-quality care for generations to come.

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[lxxxii]. Note: The Utah Health Improvement Plan (UHIP) is a collaborative, 5-year (2023–2028) statewide initiative designed to tackle key health concerns prioritized by various stakeholders and agencies deeply invested in the well-being of Utah's population. This plan underscores a unified commitment to improving public health outcomes to achieve optimal mental, physical, and economic health. The UHIP is led and coordinated primarily by DHHS and local health department (LHD) staff but relies on strong participation from many organizations and individuals to maximize impact to move the needle within selected priorities.

The Low-Income Populations working group is one of four working groups supporting the UHIP's objectives. Key objectives for this working group include:

- Increased community engagement;
- Decreased social isolation;
- Increased food security among Utah families; and
- Increased federal earned income tax credit usage among eligible Utahns.

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