KENTUCKY RURAL HEALTH TRANSFORMATION PROGRAM APPLICATION

Project Narrative

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RURAL HEALTH NEEDS AND TARGET POPULATION

The Commonwealth of Kentucky is the 10th most rural state in the country, with 1.87 million constituents (41.6%) of its total state population residing in a rural area as defined by HRSA (inclusive of the Goldsmith Modification)[1] and designated as the specific criterion for identifying rural areas in this application (see Appendix A and Appendix B in *Other Supporting Documentation*). The target population includes all rural residents within 109 rural and non-metropolitan counties identified by this HRSA definition, representing 90.8% of the total 120 counties in the state. These rural communities face some of the most significant health access challenges in the Commonwealth and across the country, including high rates of chronic disease, maternal health deserts, behavioral health crises and limited access to preventive dental care and emergency services. To systematically address Kentucky's rural health needs, we have designed five interrelated initiatives to build rural health infrastructure and provide sustainable improvements. Our program is designed to directly serve Kentucky's rural counties while delivering broader, statewide impact through innovation, technology-enabled care, and strengthened clinical and non-clinical workforce recruitment pipelines. Our Rural Health Transformation Plan (RHTP) strategy will create a resilient, integrated, and technology-enabled health system across the Commonwealth.

Rural Demographics

Rural Kentucky is characterized by the proud, resilient nature of its communities along with several challenges that impact access and quality of health care, including geographic dispersion of rural populations requiring longer travel times to access care, limited access to primary care providers and specialists, and higher rates of chronic diseases and preventable hospitalizations compared to urban areas. These health challenges are exacerbated by socioeconomic factors shaping rural health in Kentucky (see Figure 1).

Socioeconomic Factor	Rural/Non-Metro Kentucky	Implication for Kentucky RHTP strategy
Population Size and Density	1.87 million residents; Population density in rural counties averages below 50 persons per square mile, with 70% of the area classified as low-density (<30 persons/sq mi), particularly in eastern Appalachian and western regions.[2]	Improving rural health access will require investment in technology and a workforce focused on community-based, decentralized care for chronic care, maternal health, behavioral health, dental health, and emergency management services.
Median Household Income	$52,000, which is significantly lower than metro average of $64,526.	Limited preventive care and behaviors (e.g., healthy food, exercise) result in higher rates of obesity, diabetes, heart disease, asthma, mental health, and lower life expectancy.
Education and Employment	15.5% of adults lack a high school diploma (74% higher than metro areas), only 10.2% of rural residents hold bachelor's degrees, and non-metro unemployment rate is 4.7%.	Lack of access to education and employment correlates directly with poor health literacy, health outcomes, and engagement in disease self-management programs.
Health Insurance Coverage	7.5% Uninsured Rate (Ages 0-64) in non-metro counties, which is 50% higher than the metro rate.	Lack of health insurance impacts access to care and reduces resources available to community hospitals and health facilities.

Figure 1. Kentucky Rural Health Socioeconomic Conditions

Health Outcomes

According to America's Health Rankings, Kentucky ranks 41st out of 50 states.[3] Average life expectancy ranges from 64.5 to 79.7 years across counties, with a lower life expectancy in counties within Eastern rural areas, such as Harlan, Owsley, and Perry.[4] To address this, Kentucky's RHTP strategies target five critical rural health priorities that disproportionately impact our rural Kentuckians: 1) chronic disease, 2) maternal health, 3) behavioral health, 4) oral health, and 5) emergency medical services (EMS) and trauma systems.

1) Chronic Disease: Kentucky faces a high burden of chronic disease, including cardiovascular disease, chronic obstructive pulmonary disease, obesity, and diabetes (see Appendix C in *Other Supporting Documentation*). Among these, diabetes disproportionately affects rural communities and is a critical priority due to its high prevalence, severe mortality impact, and substantial cost burden. Current efforts focus heavily on downstream care targeting complications and hospitalizations rather than upstream prevention, a reactive model that perpetuates a cycle of high costs and poor health outcomes. Over the past decade, the state's age-adjusted diabetes

mortality rate has been 11.4% to 39.2% higher than national rates.[5] Kentucky consistently ranks among the ten worst states for both adult diabetes prevalence and diabetes-related mortality (see Appendix D in *Other Supporting Documentation)*.[6] Additionally, over 100,000 Kentuckians are unaware they are diabetic,[7] and only half of adults were screened for diabetes in 2021.[8] Access to evidence-based programs such as the Diabetes Prevention Program (DPP) and Diabetes Self-Management Education and Support (DSMES) is limited, and participation is low. In 2023, only 0.4% of adults with diagnosed diabetes (718 of 172,735) engaged in DSMES. Barriers such as transportation, income, access to affordable healthy food, and safe places for physical activity, especially prevalent in rural areas, further restrict progress.[9]

2) Maternal Health: Kentucky faces a maternal health crisis, with nearly 46% of its counties classified as maternity care deserts and 58% of rural women living over 30 minutes from a birthing hospital (see Appendix E in *Other Supporting Documentation)*, contributing to inadequate prenatal care for 14.9% of maternity patients statewide.[10] Kentucky's maternal mortality rate for pregnancy-associated deaths is among the highest in the US, with nearly half its counties lacking obstetric services. While pregnancy-related deaths are small, non-obstetrical causes (e.g., substance use disorder and mental health) lead to 82% of maternal deaths being deemed preventable by the state's Maternal Mortality Review Committee.[11] More than 50% of maternal mortality occurs after delivery, with most deaths happening between 43 days and one year postpartum.[12] As of 2020, Kentucky ranked 33rd out of all 50 US states in infant mortality, and Kentucky's infant mortality rates have increased in recent years.[13] Kentucky's preterm birth rate, a leading driver of infant mortality, long-term disability, and high healthcare costs, is 11.3% (2023), exceeding the national average of 10.4% and ranking 42nd in the nation.[14]

3) Behavioral Health: Rural Kentucky has high rates of untreated mental illness, suicide, and overdose. Suicide is a leading cause of death in Kentucky, ranking among the top five for adults under 45 and 13th overall across age groups.[15] Costs associated with Kentucky's opioid use disorder (OUD) and fatal overdoses (e.g., substance use treatment, criminal justice, lost productivity, reduced quality of life, etc.) totaled nearly $24.5 million in 2017, with per-resident costs among the nation's highest.[16] With limited mental health professionals in rural Kentucky people (see Appendix F in *Other Supporting Documentation)*, such as 30 psychologists per 100,000,[17] behavioral health crisis response too often falls to first responders and emergency departments (EDs). In Kentucky, EDs have reported about 1.1 million annual diagnoses of mental illness or substance use disorder every year since 2020.[18] The problem continues to grow as post-pandemic data shows worsening pediatric boarding with a disproportionate impact on rural youth, high ED utilization, and deepening rural behavioral health workforce shortages.

4) Oral Health: Oral health is linked to chronic disease prevention, diabetes management, behavioral health recovery, and maternal care, positioning this initiative as a lever for whole-person health and healthcare cost reduction. Rural residents experience higher rates of untreated tooth decay, gum disease, and tooth loss compared to urban residents, driven by geographic isolation, transportation barriers, and a shortage of dental professionals.[19] The dental workforce is heavily concentrated in urban areas, leaving the vast rural western Kentucky and eastern Appalachian region underserved (see Appendix G in *Other Supporting Documentation)*. There are severe dental care workforce shortages in 32 counties that have dentist-to-population ratios at or above 1:5,000, far exceeding the national average of 1:1,360. Additionally, five Kentucky counties having no practicing dentists at all.[20] Due to the high expense of dental training programs, schools like the Kentucky Community and Technical College System (KCTCS) have

not been able to keep up with the immense demand for hygienist slots.[21] The negative impact on constituents is apparent: 42.4% of Kentucky adults did not visit a dentist in the past year, and rural Appalachian counties have the lowest dental visit rates and the highest rates of complete tooth loss among seniors. Nationwide, nearly 45% of adults aged 65+ have lost six or more teeth, and 23% have lost all their natural teeth due to decay or gum disease.[22] Additionally, preventable non-traumatic dental presentations (NTDPs) drive significant costs in acute care settings with emergency department visits for these conditions exceeding $44 million in 2019.[23]

5) EMS and Trauma System: Timely response to a health emergency is critical for many conditions including strokes, heart attacks, respiratory distress, and trauma. Compared to national benchmarks, Kentucky's emergency management systems performance demonstrates several areas for improvement, most notably in pre-hospital assessments and information documentation to support the care team.[24] Kentucky lacks a centralized hub to coordinate emergency medical and trauma system response, leading to inefficiencies in patient transport and adversely impacts the quality and timeliness of medical interventions for rural residents, particularly for natural disasters or medical surges.[25] A core challenge for rural Kentucky's EMS and trauma services is a large geographic workforce gap as 45% of licensed paramedics are concentrated in the five largest metropolitan counties, leaving only 1,631 paramedics for the 115 remaining counties.[26] In fact, 91.7% of Kentucky counties are ambulance deserts where people or places are at least 25 minutes away from the nearest ambulance station (see Appendix H in *Other Supporting Documentation)*.[27] Fatality rates from vehicular accidents in rural areas are almost twice as high compared to those in urban areas. The importance of investing in rural EMS and trauma response systems cannot be understated.[28]

Healthcare Access

Healthcare access in rural Kentucky is a consistent challenge across our five rural health focus

areas. Geographic isolation and provider shortages remain a significant barrier to health care access and outcomes improvement. In fact, 107 of Kentucky's 120 counties are designated as Health Professional Shortage Areas (HPSAs)[29] with 94% of Kentucky's rural areas facing a primary care physician shortage compared to 65% nationally, according to a 2023 HRSA report. Maternal health deserts force Kentuckians to travel an average of 20.3 miles to the nearest birthing facility, with those living in counties with the top 20% highest travel times facing up to 70.4 miles (78 minutes on average) to reach the nearest birthing facility.[30] Similarly, access to behavioral health is strained by severe provider shortages in Kentucky.[31] For dental health, 32 of Kentucky's rural counties have severe workforce shortages with dentist-to-population ratios that are 73% below the national average.[32] With regard to EMS and trauma systems, the Kentucky Office of Rural Health (KORH) found that only 60% of rural counties have sufficient access to these services. While telehealth has begun to bridge the gap, Kentucky ranks 41st of 50 states in percentage of households with reliable broadband and a computer, smartphone or tablet required for telehealth access.[33,34] In fact, a 2023 analysis of rural communities in the Appalachian region of Eastern Kentucky found nearly 17% of households had no internet subscription or access through dial-up or broadband.[35]

Rural Facility Financial Health

The Kentucky rural health facility landscape includes 29 Critical Access Hospitals (CAHs), 420 Rural Health Clinics (RHCs), 41 Short Term/PPS Hospitals, two Rural Emergency Hospitals, and 414 Federally Qualified Health Centers (FQHCs) sites (see Appendix I in *Other Supporting Documentation)*.[36] These rural health facilities typically have operating margins of ~1-2% given the higher percentage of Medicaid patients.[37] According to research from KORH, the total number of rural Kentucky hospital closures has increased to seven since 2010, with another 35 rural hospitals at risk of closure (one of the highest states nationally).[38,39]

Target Populations and Geographic Areas

Kentucky's RHTP drives improvements in sustainable health access and prevention across 90.8% of the Commonwealth (109 of 120 counties designated as rural and non-metropolitan counties). Moreover, these rural community improvement efforts will promote innovations in clinical care and strengthen technology and data infrastructure that will benefit the entire state. We have selected five rural health priority focus areas that address health conditions and rural populations most affected by gaps in care and access across Kentucky, including diabetes and other chronic conditions, pregnant and postpartum women and infants in maternity care deserts, individuals experiencing behavioral health crises, residents lacking access to preventative dental care, and patients experiencing medical and trauma emergencies requiring timely prehospital emergency management services. For each priority focus area, Kentucky has designed sustainable care innovations that will be piloted in specific regions and rural counties during the first budget period of RHTP funding. These rural health innovations will be refined and scaled across other regions and counties over the five-year period.

RURAL HEALTH TRANSFORMATION PLAN: GOALS AND STRATEGIES

Kentucky's RHTP Vision, Goals, and Strategies

Kentucky's RHTP is a bold step forward to reimagine rural health care across the Commonwealth. The Kentucky Cabinet for Health and Family Services (CHFS), with input from rural health providers and community partners, proposes five community-driven initiatives under one integrated statewide framework. This framework supports digital innovation, expands workforce capacity, and promotes community partnerships to create a sustainable, value-based system of care aligning rural community efforts to improve access and prevention of health conditions that disproportionately impact rural Kentuckians. Kentucky's five initiatives are intentionally designed to function as interdependent components of a single statewide system.

KENTUCKY'S RHTP PRIORITY FOCUS AREAS			
	Five Initiatives	**Strategic Goal**	**Use of Funds**
1	**Rural Community Hubs for Chronic Care Innovation** Enhance chronic care innovation, starting with obesity and diabetes, through local community hubs designed to scale evidence-based interventions and digital health supports such as AI-enabled self-management coaching across the lifespan	Make Rural America Healthy Again, Tech Innovation	A, C, D, E, F, G, I, J, K
2	**PoWERing Maternal and Infant Health: Community-based Teams** Enable timely initiation of quality perinatal care from early pregnancy to postpartum in maternity care deserts through a network of coordinated, telehealth-enabled maternal care teams	Sustainable Access	A, B, C, D, E, F, G, H, I, K
3	**Rapid Response to Recovery: EmPATH Model, Mobile Crisis and Telehealth** Provide person-centered, technology-enabled access to integrated crisis care, linking EMS, behavioral health providers, and mobile crisis units through shared data and referral platforms	Innovative Care	D, E, F, G, H, I, J, K
4	**Rooted in Health: Rural Dental Access Program** Expand dental hygiene training, externship programs, and mobile/teledental hubs to address unmet preventive oral health needs	Workforce Development	A, B, D, E, F, G, I, J, K
5	**From Crisis to Care: Integrated EMS and Trauma Response** Enhance prehospital capacity, enabling treat-in-place protocols and improved coordination with hospital trauma care	Sustainable Access	A, B, D, E, F, G, K

Figure 2. Kentucky's Rural Health Priorities

Across these five rural health priorities, Kentucky will invest to improve access, sustainability, workforce development, care innovation, and technology innovation. Specifically, Kentucky will invest in consumer-facing technologies, such as mobile apps and conversational AI assistants, to improve access to care and move upstream in prevention of chronic diseases. Kentucky will expand clinical and non-clinical workforce capacity in rural communities for clinicians, pharmacists, paramedics, community health workers, doulas, dental hygienists, and others. Kentucky will invest in statewide data interoperability standards, in alignment with the CMS Interoperability Framework, to enable care innovation through more efficient bi-directional data sharing between providers, payers, public health, and other stakeholders.[40] At the same time, these data interoperability investments will lower system costs and reduce provider administrative burden by eliminating manual paper-based processes, as demonstrated by the CMS "kill the clipboard" initiative.[41]

Taken together, the Kentucky RHTP vision, goals, and strategies for rural health transformation is focused on care innovation and collaboration across four key dimensions of health quality: Engagement, Access, Prevention, and Delivery (see Appendix J. Kentucky Collective Action Framework (CAF) in *Other Supporting Documentation*). These four dimensions reflect an evidence-based, patient-centered approach to aligning rural health stakeholders around shared priorities for population health. The CAF focuses Kentucky's RHTP strategies on hub-and-spoke delivery models to improve financial stability and mitigate causal risks for rural hospitals.

Over the five-year RHTP grant period, Kentucky will implement sustainable improvements funded through existing reimbursement models, alternative payment models, and new revenue-generating business models. Our longer-term aspiration to carry forward the RHTP strategies and CAF mindset is to establish a Public-Private Partnership (PPP) model, led by an independent non-profit organization and funded through an endowment of charitable donations from private sector foundations and philanthropic organizations, as described in the *Sustainability Plan*.[42]

To actively manage the structured, disciplined implementation of Kentucky's RHTP vision, goals, and strategies, we will establish an A^3 Transformation Team (Aspire, Activate, Attain). The A^3 Team will focus on overall program execution, initiative coordination, and quality through five core functions: strategic management and oversight, initiative coordination and efficiency, community stakeholder collaboration, fiscal governance and accountability, and stakeholder engagement and communication (see Figure 3).

Figure 3. Kentucky's Rural Health Transformation Team

Improving Access and Outcomes

The five priority focus areas included in Kentucky's RHTP were identified through a statewide survey of rural health stakeholders conducted from July to September 2025. These five priorities are intentionally designed to improve rural health access and deliver outcomes by functioning as interconnected components of a single health system, allowing Kentucky to measure both individual and collective impact. Individually, each of the five priorities align with the CMS RHTP core outcomes of improving access and prevention, strengthening care coordination, and supporting community-based innovation. Collectively, our rural health stakeholders agree (see Letters of Support in *Other Supporting Documentation*) these five priorities represent clear and meaningful opportunities for Kentucky to transform rural health through care innovations and cross-system collaboration to improve outcomes, reduce costs, and increase quality.

Kentucky will establish a public-facing performance dashboard of evidence-based "leading indicators" and project-specific "Objectives and Key Results" (OKRs) to track, monitor, and report on milestone-based progress measures for implementation of each priority area.[43] Our preliminary OKRs for each priority area are summarized later in this document. To define our initial set of evidence-based leading indicators, Kentucky has initiated discussions with several leading academic institutions across the state, including the University of Kentucky (UK) College of Public Health Biostatistics Department and the University of Louisville School of Public Health & Information Sciences. We anticipate these leading indicators and OKRs will be refined over the five-year lifecycle of the RHTP program.

Technology Use and Data-Driven Solutions

Across our five RHTP priority areas, Kentucky will make several coordinated investments in technology infrastructure and data interoperability to enable long-term care innovation and stakeholder collaboration (see Appendix K in *Other Supporting Documentation*).

Digital Health, Telehealth, and Mobile Health: Kentucky's approach is aligned with CMS's Health Tech Ecosystem vision and criteria for data interoperability and patient-facing apps, "To unlock the full potential of a modern, patient-centered healthcare system by aligning common infrastructure with private-sector innovation across a set of clearly defined categories that reflect the essential roles needed to make real-time, consented health data access work, securely, reliably, and at scale."[44] Kentucky's RHTP will invest in modern health data exchange, compliant with TEFCA and FHIR-API standards, that put patients and providers first to improve care coordination and outcomes tracking. We will use standardized digital tools for data capture, referral tracking, and care-plan monitoring.

Kentucky will explore AI-enabled consumer-facing technologies such as health coaching, gamified incentives and rewards, and digital assistants leveraging conversational AI to deliver personalized nudges and education. Kentucky's RHTP initiatives will integrate telehealth, digital therapeutics (DTx), mobile health apps, remote patient monitoring, and consumer wearable devices to improve patient access, engagement and behavior change (e.g., physical activity, nutrition, medication adherence). The health data captured through these digital devices will enable future AI/ML predictive analytics applications for consumer engagement, decision-support and/or reduction of administrative burdens for rural health providers. Further, this data will provide rapid-cycle feedback on rural health "leading indicators" and OKR measures which is central to Kentucky's collective impact approach, allowing community partners to measure shared progress and adjust interventions.

Data Interoperability: Kentucky's approach is consistent with CMS's Interoperability and Prior Authorization Final Rule, ONC's TEFCA framework, and HHS guidance for AI readiness and data modernization. Kentucky will leverage national standards (FHIR, TEFCA, Core USCDI,

USCDI+) to enable seamless, appropriate, secure trusted information exchange to improve care coordination, enable predictive analytics, and train machine-learning care navigation agents for future deployment to patients and providers in rural areas. In doing so, the Commonwealth will establish a statewide, standards-based data infrastructure that meets or exceeds national interoperability expectations while remaining vendor-neutral and scalable. Kentucky's vision to improve cross-stakeholder data exchange is a secure, cloud-based, EHR-agnostic, open-source data model that integrates both structured and unstructured data with AI-based semantic search capabilities for clinicians, pharmacies, healthcare facilities, public health, and others.[45] This data interoperability infrastructure, which has been successfully deployed and demonstrated in other states, will provide the foundation for a potential future Kentucky Health Data Utility.[46]

RHTP Collaboration Hub: Kentucky will establish a digital RHTP Collaboration Hub, named Vitality Signs. The Hub will serve as a digital front door to Kentucky's RHTP efforts to enable community-level collaboration and information sharing of Kentucky-specific leading practices. The Hub will include a dashboard of county-level rural health leading indicators linked to Kentucky's Collective Action Framework (described in *RHTP Vision, Goals, and Strategies*) as well as RHTP-specific OKRs for ongoing program status monitoring. After initial launch, Kentucky will explore opportunities with the Kentucky Health Information Exchange (KHIE), KY Center for Statistics (KYStats), the University of Kentucky to expand the rural health dashboard, data availability, and visualization through geo-mapping of interrelated health factors and leading indicators (e.g., access to retail grocery stores, farmer's markets, etc.)

Kentucky's vision for its digital health infrastructure creates future opportunities for CMS and CDC interoperability pilots across the Commonwealth of Kentucky. While the startup cost of these technology infrastructure and data interoperability investments is reflected in the primary

initiative titled, *Rural Community Hubs for Chronic Care Innovation*, the longer-term benefits of statewide data interoperability will support all five rural health priorities and enable broader health care innovation, collaboration, and operational efficiency across Kentucky.

Partnerships

Kentucky's RHTP will leverage a collective-impact partnership model to coordinate and build on regional and community-level strategic partnerships across our five rural health priority focus areas. Many of our rural health stakeholders and partner organizations have signed one or more letters of support for Kentucky's five rural health priority focus areas. Kentucky's RTHP is designed around active participation, engagement, and collaboration with rural health stakeholders in communities across the Commonwealth, including local hospitals and clinics, community health centers and FQHCs, local health departments (LHDs), community mental health centers (CMHCs), certified community behavioral health centers (CCBHCs), as well as Area Agencies on Aging and Independent Living (AAAILs), senior centers, nursing homes, long-term care (LTC) facilities, community-based organizations (CBOs), and faith-based organizations in each rural community. As described in the *Sustainability Plan* section of this document, Kentucky aspires to establish a Public-Private Partnership (PPP) model to provide ongoing stakeholder alignment on shared outcomes and collective actions.

Workforce

Kentucky will expand our rural health workforce through active collaboration, training and certification programs with local community colleges, such as the Kentucky Community & Technical College System (KCTCS). We will expand the number of community health workers (CHWs), midwives and doulas, peer support networks, behavioral health teams, dental hygienists, and EMS paramedics in rural communities. Additionally, Kentucky will expand the role of Kentucky Health Navigators (kynectors) to support patient, family and caregiver

navigation of the rural health system, and explore scope of practice expansion for pharmacists. Through partnerships with Kentucky's academic institutions, extensions and community college system, Kentucky will coordinate student placements, research residencies, and public-health fellowships that align academic preparation with rural practice. This approach is aligned with HRSA and CDC rural workforce priorities and ensures long-term sustainability of capacity-building efforts. Our longer-term aspiration is to attract, recruit, and retain primary care and specialist clinicians in rural communities. These efforts will be supported by shared clinical workforce planning with accredited institutions, providers, FQHCs, CBOs, and LHDs to define recruitment, training, retention strategies, and metrics as leading indicators of success.

Cause Identification and Financial Solvency Strategies

Kentucky's RHTP will address the financial stability of rural hospitals and providers by engaging the community in migrating rural patient volumes to lower cost care settings, telehealth and/or remote digital and mobile health modalities of care across rural communities. The result of Kentucky's focus on rural health care innovation and collaboration will enable hospitals to focus on acute, high-cost cases and position hospitals at the core of rural community health. This hub-and-spoke model for Kentucky's RHTP will position the rural community hospitals at the core while enabling remote telehealth, treatment-in-place protocols for lower complexity cases. The technology infrastructure and data interoperability established through Kentucky's RHTP priority focus areas will expand clinical hub-and-spoke, hospital-to-hospital telehealth consults to expand the reach of primary care and specialty physicians as well as behavioral health providers, pharmacists, and dentists. Rural health care "deserts" for chronic conditions, maternal and child health, behavioral health, and dental health would be addressed through this hub-and-spoke model that will improve local community access, support prevention strategies, increase capacity for initial treatment, and refer more complex cases to regional hospitals and clinics.

Kentucky will continue working with providers, commercial payers, and Medicaid managed care organizations (MCOs) to assess reimbursement pathways and alternative payment models to improve provider network adequacy and geographic coverage models for rural communities. We recognize the long-term sustainability of future care innovations is dependent on predictable payments. In cases where existing reimbursement does not exist, Kentucky will work with providers, employers, commercial health plans, and MCOs to analyze outcomes data and design future value added services (VAS), bundled payments, and/or value-based contracting models. Kentucky's RHTP demonstrates how the rural health system can leverage the principles of collective-impact, national data interoperability standards, and a deliberate strategy for workforce and financial sustainability to connect people, data, and organizations through a shared purpose: to move from fragmented care toward a seamless, sustainable health system. The RHTP reflects Kentucky's commitment to measurable results, transparency, and long-term renewal. Through collaboration, interoperability, and local community-based leadership, Kentucky is not merely participating in rural transformation, it is defining it.

Legislative or Regulatory Action

Kentucky appreciates the importance of the legislative and regulatory environment to improving access, quality, and cost of care, and is committed to thoughtfully pursuing policy updates that will advance public health throughout the state, particularly in rural areas. At this time, the Commonwealth believes the current policy environment supports the changes included in this RHTP proposal.

Other Required Information

Below please find the information requested from Kentucky as flagged in Table 4 of the Notice of Funding Opportunity.

State Policies: For the list of current policies related to the "State policy actions" technical score factors, please see Appendix L in *Other Supporting Documentation.*

Factor A.2: Certified Community Behavioral Health Clinics (CCBHCs): There are four CCBHCs with 55 locations in Kentucky. Refer to *Other Supporting Documentation - KY CCBHC Data* for details.

Factor A.7: Disproportionate Share Hospital (DSH) Payment: In FFY 2025, five hospitals received DSH payments: Cardinal Hill Rehabilitation Hospital, Tug Valley ARH Regional Medical Center, Central State Hospital, Eastern State Hospital, and Western State Hospital. We anticipate payments for the three state psych hospitals (Central, Eastern, Western) in FFY 2026.

PROPOSED INITIATIVES AND USE OF FUNDS

Initiative: Rural Community Hubs for Chronic Care Innovation

Initiative Description

Kentucky faces a long-standing population health challenge with chronic diseases, especially obesity and diabetes, in rural areas where access to preventive care is limited and multiple social and behavioral factors adversely impact health outcomes (e.g., poverty, unemployment, food insecurity, limited transportation, isolation, and unhealthy behaviors such as tobacco use and physical inactivity). The *Rural Community Hubs for Chronic Care Innovation* initiative seeks to unite fragmented interventions, programs, resources, and technology tools for local community organizations to enable coordinated interventions across the chronic disease continuum, from early education and engagement to prevention, access, and delivery of ongoing chronic care management solutions. We envision these Rural Community Hubs will share a common technology infrastructure and be locally led at a regional level to align rural health stakeholders on shared priorities and outcome measures based on community need.

Today, Kentucky's rural health stakeholders operate in a patchwork of programs and interventions to prevent, treat and manage chronic diseases. These stakeholders, including providers, Medicaid MCOs, CBOs, state agencies and LHDs, among others are each driving toward individual, siloed efforts. This fragmentation of chronic disease programs has made it challenging for rural health providers, community health workers (CHWs), caregivers, and patients to navigate an organized, cohesive care pathway to prevent and manage chronic disease. The Rural Community Hubs concept provides a digital collaboration hub, consumer-facing technologies, and navigation support through CHWs and kynectors to empower patients with more comprehensive chronic disease pathways and improve care coordination and data sharing.

The Commonwealth of Kentucky struggles with a high burden of obesity and diabetes. In fact, diabetes cost the state $6.1 billion in 2023 with mortality rates up to 39% higher than the national average.[47] For this reason, we have prioritized obesity and diabetes as an initial chronic disease pilot for the Rural Community Hubs, with the clear roadmap over time to expand and address other chronic conditions such as hypertension, heart disease, COPD and others. For each chronic disease, we envision the Rural Community Hubs will create an integrated, evidence-based and digitally supported care plan for chronic disease prevention and management to address:

Fragmented chronic disease prevention and management in rural communities	• **Collaboration hub platform infrastructure** to align and coordinate rural health stakeholders • **Operational assets, toolkits, and technical assistance** • **Mini grants** to support locally defined cross-stakeholder innovations
Rural patient access and navigation challenges	• **CHW training and expansion** to build a robust, locally rooted workforce • **Locally deployed, EHR-agnostic closed-loop care coordination and referral tool** for frontline CHWs, CBOs, and first responders to capture patient information and referral for care • **Consumer-facing technology, digital therapeutics and mobile health apps** to improve access, health literacy, patient empowerment and engagement through digital health coaching
Siloed patient health data across providers, payers/ MCOs, CBOs, patients and caregivers	• **Open-source, FHIR API-driven data interoperability** infrastructure to enable cross-stakeholder data sharing, analytics and AI use cases • **Digital platform to drive local collaboration** and coordination on community health needs • **KHIE/CRISP community data integration** across clinical, claims, CBOs, and public health and human services enrollment and utilization data (e.g., SNAP, WIC, TANF)

Figure 4. Approach to Rural Community Hubs for Chronic Care Innovation

Together, these Rural Community Hubs will reduce fragmentation of chronic disease prevention and management, providing the integrated patient data required to improve care pathways and quantify patient outcomes resulting from various interventions to reduce overall cost of care. For example, Kentucky has several successful Food-is-Medicine/Food-as-Health initiatives.[48] By improving collaboration, Kentucky can move upstream on the diabetes prevention curve, shifting from reactive, compliance-driven care to coordinated, hyperlocal community action.

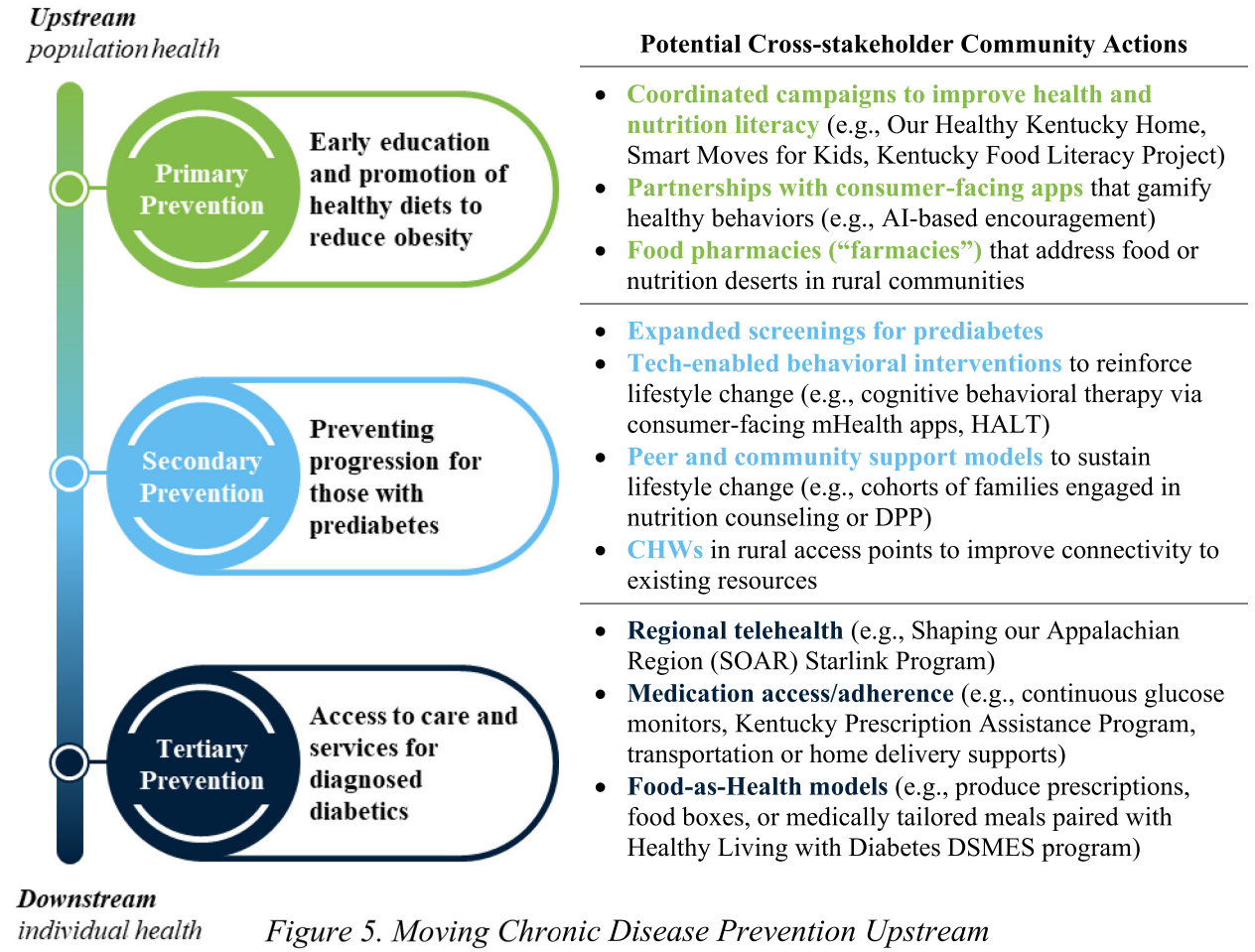

Figure 5. Moving Chronic Disease Prevention Upstream

Sustainability Consideration: This initiative will leverage traditional reimbursement models and explore future outcomes-based alternative payment models, Public-Private Partnership (PPP) structures, and potential to establish an endowment for collective impact investments to provide long-term sustainable funding, as described in *Sustainability Plan*.

Main Strategic Goal: Make Rural America Healthy Again, Tech Innovation

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

Technical Score Factors: B.1, B.2, C.1, F.1, F.2, F.3

Key Stakeholders: Healthcare Providers, Pharmacies, LHDs, Area Development Districts (ADDs), Area Agencies for Aging and Independent Living (AAAILs), Senior Centers, Nursing

Homes, Long-term Care Facilities, Employers, Commercial Payers and MCOs, CBOs, Farmers and Food Retailers, Schools, Educational Institutions, CHWs, State and Local Agencies.

Outcomes: The *Rural Community Hubs for Chronic Care Innovation* initiative will track a set of disease-specific outcome metrics to measure the effectiveness of the Rural Collaboration Hub model in improving chronic disease prevention and management. These outcome metrics will include both lagging clinical outcome measures (e.g., diabetes prevalence rates) along with root cause leading indicators of disease risk (e.g., obesity rates, physical inactivity). Over time, dashboards will be expanded to include other chronic diseases and data visualization capabilities (e.g., zip code level geospatial mapping tools, overlays of food deserts) to improve stakeholder insights, increase transparency, promote accountability, focus interventions, and provide rapid-cycle feedback to inform local initiatives and strategies. While specific outcome metrics will vary by disease, illustrative metrics include adult chronic disease screening rates, percentage of adults engaged in evidence-based chronic disease prevention and management programs, and hospital readmissions or preventable hospitalizations for chronic disease complications. Across these disease-specific outcome metrics, Kentucky will identify OKRs to measure the overall progress of the initiative in reducing fragmentation and aligning stakeholders.

Objective: Stand up a durable Rural Community Hub infrastructure that enables earlier prevention, improved care coordination, and measurable improvements in rural chronic care across all counties.				
Key Result	**Measurable Outcomes**	**Baseline**	**Target**	**Relation to Initiative**
1) Development of Rural Community Hubs	**Hub coverage and activation:** % of rural counties that are part of an active hub (charter adopted; monthly convenings underway)	Baseline will be established in Year 1.	33% of counties in an active Hub by Year 2. 90% of counties in an active Hub by Year 5.	Verifies statewide hub activation, proving community led infrastructure is operating).
	Stakeholder engagement: # of active partners in each rural community hub	Baseline will be established in Year 1.	5 partners per Hub by Year 2. 10 partners per Hub by Year 4.	Tracks cross-sector partners engaged (e.g., onboarded to digital collaboration platform), demonstrating stakeholder collaboration.

Objective: Stand up a durable Rural Community Hub infrastructure that enables earlier prevention, improved care coordination, and measurable improvements in rural chronic care across all counties.				
Key Result	**Measurable Outcomes**	**Baseline**	**Target**	**Relation to Initiative**
2) Chronic Care Activation	**Local initiative coverage:** # of chronic disease or rural health initiatives launched locally with multi-stakeholder engagement	Baseline will be established in Year 1.	2 initiatives by Year 2. 4 initiatives by Year 4.	Shows hubs enabling locally planned, aligned, implemented innovation with measurable impact.
3) Bidirectional Data Sharing	**Data interoperability:** % of partner systems (appropriate for connections) connected via FHIR interoperable standards	Baseline will be established in Year 1.	25% by Year 3. 75% by Year 5.	Represents the number of successful connections between previously siloed data systems.
	Timely referral closure: % of total referrals closed using care coordination tool	Baseline will be established in Year 1.	Dependent on baseline, targets to be determined in Year 1.	Assesses referral closure speed, evidencing closed loop coordination reducing delays.
4) CHW Training	**Certified CHWs with Chronic Disease Specialization:** % of certified CHWs who have completed state-approved specialized training for chronic-disease	Baseline will be established in Year 1.	Dependent on baseline, targets to be determined in Year 1.	Demonstrates expansion of CHW expertise to support chronic disease prevention, management, and intervention.

Figure 6. OKRs for Rural Community Hubs Initiative

Supporting Evidence Examples:

Component	Examples of Success
Community care models to integrate clinical, social, and community services	• Iowa Diabetes Community HUB • North Carolina Minority Diabetes Prevention Program (MDPP) • Indiana's Diabetes Impact Project – Indianapolis Neighborhoods (DIP-IN) • Washington State Accountable Communities of Health • Winter Park Health Foundation • StriveTogether
Digital infrastructure to power integrated, community-based health solutions	• ConnectWellSD • Oregon Wellness Network (OWN) • California Accountable Communities for Health Initiative • Striving Together to Reduce Violence in Neighborhoods (STRiVIN') • North Carolina NCCARE360 platform • Ballad Health Closed-loop Referral Network • One Utah Health Collaborative • WNY Integrated Care Collaborative

Figure 7. Examples of Similar Models for Rural Community Hubs Initiative

Impacted Counties: Kentucky has 109 rural or non-metropolitan rural counties (as defined by HRSA), with chronic health burden rates ranging from 38.9% to 69.4%.[49] The *Rural Community Hubs for Chronic Care Innovation* initiative is designed to reach all rural and non-metropolitan rural counties across the state, beginning with pilot implementation in selected Area Development Districts (ADDs) with a focus on diabetes and expanding to all 15 ADDs and additional chronic disease areas over time (see Appendix M for a map of Kentucky's ADDs in *Other Supporting Documentation)*. Leveraging the repeatable structure described in the initiative to scale local, cross-system partnerships, we will prioritize the deployment of Rural Community Hubs within ADDs exhibiting the highest burden of obesity, diabetes, and other chronic diseases – using the pilot phase as a springboard for systematic rollout across all 15 ADDs. Over the five-year grant period, initiative components are expected to have a positive statewide impact in all 120 counties. Initial pilots will prioritize rural ADDs with the highest rates of undiagnosed diabetes, obesity, limited screening infrastructure, and elevated chronic disease burden. In addition to Rural Community Hub deployment in ADDs, foundational technology, data tools, and community networks developed through this initiative will eventually have a statewide impact, supporting care coordination and chronic disease prevention and management across all 109 rural or non-metropolitan rural counties in Kentucky.

Estimated Required Funding: Approximately $50-56 million per budget period (of the hypothetical $200 million), for an estimated total of $263 million over the five RHTP budget periods. See *Budget Narrative* for additional details.

Initiative: PoWERing Rural Maternal and Infant Health: Community-Based Teams

Initiative Description

The PoWER Team (**P**eople Wh**o** **W**ork for **E**ngagement and **R**esilience) initiative is a scalable patient-centered and community-based model designed to provide access to perinatal care and address Kentucky's maternity care deserts. Kentucky faces a maternal health crisis: nearly 46% of its counties are maternity care deserts, 58% of rural women live over 30 minutes from a birthing hospital, and maternal and infant death rates are among the highest in the nation.[50] PoWER Teams, comprised of a perinatal CHWs, doulas, and peer support specialist (PSS), as needed, will combat the effects of maternity care deserts by supporting pregnant women from pregnancy confirmation through one year after the end of pregnancy. Each local PoWER Team will be deployed in partnership with an LHD, RHC, or FQHC. PoWER Teams will be coordinated by a centralized telehealth nurse and overseen by a delivery provider throughout prenatal and postpartum care:

1) **Pre-pregnancy Education and Awareness:** PoWER Teams will collaborate with LHDs, schools, and community groups to promote early pregnancy awareness, health literacy, and resource access, alongside the Kentucky Department of Education (KDE) and CHFS Kentucky Department for Public Health's School Health Branch. The PoWER Teams will support workforce mentorship and training within KCTCS and other Kentucky programs.
2) **Confirmation of Pregnancy:** The PoWER Team will use Kentucky Medicaid's "Notification of Pregnancy" tool (eNOP) to screen for social determinants of health and obstetric history, assess needs, and determine eligibility. Eligible patients will be assigned to a PoWER team and receive a ***PoWERpack*** (e.g., scale, blood pressure cuff, fetal doppler, educational materials, consumer-facing mobile app) to remotely monitor their health and

connect with providers via telehealth. Healthcare providers, government programs like WIC, TANF, SNAP, and the Health Access Nurturing Development Services (HANDS) program, as well as LHDs and kynectors may make Medicaid eNOP assessment referrals.

3) **Prenatal Care:** 42% of rural maternity care deserts have preterm birth rates that exceed the state average, largely attributable to chronic health conditions.[51] PoWER Teams will offer remote telehealth visits and physical visits at co-located community hubs to monitor vital signs and will utilize interoperable technology solutions to transfer data to providers. Teams will connect moms to the HANDS program and other wraparound services such as WIC, KY Moms Maternal Assistance Towards Recovery (KY Moms MATR), birthing classes, food banks, transportation, Kentucky Tobacco Quit Line's perinatal program, and other value-added benefit referrals. The PoWER Team model integrates insights and principles from the ACOG-endorsed Michigan Plan for Appropriate, Tailored Healthcare in pregnancy (MiPATH) to tailor prenatal visit frequency and modality based on individual medical and social risk. Trend data from PoWERpack devices and consumer-facing mobile apps will be analyzed using AI to provide proactive coaching, encouragement, and reminders aligned to maternal health needs. Monthly collaborative reviews between providers, nurses, and PoWER Teams will support delivery planning and knowledge sharing. From pregnancy through up to one year postpartum, PoWER Teams will maintain contact with patients to assess mental health needs and provide nutrition counseling and pregnancy education.
4) **Delivery:** The prenatal support from PoWER Teams will reduce the risk throughout a mother's pregnancy and decrease likelihood of complications to increase the likelihood mothers can deliver at their local hospital. Similar efforts by Texas RMOMS[52] indicate that by utilizing coordinated care to avoid complications, Kentucky can save ~$36k per preterm

infant,[53] ~$270k per NICU admission,[54] and ~$13k per c-section.[55] A PoWER Team doula will provide in-person support during labor, delivery, and support for immediate postpartum newborn care.

5) **Postpartum Care:** More than 50% of the state's maternal mortality occurs after delivery, with most deaths happening within one year postpartum due to substance use disorder and mental health, indicating an urgent need for coordinated care through one year postpartum.[56] In the first four weeks postpartum, the PoWER Team will conduct home visits and mental health screenings, provide transportation for postnatal and pediatric appointments, and connect enrollees to support services (e.g., financial planning, childcare, CPR training, mental health care). During this time, the maternal health mobile app will proactively provide health education for mother and infant, answer questions using conversational AI, encourage healthy behaviors, and monitor health trends. From weeks 5–12, telehealth check-ins will continue, and mothers will be linked to HANDS and/or KY Moms MATR programs as needed. In the first year postpartum, the PoWER Team will provide continued education and support on recovery, infant care, and child development.

Ultimately, PoWER Teams will deliver earlier access to coordinated, high-quality care and reduce gaps in prenatal and postpartum services for rural maternity patients. To scale this model effectively, the initiative will also expand the community workforce. Specifically, Kentucky will fund the creation of a perinatal CHW certification program within the Kentucky Office of Community Health Workers to build a pipeline of trained professionals equipped to serve in rural maternal care PoWER Teams. Additionally, the initiative will provide resources to expand the number of HANDS workers, improving timely access to home visiting services for families referred by PoWER Teams. These workforce investments are essential to sustaining the PoWER

Teams' reach and impact across Kentucky's rural communities.

Sustainability Consideration: The *PoWERing Rural Maternal and Infant Health* initiative is focused on establishing financially sustainable PoWER Teams and HANDS positions over the five-year grant period. To do so, RHTP funding will be used to cover start-up costs and supplement operating costs so that the initiative is revenue-generating and reimbursable after start-up through existing payment models. We will work with teams to define targets to reach self-sustaining breakeven patient volumes by the end of the grant period as RHTP funding is scaled down. Refer to *Sustainability Plan* for additional information.

Main Strategic Goal: Sustainable Access

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

Technical Score Factors: B.1, B.2, C.1, D.1, F.1, F.2, F.3

Key Stakeholders: State Academic Institutions, LHDs, FQHCs, RHCs, K-12 Schools, CBOs, CMHCs, Medicaid MCOs, State and Local Agencies

Outcomes:

Objective: To increase early access, engagement, and quality of maternal health care for rural families				
Key Result	**Measurable Outcomes**	**Baseline**	**Target**	**Relation to Initiative**
1) Increased Early Prenatal Engagement	% of pregnant women in rural counties who complete a first prenatal visit within the first trimester	75.5% (as of 2024)	78% by Year 3. 80% by Year 5.	Early engagement via PoWER Team outreach, education, and intake processes enables patients to be connected to care sooner to receive coordinated support.
2) Expanded Enrollment in Wraparound Support Programs	# of rural maternal patients enrolled in evidence-based support programs within 30 days of confirming pregnancy (e.g., HANDS, WIC, KY Moms MATR, SNAP, Nutrition)	Baseline will be established in Year 1.	15% increase in enrollment by Year 3. 20% increase in enrollment by Year 5.	PoWER Teams connect patients to wraparound services, leveraging their partnerships and care coordination role to address social drivers of health and improve maternal outcomes.

Objective: To increase early access, engagement, and quality of maternal health care for rural families				
Key Result	**Measurable Outcomes**	**Baseline**	**Target**	**Relation to Initiative**
3) Improved Adherence to Recommended Prenatal and Postpartum Visits	% of rural maternal patients who complete the recommended number of prenatal and postpartum visits (including telehealth)	Baseline will be established in Year 1.	Dependent on baseline, targets to be determined in Year 1.	Through ongoing engagement, reminders, transportation support, and personalized care planning, PoWER Teams help patients overcome barriers and maintain consistent contact with providers pre- and postpartum.
4) Increased Maternal Behavioral Health Screening and Referral	% of rural women (pre- and postpartum) screened for behavioral health needs % of rural women (pre- and postpartum) with positive behavioral health screens referred to appropriate services	Baselines will be established in Year 1.	Dependent on baselines, targets to be determined in Year 1.	PoWER Teams are trained to identify behavioral health needs early and facilitate referrals, integrating mental health into routine maternal care and reducing gaps in support.
5) Increased Access to Nutrition and Coordinated Care	% of eligible rural patients with a PoWER Team or enrolled in a coordinated care pathway within 14 days of confirming pregnancy	Baseline will be established in Year 1.	Dependent on baseline, targets to be determined in Year 1.	The PoWER Team model provides coordinated, multidisciplinary care; tracking assignment to teams or pathways demonstrates the initiative's reach and system transformation.
6) Improved continuum of care via integrated postpartum support	% of rural children who have had 6 or more well-child visits in the first 15 months of life	67.3% (as of 2024; Medicaid; statewide)	74% by Year 3. 80% by Year 5.	The PoWER Team initiative strengthens early access to coordinated perinatal care in rural areas, directly supporting increased well-child visits through home visits, telehealth, and linkage to pediatric services.

Figure 8. OKRs for PoWER Teams Initiative

Supporting Evidence Examples:

Component	Examples of Success
Coordinated Perinatal Care Models	• Kentucky HANDS • Texas Rural Maternity and Obstetrics Management Strategies (T-RMOMS) • North Carolina Maternal Support Services • Michigan Maternal, Infant and Early Childhood Home Visiting (MIECHV)
Telematernal Care Models	• The University of Michigan MiPATH: Pregnancy and Postpartum • NC Maternal Outreach Through Telehealth for Rural: The MOTHeRS Project • UK Kentucky Angels
Workforce Models Leveraging Non-traditional Paraprofessional Providers	• Montana One Health • Effects of Maternity Care Coordination on Pregnancy Outcomes

Figure 9. Examples of Similar Models for PoWER Teams Initiative

Impacted Counties: Selection of pilot and expansion sites for PoWER Teams will consider counties that have the most severe needs, such as elevated maternal vulnerability, preterm birth rates, chronic health burden, provider shortages, and travel distances to care. For example, Kentucky has 55 counties classified as maternity care deserts, with 58% of rural women living more than 30 minutes from a birthing hospital (e.g., regions of elevated need include Lake Cumberland, Bluegrass, Kentucky River, and Barren River).[57]

Estimated Required Funding: Approximately $15-53 million per budget period (of the hypothetical $200 million), for an estimated total of $158 million over the five RHTP budget periods. See *Budget Narrative* for additional details.

Initiative: Rapid Response to Recovery: EmPATH Model, Mobile Crisis and Telehealth

Initiative Description

The *Rapid Response to Recovery* initiative will build on Kentucky's Emergency Psychiatric Assessment, Treatment and Healing (EmPATH) model and Mobile Crisis Intervention services to become an integrated, interoperable system that supports individuals through the entire behavioral health crisis continuum.[58] Rural Kentucky faces a behavioral health crisis marked by high rates of untreated mental illness, suicide, substance use disorder (SUD), and overdose.[59,60,61,62] The state incurs hundreds of millions of dollars in healthcare costs annually due to individuals using emergency services, lost productivity, and cycling between hospitals, jails, and shelters. This initiative will reduce these state costs and minimize mental health system reliance on first responders by building a person-centered, interoperable continuum of care to expand EmPATH units and provide integrated wraparound supports and real-time navigation to patients from initial call through recovery.

Component 1: Scale EmPATH to include two new units in Eastern Kentucky, one new unit in Western Kentucky, and one additional unit whose location will be determined mid-grant after evaluation. EmPATH units offer immediate assessment, stabilization, and connection to community care for those in behavioral health crisis thereby achieving high rates of patient stabilization, rapid discharge, and improved follow-up engagement. Since the July 2024 launch at UK HealthCare, the EmPATH unit has served nearly 5,500 patients, with 76% stabilized and discharged to community services and follow-up engagement rates more than doubling from baseline. Each unit will be designed in partnership providers, including CMHCs and current CCBHCs, to similarly address unmet needs, increase community connections, and reduce disparities. The model provides a safe environment for rapid psychiatric treatment within a 23-hour observation window, creating timely access and direct linkage to care in rural regions. Expanding EmPATH units will reduce ED boarding times from the current average of 14 hours and $2,200 per patient,[63,64,65] strengthen the workforce, and generate cost savings.

Component 2: Expand community-based crisis support by integrating Mobile Crisis Intervention Services (MCIS) teams, including the Community Paramedicine and Community Co-Response (CCR) model, to deliver 24/7 crisis intervention statewide. These teams will expand the reach of services by pairing first responders with behavioral health specialists and/or training paramedics to de-escalate crises, screen for health needs, and support timely response to overdose and opioid use disorder (OUD). These models improve rural crisis response and offer direct access to EmPATH units for quicker stabilization. State pilots have already shown positive impact in line with other leading states.[66] For example, Kentucky's three-county paramedicine pilot has demonstrated successful training of EMS personnel to address behavioral health crises, reduced mental health stigma, and increased utilization of wraparound services. Additionally, a

pilot of six Co-responder Units (CRU) indicates individuals are 33% less likely to be transported to an emergency department (ED) than those without CRU involvement. Ultimately, this initiative will scale these models into new counties to increase access to timely care, minimize ED use, and build a sustainable, cross-trained workforce.

Component 3: Launch a centralized telebehavioral health hub with EmPATH-trained behavioral health professionals to deliver real-time, virtual assessments, consultations, and follow-ups to rural hospitals, PCP offices, and first responders. Approximately 52% of Kentucky's rural population lives in Mental Health Professional Shortage Areas (MHPSAs) and the low 1,510:1 (vs. 1,068:1 nationally) mental health counselor ratios statewide, indicating a need for alternative treatment options. A telehealth system integrated with existing EHRs will streamline triage, risk evaluation, and treatment planning for behavioral health crises thereby reducing unnecessary admissions and expediting transfers to EmPATH units or community care. A similar program in rural Texas has seen about half of patients become stabilized and treated as outpatients and therefore freeing up beds and staff, increasing safety, and decreasing unnecessary inpatient admissions.[67] In South Carolina, a telebehavioral health hub lowered ED admission rates from 22% to 11%, shortened inpatient stays by 0.86 days, and saved $2,336 per patient within 30 days.[68] By integrating EmPATH's protocols into ED workflows, this telebehavioral health hub will improve outcomes, shorten ED boarding times, and offer local providers specialized support. A statewide network will enable consistent, high-quality psychiatric care for rural patients while optimizing Kentucky's existing resources. In addition, Kentucky will allocate funds for consumer-facing mobile health applications to support the continuity of recovery care for providers, caregivers, and patients discharged from EmPATH units, paramedicine interventions, and telebehavioral health programs.

Component 4: Integrate a real-time technology platform to facilitate seamless electronic connections beginning with crisis call and first responders and throughout the care continuum to enable centralized tracking of each patient's journey and "kill the clipboard." Kentucky's crisis call system is experiencing a sharp growth in demand with a 5% increase to CMHCs and a 33% increase to 988 calls. This signals a greater willingness among Kentuckians to seek help but has also resulted in strained capacity and response rates falling below 90%.[69] The system will be built in collaboration with the chronic health platform and enable interoperability across platforms, directing 988 calls to appropriate teams to shorten response times, improve safety, and facilitate triage needs. It will incorporate features such as EHR integration, telehealth connectivity, and automated referral tracking to re-direct encounters away from the ED and towards community resources. With robust data collection and advanced analytics capabilities, Kentucky will monitor key metrics (e.g., response times, stabilization rates, follow-up engagement, cost savings) across the entire crisis continuum. This approach will help centralize referral management and reporting, streamline administrative processes, enable providers and stakeholders to collaborate statewide, and employ AI-enabled tools to drive system performance. This approach will impact all counties across the state, ensuring Kentuckians in crisis have "someone to call, someone to respond, and somewhere to go," with real-time navigation supporting the mental health workforce.

Sustainability Consideration: The *Rapid Response to Recovery* initiative will support startup costs to establish new EmPATH units, expand mobile paramedicine/co-responder teams to new counties, and launching telebehavioral health infrastructure including a mobile health app. Each component is designed to reduce reliance on RHTP dollars over time as services are reimbursed through a mix of Medicaid/Medicare (~65%) and commercial insurance (~20%). This approach

incentivizes the transition to billable revenue from patient services while also partnering with CMHCs, current CCBHCs, and other providers to leverage existing Medicaid reimbursement and diversified funding streams. Refer to the *Sustainability Plan* section for details.

Main Strategic Goal: Innovative Care

Use of Funds: D, E, F, G, H, I, J, K

Technical Score Factors: B.1, C.1, C.2, D.1, E.1, F.1, F.2

Key Stakeholders: Rural Hospitals, CCBHCs, CMHCs, First Responders, EMS, Paramedicine Providers, Co-Responders, CBOs, KORH, UK

Outcomes: The *Rapid Response to Recovery* initiative will transform Kentucky's behavioral health crisis system by expanding community-based crisis support, scaling EmPATH units for rapid stabilization, and launching a centralized telebehavioral health hub and mobile health app. These initiatives will improve timely access to high acuity psychiatric crisis care, enhance patient outcomes, enable successful handoffs to community partners, and provide a mobile health app to empower patients with resources and encouragement throughout their recovery journey.

Objective: Improve timely access to high acuity behavioral health crisis care, enhance patient outcomes, and enable successful handoffs to community partners				
Key Result	**Measurable Outcomes**	**Baseline**	**Target**	**Relation to Initiative**
1) Increased utilization of community paramedicine and co-responder teams	% of EMS incidents responded with paramedicine or co-responders	Baseline will be established in Year 1 for pilot counties. *(33% average in current operating units, as of 2025)*	10% by Year 2. 40% by Year 5.	EMS providers responding to crisis calls with trained behavioral health support will improve patient experience.
2) Decreased ED utilization for behavioral health	# of adult ED visits primarily for behavioral disorders	*36,362 ED visits with primary diagnosis for behavioral health, statewide*	3% decrease by Year 2. 10% decrease by Year 5.	Opening EmPATH units and launching community paramedicine and co-responder teams will reduce behavioral health ED utilization.

Objective: Improve timely access to high acuity behavioral health crisis care, enhance patient outcomes, and enable successful handoffs to community partners				
Key Result	**Measurable Outcomes**	**Baseline**	**Target**	**Relation to Initiative**
3) Increased likelihood an individual enters active treatment	% of patients seen at EmPATH units who complete their first follow up appointment	Baseline will be established in Year 1 for pilot units. *(65% in current unit, as of 2025)*	Achieve 30% adherence by Year 3. Achieve 50% adherence by Year 5.	Increasing active treatment will accelerate patient recovery. EmPATH units enable more rapid treatment and connection to local CMHCs and CCBHCs for follow up care.
4) Increased access to telebehavioral health support for urgent response	% of telehealth services delivered in primary care settings for behavioral health crisis response	Baseline will be established in Year 1. *(Net new service)*	10% by Year 3. 33% by year 5.	A telebehavioral health hub for crisis response will enable more rapid response for patients and reduce ED visits by redirecting individuals in need to telebehavioral health support rather than admitting them to EDs

Figure 10. OKRs for Rapid Response to Recovery Initiative

Supporting Evidence

Component	Examples of Success
EmPATH Models	• SCDHHS EmPATH Units and SCHA learning collaborative (South Carolina) • Centra Health Lynchburg General Hospital EmPATH Unit (Virginia)
Community-based Crisis Support	• Crisis Assistance Response and Engagement (Care) Pilot Program (Chicago) • Eugene CAHOOTS (Oregon) • National MCT Benchmarks 2024 to 2025 (NRI State Profiles)
Telebehavioral Health Models	• Statewide centralized telebehavioral health hub (South Carolina) • Texas Tech Rural Telebehavioral health Initiative (Texas)
Real-Time Technology Platform	• GCAL & Behavioral Health Link Platform (Georgia) • STRIVIN' Community CareLink (Missouri)

Figure 11. Examples of Similar Models for Rapid Response to Recovery Initiative

Impacted Counties: Implementation of this initiative will begin with Eastern Kentucky's FIVCO region and surrounding counties with the development of one EmPATH unit and the launch of paramedicine and co-responder programs. In phase 2, the initiative will impact four additional Eastern Kentucky ADDs and by phase 3 start to reach Western Kentucky. Over the five-year grant period, telebehavioral health components are expected to have a positive impact across most of the state's rural counties.

Estimated Required Funding: Approximately $30-43 million per budget period (of

hypothetical $200 million), for an estimated total of $190 million over the five RHTP budget periods. See *Budget Narrative* for additional details.

Initiative Name: Rooted in Health: Kentucky Rural Dental Access Program

Initiative Description

Rooted in Health will improve dental care in rural communities through workforce development, teledentistry support, expanded community access points for oral care, and reduced ED visits for non-emergent dental pain at EDs. This initiative includes the following components:

1) **Increase the number of accredited dental hygienist education programs** in Kentucky and increase externship opportunities with rural providers
2) **Provide startup funding to develop a statewide teledental network** to support rural providers and public health hygiene teams
3) **Fund expanded mobile and/or portable dental care units** to deliver care in rural communities lacking sufficient access points
4) **Equip ED physicians with increased ability to administer intraoral injections** of long-acting local anesthetics through a mobile training program to reduce opioid administration and prescriptions for dental pain in EDs

Component 1: Accredited Dental Hygiene Programs: Kentucky will support start-up costs for accreditation of dental hygienist programs, including administrative and equipment costs. This initiative will also provide participating programs funding for rural externships with public health hygiene units and rural private practices. Kentucky has engaged several potential campuses for expansion, including multiple campuses of KCTCS. The funding for this component will prioritize establishment and supporting expansion of existing training programs.

Component 2: Teledental Hubs: The state will partner with Kentucky's dental colleges to fund startup costs necessary to launch and staff centralized hubs for teledentistry. The hubs will have satellite clinics as spokes across rural Kentucky that will connect with the hubs for billable consultations. Public health hygiene teams will be assigned to each hub to access necessary (virtual) oversight for more complex cases at each satellite clinic to enable hygienists in the field to provide care under the supervision of the hub site dentist. Hub sites will incorporate administration of the teledentistry hubs into their academic programs and connect dentistry students into the program, providing students with more exposure to the oral healthcare needs of rural Kentuckians. Through the administration of the hub network, hygiene teams will enhance data collection, expand use of interoperable clinical records (e.g., Oral Health Interoperability Alliance), embed consumer-facing technology, and explore opportunities to embed artificial intelligence into consultations and closed loop referrals initiated by the hub.

Component 3: Portable and Mobile Dental Care:

- **Increase number of Public Health Dental Hygiene Programs and increase the number of patients served by the portable clinics:** The Public Health Dental Hygiene Program provides preventive dental services and oral health education through portable units designed to transport equipment for temporary use on-site in rural K-12 schools. Kentucky will increase the number of teams with the goal of addressing all jurisdictions with demonstrated need. Kentucky will provide partners with funding to hire staff and procure equipment. Local health districts will receive additional incentive funding when meeting patient interaction targets (e.g., number of cleanings). The added incentive will partially support staffing costs for hygienists, dental assistants, a CHW, and a coordinator. Patient interaction targets will be set at the jurisdiction level and be based on a % of the total addressable Medicaid population

within a local health district. Any patient seen, regardless of insurance status, will count toward a district's incentive target.

- **Provide public health hygienists with a supervising dentist, enabling service to adults and seniors with more complex needs in long-term care (LTC) settings:** Each public health hygiene team will be connected to a supervising dentist at one of the teledental hubs. Supervising dentists can authorize public health hygienists to administer silver diamine fluoride (SDF) treatments and care for patients beyond the American Society of Anesthesiologists (ASA) classification of ASA II+ (ASA II+ refers to any patient that does not meet the ASA I classification of "A person in good health"). With the general supervision arrangement, public health hygiene teams will be able to deploy portable units to additional community sites—such as LTC facilities, where there is high and recurring need—and other community organizations to host portable clinics to reach underserved adults in rural Kentucky.
- **Deploy mobile dental health vans capable of more complex oral care unmet by public health hygienists:** Kentucky will fund start-up costs for mobile dental units that can provide the full spectrum of dental care (including restorative and extractive services) and denture care for seniors in long-term care settings. The state will seek a partner(s) to provide dental health services to underserved rural populations, especially in areas identified by the public health hygiene teams to be of particularly high need.

Component 4: Intraoral Injection Education for ED Physicians*:* Kentucky will train ED physicians to administer intraoral injections of long-acting local anesthetics through a mobile training program. This initiative will support ED clinician trainings conducted by a dentist or oral/maxillofacial surgeon, including costs associated with equipment, supplies and labor. The

training will increase the number of emergency physicians using local anesthetics to provide immediate pain relief, reduce the use of opioid medications for dental pain, and reduce return ED visits within 48 hours. The training will also include an overview of what should be included in a patient's care kit and engage non-clinical staff who can help connect patients to a CHW to facilitate follow-up dental care where the underlying cause of pain can be treated.

Sustainability Consideration: The Kentucky *Rooted in Health* initiative is focused on establishing financially sustainable rural dental services and training programs over the five-year grant period. To do so, RHTP funding will be used to cover start-up infrastructure costs and temporarily supplement operating costs. Once operational, the public health hygiene programs and mobile services will be revenue-generating through reimbursable services. We will work with teams to define targets to reach self-sustaining breakeven patient volumes by the end of the grant period as RHTP funding is scaled down. Refer to the *Sustainability Plan* section for additional information.

Main Strategic Goal: Workforce Development

Use of Funds: A, B, D, E, F, G, I, J, K

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

Key Stakeholders: State academic institutions, LHDs, FQHCs, K-12 schools, LTC settings, adult day care centers, private dental practices, EDs, and constituent advocacy groups

Outcomes: *Rooted in Health* will adapt operations in real time by tracking a focused set of metrics year over year. These align with identified outcomes tied to improving dental care access, strengthening workforce capacity, and reducing emergency department utilization for non-emergent dental conditions. Each metric was chosen for its ability to provide actionable insights, reflect meaningful change, and guide continuous improvement across components.

Objective: Improve the oral health of rural Kentuckians through preventative cleanings and improved connectivity with oral health specialists				
Key Result	**Measurable Outcomes**	**Baseline**	**Target**	**Relation to Initiative**
1) Increased preventative oral care utilization for adults	% of adults on Medicaid (18+) that have a claim for dental cleaning(s) within the past year	6% (as of 2025)	5% increase by Year 3. 10% increase by Year 5.	Increased public health hygiene teams serving adults in community settings as well as increasing resources to develop mobile care capacity will increase the percentage of adults accessing preventative dental care.
2) Increased preventative oral care utilization for children	% of children (aged 4 to 20) on Medicaid that have a claim for dental cleaning(s) within the past year	44% (as of 2025)	5% increase by Year 3. 15% increase by Year 5.	The increase in number of public health hygiene teams will increase the number of children able to access a dental cleaning at or through school.
3) Increased supply of dental hygienists in rural counties	# of dental hygiene students that graduate from a Kentucky-based program	102 (as of 2025)	10% increase by Year 3. 50% increase by Year 5.	The creation of new dental hygiene programs will increase the number of graduates; increased externships with public health hygiene programs in rural communities will increase the percentage of newly trained hygienists who choose to stay in Kentucky.
	# of licensed dental hygienists registered in a fully rural counties (based on business location and county HRSA designation)	873 (as of 2025)	8% increase by Year 3. 15% increase by Year 5	
4) Reduced emergency department visits from preventable dental needs	# of hospital visits for non-traumatic dental presentations in EDs	33,960 (as of 2024)	10% decrease by Year 3. 20% decrease by Year 5.	The administration of trainings for emergency department physicians and staff will reduce the number of recurring visits (patients with dental pain are more likely to return to an ED without a proper dental handoff).
5) Increased utilization of telehealth systems for dental care delivery	# of virtual consults with dentists and/or specialists through Medicaid	9 (as of 2025)	500% increase by Year 3. 1000% increase by Year 5.	Establishing a dental telehealth network and distributed supplies to public health hygiene units as well as rural practices will make it easier to access consults.

Figure 12. OKRs for Rooted in Health Initiative

Supporting Evidence Examples:

Component	Examples of Success
Accredited Dental Hygiene Programs	• Health Resources & Services Administration Oral Health Workforce Development Programs
Portable and Mobile Dental Care	• Reaching Vulnerable Populations through Portable and Mobile Dentistry—Current and Future Opportunities • New York University College of Dentistry's "Smiling Faces, Going Places" • 2023-2025 Minnesota Dental Safety Net Formula Grant Program

Component	Examples of Success

Teledental Models	• The Virtual Dental Home Model
	  • The California Dental Transformation Initiative
	  • The UCSF/Tuolumne County Virtual Dental Home
	  • The Colorado SMILES Initiative
	  • The Oregon Virtual Dental Home
	  • The Hawaii Virtual Dental Home
	  • The Idaho Virtual Dental Home
	  • The Iowa Virtual Dental Home
	  • The Maine Virtual Dental Home
	• The School-Based Telehealth Network Grant Program

Intraoral Injection Education for ED Physicians	• Wisconsin Dental Pain Protocol

Figure 13. Examples of Similar Models for Rooted in Health Initiative

Impacted Counties: Early implementation of this initiative will focus on Kentucky's rural and non-metropolitan rural counties (as defined by HRSA). Selection of pilot sites and/or initial expansion sites for academic programs and public health hygiene teams will consider the counties that have the most severe needs. For example, as of 2023, five Kentucky counties have no practicing dentists: four of the five counties with no dentists are designated rural (Ballard, Fulton, Jackson, and Robertson), and three of the five counties designated as Appalachian have no dentists (Edmonson, Jackson, and Robertson).[70] These counties will be of particular focus for mobile oral care unit deployment for restorative and extractive care (beyond the scope of practice for a hygienist). Over five years, initiative components are expected to have statewide impact.

Estimated Required Funding: Approximately $16-33 million per budget period (of the hypothetical $200 million), for an estimated total of $119 million over the five RHTP budget periods. See *Budget Narrative* for additional details.

Initiative: From Crisis to Care: Integrated EMS and Trauma Response

Initiative Description

This initiative will enhance prehospital care capacity, responsiveness, and coordination by enhancing workforce training, mobile resources, and telemedicine, thereby empowering EMS professionals to treat patients in place and ensuring smoother coordination with hospitals for trauma and specialty care. There are five main components of this initiative.

Component 1: EMS and CHW Workforce Recruitment & Development*:* The most significant unmet health need facing Kentucky's rural population is ensuring an adequate EMS and paramedic workforce to meet demand. Rural areas often struggle with insufficient numbers of trained paramedics and EMS professionals, resulting in delayed response times and limited access to timely care. In fact, the Kentucky Board of Emergency Medical Services (KBEMS) reported that 21% of prehospital providers will not renew their license in Kentucky and the number of new certified paramedics is less than the number leaving the workforce.[71] The Commonwealth proposes funding new education and training programs to increase the production of trained paramedics in Kentucky. Additionally, we will support the costs of initial education courses for Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), and Paramedic students. We also intend to expand access to CHW training to ensure statewide availability given funding gaps in rural areas to establish training programs and apprenticeship sites. Lastly, to support training, particularly in rural areas, we will establish an EMS education mobile equipment program that will integrate technology, enhanced simulation labs, tele-education, and hybrid course delivery.

Component 2: Post-Response Case Management: To bridge the gap between EMS response and ensuring patients receive appropriate services, the Commonwealth proposes providing post-

response case management. We will train EMS providers to utilize a social determinants of health (SDOH) assessment tool, such as the PRAPARE screening tool. This tool will enable EMS professionals to identify and address patient needs during emergency responses. In addition, EMS providers will receive training and technical assistance on conducting SDOH assessments, using the findings to inform their care decisions, and healthcare billing training to ensure the sustainability of these services. By integrating CHWs into EMS care teams, they will deliver evidence-based chronic disease interventions, preventive education and support, provide post-hospital follow-up, connect patients to medical and social resources, coordinate transportation, facilitate telehealth, and support remote monitoring programs.

Component 3: Treatment in Place (TIP) Care and Transport to Alternative Destination (TAD): Many Kentucky patients require transportation over long distances to reach appropriate facilities which can tie up scarce EMS resources and leave communities temporarily unprotected. The Commonwealth proposes a comprehensive approach to EMS by incorporating both TIP and TAD strategies. The plan establishes a system enabling ambulance crews in rural areas to deliver telemedicine services, allowing trained EMS personnel to assess and treat patients on site through real-time video consultations with qualified healthcare practitioners who can provide diagnoses, develop treatment plans, and offer follow-up recommendations without requiring hospital transport. Additionally, the proposal introduces a process authorizing agencies to transport patients to facilities better suited for their needs, such as urgent care centers, FQHCs, or behavioral health crisis stabilization units instead of traditional EDs. This dual strategy not only enhances patient care and resource efficiency but also supports ongoing partnerships among EMS, physicians, and other healthcare professionals to deliver emergency care, chronic disease management, preventive interventions, and screening services under appropriate supervision.

Component 4: Establish Regional Medical Operations Coordination Centers (RMOCC):

A major challenge in the Commonwealth is the lack of sufficient real-time information to support EMS providers and trauma centers in directing their limited resources and identifying the most appropriate hospital or facility for patient care. Kentucky's proposed RMOCC is designed to assure timely access to specialty care—such as trauma, stroke, cardiac, and pediatric services—and expand trauma centers capacity and efficiency by providing real-time visibility into bed and critical resource availability as well as coordinating patient transfers statewide. The RMOCC aims to minimize delays in emergent care by balancing EMS workloads and reducing emergency department crowding through region-wide coordination. It standardizes response protocols for both planned and unplanned surges such as mass casualty incidents, severe weather events, and infectious disease outbreaks thereby ensuring the region can rapidly adapt to evolving demands. The RMOCC will serve as a centralized operational hub, offering a comprehensive situational awareness platform that tracks real-time bed status across emergency, intensive care, and pediatric units as well as trauma bays, cath labs, operating rooms, ventilators, and diversion statuses. It will also monitor EMS system readiness by providing updates on call volumes, unit availability, and hospital offload times in addition to highlighting pediatric capabilities to ensure appropriate care for children. A dedicated transfer and load-balancing desk will operate around the clock, enabling one-call coordination for interfacility transfers with clear escalation pathways for critical conditions supported by protocol-based triage and teleconsultation with specialty providers. During surges or emergencies, the RMOCC will support region-specific clinical coordination to facilitate mutual aid—including staffing, transport, and equipment pooling—and specialized pediatric and neonatal transfer plans. The center will also support ongoing quality improvement through data analytics, after-action

reviews, regular clinical performance collaboratives, and public reporting to foster transparency and continuous enhancement of emergency medical services across Kentucky.

Component 5: Establishment of a Special Needs Tracking and Awareness Response System (STARS) for Children with Complex Medical Needs: Children with complex medical needs living in rural areas within the Commonwealth are far from the specialty clinics where they receive their care, and EMS is likely to have very little information about their complex care at the time of an emergency. The STARS program is an initiative to aid in EMS care of children with complex medical needs. These children present a special challenge in emergency care as they often have atypical vital signs at baseline, require specialized equipment, and have non-standard physiology that can mean typical treatments in an emergency may not work. The program will collaborate with the child's treatment team to develop information specific to that child and share it with participating EMS agencies, getting the right information to the right people at the right time to help care for children with these complex medical cases.

Sustainability Consideration: This initiative is built for long-term sustainability through strategic investments in infrastructure, workforce development, and diversified funding streams, including insurance reimbursements and participation fees. Refer to the *Sustainability Plan* section for additional information.

Main Strategic Goal: Sustainable Access

Use of Funds: A, B, D, E, F, G, K

Technical Score Factors: B.1, C.1, C.2, D. 1, F.1, F.2

Key Stakeholders: KBEMS, KORH, Kentucky Hospital Association (KHA), Rural Hospitals, State Level 1/2/3 Trauma Hospitals, EMS Providers, EMS and CHW Training Organizations, FQHCs, Kentucky Primary Care Association, SUD Centers, CCBHCs, VA Medical Centers

Outcomes: Below are four outcomes that will be tracked by the Commonwealth for this initiative. As this initiative will begin with pilot programs in the Appalachian Region of Kentucky, the Commonwealth will begin tracking within the pilot counties.

Objective: To enhance prehospital care capacity, responsiveness, and coordination				
Key Result	**Measurable Outcomes**	**Baseline**	**Target**	**Relation to Initiative**
1) Build Capacity for EMS providers and CHWs	Annual # of newly certified EMTs, AEMTs, paramedics, and CHWs	507 emergency medical responders 4,501 paramedics ~650 CHWs	Dependent on baseline, targets to be determined in Year 1.	Tracking the annual number of newly certified professional ensures that Kentucky has a robust and qualified emergency response team capable of meeting increased demand and improving health outcomes.
2) Appropriate Level of Care	% of EMS calls resulting in TIP or TAD	Baseline will be established in Year 1.	Dependent on baseline, targets to be determined in Year 1.	Monitoring the percentage of EMS calls resulting in TIP or TAD reflects efforts to optimize patient care and resource allocation to ensure that patients receive the most appropriate level of care for their needs.
3) Improved Patient Outcomes	% of preventable hospital ED visits	Baseline will be established in Year 1.	Dependent on baseline, targets to be determined in Year 1.	Evaluating rates of preventable hospital ED visits provides critical feedback on the quality and effectiveness of EMS and trauma services.
4) Better Coordinated EMS and Trauma Systems	% of RMOCC partners' access to up-to-date facility and patient-specific care	Baseline will be established in Year 1.	Dependent on baseline, targets to be determined in Year 1.	Measuring access to up-to-date facility and patient-specific care indicates the effectiveness of system integration and information sharing, allowing EMS providers to make informed decisions, improve response times, and ensure seamless transitions between care settings.

Figure 14. OKRs for Crisis to Care Initiative

Supporting Evidence

Component	Examples of Success
Workforce Recruitment and Development	• RHI Hub – Rural EMS) and Trauma – Models and Innovations
Post-Response Case Management	• RHI Hub – Kentucky Homeplace
TIP / TAD	• Emory Prehospital and Ambulatory Virtual Emergency Services • CMS – Emergency, Triage, Treat, and Transport (ET3) Model • Health Affairs – Giving EMS Flexibility in Transporting Low-Acuity Patients Could Generate Substantial Medicare Savings
Regional Medical Operations Coordination Centers	• Inside Tennessee's Regional Coordination Centers • American College of Surgeons - Regional Medical Operations Coordination Centers • JAMA – Regional Transfer Coordination and Hospital Load Balancing During COVID-19 Surges • Southern Regional Disaster Response System: Medical Operations Coordination Cell (MOCC)
STARS	• American Academy of Pediatrics - Special Needs Tracking and Awareness Response System (STARS); Improving Emergency Care for Pediatric Patients with Complex Medical Needs • STARS: Special Needs Tracking and Awareness Response System

Figure 15. Examples of Similar Models for Crisis to Care Initiative

Impacted Counties: This initiative will start within the Appalachian Region of Kentucky, which includes 54 counties.[72] However, by the end of the program, it is anticipated this initiative will impact multiple rural or non-metropolitan counties outside Appalachia as the pilot programs expand (see Appendix B in *Other Supporting Documentation*).

Estimated Required Funding: Approximately $27-47 million per budget period (of the hypothetical $200 million), for an estimated total of $182 million over the five RHTP budget periods. See *Budget Narrative* for additional details.

IMPLEMENTATION PLAN AND TIMELINE

The table below provides a high-level overview of Kentucky's RHTP implementation plan.

Stage 0 (FY26)	**Stage 1** (FY27)	**Stage 2** (FY28)	**Stage 3** (FY29)	**Stage 4** (FY30)	**Stage 5** (FY31)
Planning	*Initial Launch*	*Early Scale*	*Implementation Mid-point*	*Near Completion*	*Fully Implemented*
1) Rural Community Hubs for Chronic Care Innovation					
• Stand up state-level RCH coordination team • Confirm backbone organization • Select 2 pilot ADDs • Define requirements and procure solutions for digital tools	• Launch RCHs in 2 ADDs (obesity and diabetes focused) • Digital collaboration hub (MVP) and care coordination tool launched in 2 ADDs • Semantic data model and governance models established	• RCHs in 5 ADDs (obesity and diabetes focused) • Digital collaboration hub (version 1) and care coordination tool in 5 ADDs • Patient matching and clinical decision support • Complete program evaluation	• RCHs in 10 ADDs (obesity and diabetes focused) • Digital collaboration hub (version 2) with mobile app in 10 ADDs • Establish advisory council • Population health analytics and virtual care capabilities	• RCHs in 15 ADDs (chronic disease focused) • Production digital collaboration hub available statewide • Identification of funding sources • Revenue cycle optimization, first AI model deployment • Complete program evaluation	• Implemented statewide for rural health initiatives • Long-term funding streams secured • RCH program transferred to non-profit, university, or PPP for sustainability • Disease registries, AI-driven care pathway capabilities
2) PoWERing Maternal and Infant Health: Community-Based Teams					
• Select pilot region and partner clinics • Develop Notification of Pregnancy (NOP) rubric for PoWER Team eligibility	• Pilot in 2 ADDs • Establish local wraparound partnership • Establish Perinatal CHW certification program • Deploy care coordination tool to active PoWER Teams	• Expand into 5 total ADDs • Pilot community education program using HANDS • Complete program evaluation	• Expand to 10 total ADDs • Reach 50% of KY's rural counties • Define APM opportunities with Medicaid and private insurers	• Expand to all 15 ADDs • Design bundled payments with Medicaid • Explore bundled payment opportunities with private insurers • Complete program evaluation	• Implemented statewide • Sustainable funding secured (e.g., PoWER teams reimbursable through MCOs and private payers)

Stage 0 (FY26)	**Stage 1** (FY27)	**Stage 2** (FY28)	**Stage 3** (FY29)	**Stage 4** (FY30)	**Stage 5** (FY31)
Planning	*Initial Launch*	*Early Scale*	*Implementation Mid-point*	*Near Completion*	*Fully Implemented*
3) Rapid Response to Recovery: EmPATH Model with Mobile Crisis and Telehealth					
• Identify pilot hospitals and community behavioral health partners • Establish EmPATH Consortium • Identify community paramedicine partners • Assess telebehavioral health readiness and determine delivery model • Execute MOUs	• Launch 1 EmPATH pilot in Eastern KY and collect initial outcome data • Launch community paramedicine pilots in 5 counties and collect initial outcome data • Build telebehavioral health program with 6 pilot participants • Award sub-grantees	• Expand Eastern KY EmPATH unit • Expand community paramedicine pilots to at least 5 new counties • Launch telebehavioral health hub to support rural EDs, PCPs and first responders in 11 counties • Complete program evaluation	• Launch 1 new EmPATH unit (Western KY) • Expand community paramedicine program to at least 5 new counties and scale integrations • Expand telebehavioral health to operate as regional consultation hubs to serve non-EmPATH hospitals/ EMS in 11 additional counties	• Launch 1 new EmPATH unit • Expand community paramedicine program to up to 10 new counties • Expand telebehavioral health program to 11 new counties • Expand collaboration of EmPATH, community paramedicine programs • Publish public KPI dashboard • Complete program evaluation	• Operate statewide collaboration hub network • Expand community paramedicine program to up to 10 new counties • Expand telebehavioral health program to 16 new counties • Reach majority rural counties through telehubs and EmPATH network • Publish leading practices, case studies, and learnings
4) Rooted in Health: Rural Dental Access Program					
• Identify expansion sites for dental hygiene programs • Identify expansion sites for public health dental hygiene teams • Establish teledental network with dental colleges • Contract dentist(s) or oral surgeon(s) to develop and conduct ED intraoral injection trainings	• Connect 50% of public health dental hygiene teams to a teledental hub, supervising dentist • Launch ED intraoral injection trainings • Select funding recipients and launch mobile dentistry	• Connect 100% of public health dental hygiene teams to a teledental hub, supervising dentist • Increase reach of public health hygiene teams to over 50 counties • Complete program evaluation	• Graduate first students from new dental hygiene programs • Provide intraoral injection trainings to ED staff in at least one facility within 20 counties	• Complete program evaluation • Increase reach of public health hygiene teams to all 15 ADDs	• Create 100th new training slot for dental hygienists at accredited training programs • Provide intraoral injection training to ED staff in at least one facility within all 15 ADDs

Stage 0 (FY26)	Stage 1 (FY27)	Stage 2 (FY28)	Stage 3 (FY29)	Stage 4 (FY30)	Stage 5 (FY31)
Planning	*Initial Launch*	*Early Scale*	*Implementation Mid-point*	*Near Completion*	*Fully Implemented*
5) From Crisis to Care: Integrated EMS and Trauma Response					
• Create workgroups • Identify organizations and partners for pilot program • Creation and approval of protocols • Define funding allocation strategy and other foundational processes • Define requirements for technology	• Launch pilots of EMS training and recruitment, post-response case management, and TIP/ TAD • Pilot expansion of STARs • Technology procurement for RMOCC • Finalize MOUs, data-use and information-sharing agreements for RMOCC	• Launch technical assistance and collaboratives to support pilot initiatives • Expand EMS training and recruitment, post-response case mgmt.., TIP and TAD, and STARs • Launch RMOCC pilot in Appalachian Region • Complete program evaluation	• Continued expansion pilot programs • Launch 2nd RMOCC • Identify state regulations or policies needed to support long-term success	• Expand pilot programs • Identification of other funding sources and partners (state, public-private partnerships, membership fees) • Use pilot evaluation to support policy regulation and policy changes and secure ongoing funding • Complete program evaluation	• Identify statewide leading practices, case studies, and lessons learned • Establish long-term funding streams to sustain work • Maintain robust state-level technology capacity for RMOCCs and EMS telehealth

Figure 16. Kentucky RHTP Implementation Plan by Initiative

Governance and Project Management Structure

The Department for Public Health (DPH) within Kentucky CHFS will serve as the lead agency supporting RHTP implementation. DPH will work collaboratively with other agencies and key stakeholders to ensure the program is fiscally responsible, meets reporting requirements, makes progress towards established goals, and is sustainable.

Kentucky intends to build a new team within DPH to support the RHTP. Kentucky's RHTP A^3 Team will function as the operational "nerve center" of the RHTP. Figure 17 below provides an overview of the intended type and count of staff that will be utilized during the program. The A^3 Team integrates program oversight, analytics, communications, and partnerships across CHFS, academic partners, and community organizations. Over five years, the A^3 Team could evolve into a public-private collaborative entity (or other entity), sustaining innovation capacity and coordination beyond the grant period.

Tier	Role Examples	FTEs	Notes
Leadership Core	Executive Director, Deputy Director	~2	Commissioner retains oversight; may rotate deputies from other CHFS divisions.
Initiative Leads	Initiative Leads for Chronic Disease, Maternal Health, Behavioral Health, Oral Health, EMS/Trauma	~5	Each manages a major program workstream; sits within an initiative team, but reports to the A3 leadership core.
Horizontal Leads	Program Managers (Clinical and Community Domains), Data Analytics, Technology Enablement, Quality and Evaluation, and Workforce Planning	~5	Ensure consistency, reporting, and provides cross-cutting capabilities.
Support Analysts	Deputies for each Initiative Lead, Financial Analysts (x2), and a Health Informatics Specialist	~8	Comprised of analysts that support Initiatives and/or Horizontal Leads.

Figure 17. Anticipated A^3 Team Staffing

Additionally, DPH anticipates hiring consulting and technical support firms to support the implementation of the RHTP in areas such as project management, technology integration, and evaluation services. Please refer to Appendix N in *Other Supporting Documentation* for a proposed organizational chart.

STAKEHOLDER ENGAGEMENT

As part of its commitment to robust engagement, Kentucky CHFS solicited input directly from rural health stakeholders including health care provider organizations, associations, and academic and research centers in late July to seek innovative ideas and recommendations for Kentucky's RHTP application. Stakeholders were asked to respond to this request by September, generating significant interest across the Commonwealth, and resulting in over 50 responses from a diverse array of organizations. Each submission was reviewed by the CHFS and used to inform the development of the five proposed initiatives for Kentucky's RHTP application.

Stakeholders

Kentucky is pleased to share letters of support for each of the five initiatives (see Letters of Support in *Other Supporting Documentation)*, demonstrating broad support for our RHTP approach. The Commonwealth is committed to working with these and other stakeholders.

Initiative	Stakeholder Engagement
Rural Community Hubs for Chronic Care Innovation	The Rural Community Hubs initiative will bring together a broad coalition of partners across Kentucky's rural health system to foster coordinated, community-driven action on chronic disease prevention and management. Key stakeholders include LHDs, ADDs AAAs, MCOs and Payers, Healthcare Providers, CBOs and FBOs, SOAR, Employers and Local Businesses, Schools and Educational Institutions, CHWs, and State Agencies.
PoWERing Maternal and Infant Health: Community-based Teams	The PoWER Team initiative will bring together a broad coalition of partners across Kentucky's rural health system to foster coordinated, community-driven action on maternal and infant health. Key stakeholders include LHDs, FQHCs, RHCs, CAHs, Primary Care Associations, Hospital Associations, Perinatal Quality Collaboratives and Perinatal Associations, Behavioral Health Providers, CBOs and FBOs, SOAR, Advocacy Organizations, Nursing and Professional Associations, Organizations from existing Maternal and Infant Health Initiatives and Home Visiting Programs (e.g., HANDS), Rural Health Centers of Excellence and the Office of Rural Health, Educational Institutions, MCOs and Payers, and State Agencies.
Rapid Response to Recovery: EmPATH Model, Mobile Crisis and Telehealth	Rural stakeholders have been engaged throughout the development of the four initiative components. The Kentucky Department for Medicaid Services led a statewide needs assessment that prioritized rural gaps through surveys, interviews, and advisory work groups with rural providers, agencies, and community members. The CCCR model was co-developed with input from over 56 individuals representing 34 organizations (rural law enforcement, EMS, CMHCs, PSAPs, peer support associations, and healthcare providers) to address unique rural challenges such as limited behavioral health resources, transportation barriers, and workforce shortages. Rural paramedicine mobile crisis teams were piloted in collaboration with city and county officials, first responders, and school resource centers, shaping program design and referral systems between 988 and 911. The EmPATH model features ongoing, deep collaboration with local CMHCs as daily partners and the establishment of a statewide EmPATH Consortium, ensuring rural voices are represented in governance, data sharing, and continuous improvement cycles.
Rooted in Health: Rural Dental Access Program	This initiative is built on the collective input and collaboration of key stakeholders across Kentucky, including the UK College of Dentistry, UK TeleCare, the University of Louisville College of Dentistry, Pikeville College of Dentistry, KCTCS, Murray State University, the Kentucky Dental Association, Kentucky Voices for Health, SOAR, the UK College of Public Health. It also includes the input of organizations representing aging and long-term care such as the Kentucky Association of Health Care Facilities, Leading Age Kentucky, the Kentucky Association of Adult Day Centers, the Kentucky Association of Area Agencies on Aging, the Kentuckiana Regional Planning & Development Agency, and the State Long-Term Care Ombudsman.
From Crisis to Care: Integrated EMS and Trauma Response	To support the development of this initiative, CHFS has consulted and will continue to consult several organizations within the EMS and trauma system community, including but not limited to KBEMS, KHA, SOAR, and KORH.

Figure 18. Initiative Stakeholder Engagement

Engagement Framework

Kentucky is committed to fostering robust, ongoing collaboration with all relevant state entities to ensure the effective implementation and success of the RHTP. Kentucky CHFS will work across agencies and leverage existing collaborative structures to align fund deployment, track milestones, and evaluate impact metrics to ensure all partners have a shared understanding of program goals and progress. Through this coordinated approach, Kentucky CHFS will maintain transparent communication channels and inclusive decision-making processes across agencies and partners. This will facilitate timely identification and resolution of challenges, promote best practices, and ensure that stakeholders are represented in shaping and monitoring the RHTP. For each initiative, Kentucky has outlined its stakeholder engagement framework.

Initiative	Engagement Framework
Rural Community Hubs for Chronic Care Innovation	Stakeholder engagement will be ongoing and formalized through State-level and District-level Coordination Teams that will facilitate regular open forums, enabling diverse voices—including those of patients and caregivers—to be represented in governance and decision-making.
PoWERing Maternal and Infant Health: Community-based Teams	Stakeholder engagement will be ongoing and formalized through State-level and Regional Coordination Teams that will facilitate regular open forums, enabling diverse voices—including those of patients, families, and frontline providers—to be represented in governance and decision-making.
Rapid Response to Recovery: EmPATH Model, Mobile Crisis and Telehealth	Supported statewide, the initiative will form an EmPATH Consortium to oversee program governance, bringing together hospitals, mental health centers, EMS, payers, and community partners. Chaired by CHFS and DBHDID leads, the Consortium will serve as the backbone for the initiative, set the agenda, budget, and measures, and support a Stakeholder Advisory Council for feedback. All core stakeholders will collaborate to align transport and treat-in-place protocols, EmPATH and telebehavioral health workflows, workforce actions, value-based payment levers, and continuous improvement cycles to drive sustainable rural impact.
Rooted in Health: Rural Dental Access Program	Kentucky will create a dedicated team of state experts within the CHFS for the duration of the grant with the expectation that each component's operations will become self-sustaining afterwards. This team will foster partnerships, set regulations and requirements as well as manage implementation rollout.
From Crisis to Care: Integrated EMS and Trauma Response	Kentucky will create several workgroups in Phase 0 to support each component of the initiative, support defining metrics, baselines, and targets, and share best practices and lessons learned during the pilot phases. We intend to reflect the communities we engage, including EMS patients, CHWs, EMS providers, and more.

Figure 19. Initiative Engagement Frameworks

METRICS AND EVALUATION PLAN

Initiative-specific metrics are outlined in the initiatives section to ensure clear accountability and alignment with program goals. For some initiatives, Kentucky plans to use Phase 0 to define baseline values and set targets in collaboration with relevant stakeholders, while also identifying appropriate data sources and specifying measurement details. Kentucky will contract with RHTP implementation partners to include requirements for measurement and accountability. Figure 20 below outlines the overall goals that will be measured throughout the program.

Initiative	Goal
Rural Community Hubs for Chronic Care Innovation	Reduce obesity and diabetes rate through evidence-based, community-led strategies focused on upstream prevention
PoWERing Maternal and Infant Health: Community-based Teams	Increase timely perinatal care in maternity care deserts through coordinated, telehealth-enabled teams
Rapid Response to Recovery: EmPATH Model, Mobile Crisis and Telehealth	Expand integrated, technology-enabled crisis care from community response to long-term support
Rooted in Health: Rural Dental Access Program	Improve rural access to preventive dental care and treatment through expanded training, geographically distributed dental hygiene clinics, and mobile, portable services
From Crisis to Care: Integrated EMS and Trauma Response	Strengthen capabilities and capacity for pre-hospital care and treatment in-place interventions

Figure 20. Potential Measures to Be Considered for Overall Program Impact

In addition to these initiative metrics, Kentucky intends to establish overall program metrics to monitor broader impact. A sample of potential measures is presented in Figure 21; Kentucky will leverage Phases 0 and 1 to assess and select measures that reflect the program's effectiveness.

Category	Metric	Type	Purpose / Rationale
Program Effectiveness & Impact			
Overall Reach	# of counties participating in at least one RHT initiative	Leading	Measures program penetration across rural Kentucky
System Transformation & Integration			
System-wide Collaboration	# of formal data-sharing or partnership MOUs executed	Leading	Reflects collective-impact strength
Innovation Adoption	# of pilot interventions scaled statewide	Lagging	Demonstrates replicability and learning

Category	Metric	Type	Purpose / Rationale
Fiscal Sustainability & Efficiency			
Fiscal Stewardship	Ratio of non-RHTP dollars leveraged (other federal, state, philanthropic, private) per RHTP dollar	Lagging	Gauges sustainability and external buy-in
Public Awareness & Engagement			
Community Engagement	# of community outreach events or town halls conducted	Leading	Engagement activity measure
	# of visits to public RHTP/Vitality Signs website or app	Leading	Digital awareness proxy
Perception & Trust	Public awareness of RHTP (survey)	Lagging	Evaluates reach of messaging
	Community satisfaction with local health services (annual survey)	Lagging	Perceived impact of transformation
Program Learning & Evaluation			
Reporting Compliance	% of initiatives submitting quarterly performance data on time	Leading	Ensures accountability

Figure 21. Potential Measures to Be Considered for Overall Program Impact

Program Evaluation

Kentucky will actively monitor and evaluate its progress toward its RHTP goals and will consider partnering with an independent evaluator, such as an academic institution, to support robust review of initiatives within our application. We recognize the importance of continuous evaluation throughout the program to monitor its current status, identify best practices, and enable ongoing improvements. Furthermore, we intend to leverage collected data to inform the program's evolution, promote its success, and long-term sustainability. Kentucky will cooperate with CMS-led evaluation or monitoring activities and is prepared to participate in assessments conducted by CMS or third-party evaluators across states.

SUSTAINABILITY PLAN

Kentucky is firmly committed to establishing and maintaining a sustainable RHTP program that will deliver long-term value for both the Commonwealth and its partners. We will pursue ongoing innovation and collaboration with rural health stakeholders and statewide partners, including the University of Kentucky's Advancing Kentucky Together Network.[73] In designing and implementing the Kentucky RHTP, we focused on operational feasibility and financial viability of each individual initiative. Beyond the duration of five-year federal investment, Kentucky aspires to establish a Public-Private Partnership (PPP) model in collaboration with rural health stakeholders. We anticipate this PPP will be led by an independent non-profit organization that will explore innovative funding models such as an endowment to pool charitable donations from public, private, and philanthropic organizations. Further, this PPP would be managed under a transparent governance structure to pursue shared priorities and collective actions across the Cabinet for Health and Family Services, academic and other community partners. This innovative approach reflects the Commonwealth's broader commitment to sustainability through collective investment, enabling rural health transformation to shift from time-limited funding to a self-sustaining model of continuous improvement.

Rural Community Hubs for Chronic Care Innovation

The *Rural Community Hubs for Chronic Care Innovation* initiative will be the starting point for this statewide Public-Private Partnership (PPP) model by engaging the broader rural health stakeholders in collaboration and collective action around shared chronic care innovation priorities. To realize this vision, the Rural Community Hubs will capture patient outcomes and demonstrate future potential for Medicaid waivers and/or outcomes-based alternative payment models to incentivize ongoing chronic care innovation through Rural Community Hubs.

Kentucky anticipates this five-year evaluation period will provide sufficient outcomes data to support design of alternative payment models and attract long-term funding from private sector foundations and philanthropies to provide sustainable funding for community-based grants.

PoWERing Maternal and Infant Health: Community-based Teams

The *PoWERing Maternal and Infant Health* initiative is designed for long-term sustainability beyond the RHTP funding period, with core functions embedded within Kentucky's existing healthcare and community infrastructure. PoWER Teams will be trained as kynectors to assist with Medicaid enrollment and renewal, providing continuous coverage through pregnancy and 12 months postpartum. PoWER Teams will screen patients for insurance status at first contact and help them leverage existing Medicaid benefits. For example, all five current Medicaid MCOs offer maternal health support services (e.g., mental health checks, breast feeding support, medical nutrition therapy) and each MCO offers a range of services that can be used to improve maternal health outcomes (e.g., reimbursement for doula services, rewards for prenatal and postpartum visit adherence, home meal plans after delivery). By coordinating existing roles through new, integrated PoWER Teams, the model minimizes the need for new hires.

A scalable, low-maintenance telehealth and care coordination platform will allow for ongoing remote monitoring, virtual visits, and seamless interoperable data sharing with providers. Once implemented, this technology requires minimal ongoing investment, can be scaled statewide, and can effectively help "kill the clipboard." Through rigorous data collection (e.g., MCCC's Azara/NextGen EHR integration model), we expect this initiative to show improvements in maternal/infant outcomes, cost savings, and patient engagement. Reimbursement models for the initiative are anchored in Medicaid-covered services for doulas, certified nurse midwives, telehealth, peer support specialists, and CHW support to fund this workforce expansion.

As the program proves its effectiveness, Kentucky will pursue bundled payment models for Medicaid and advocate for commercial payers and self-insured employers to offer PoWER Team services as a covered benefit. This approach positions PoWER Teams as a transformative, evidence-based solution that can be sustained beyond the initial grant period.

Rapid Response to Recovery: EmPATH Model, Mobile Crisis and Telehealth

To drive towards long-term sustainability after RHTP funding periods, Kentucky will integrate the *Rapid Response to Recovery* initiative into its established state and regional behavioral health systems. This approach will maximize existing resources through Medicaid reimbursement and explore future value-based contracts with managed care organizations and commercial payers, as well as ongoing collaboration with hospitals, CMHCs, CCBHCs, EMS, and CBOs.

RHTP funding will support initial investments in facility upgrades, workforce development, and infrastructure establishment. Once operational, we anticipate reimbursement for billable services will surpass operating costs, allowing for modest margins. Kentucky has already developed and refined best practices for EmPATH's revenue cycle management, payers are well-acquainted with these services, and the current unit has demonstrated a path towards cost recovery. Paramedicine, co-responder services, and telebehavioral health consultations will be billed using existing codes, with appropriate modifiers and place-of-service codes, consistent with CMS and Kentucky Medicaid guidelines. The state's intent is to continue supporting CCBHCs, which would enable further cost-based reimbursements for these services. Throughout the grant period, demonstration of reduced healthcare costs and improved quality of care through EmPATH units, paramedicine, co-responder response, and telebehavioral health access will demonstrate value for ongoing payer support. Beyond the five-year grant period, governance will be maintained by the EmPATH Consortium to monitor program fidelity, data reporting, and ongoing improvements.

Rooted in Health: Rural Dental Access Program

Each component of the *Rooted in Health* initiative has identified a pathway to sustainability:

- **Component 1: Accredited Dental Hygiene Programs**: Dental hygiene programs will generate recurring revenue through tuition payments.
- **Component 2: Teledental Hubs**: The Teledental Hubs will bill insurance for consults and generate revenue through referrals from the public health hygienists. To enable this model, a statewide network of distributed telehealth equipment will be established in rural dental clinics (spokes). The funding for Hub dentists will be supported by the growth of rural clinics, with subsidies declining over the life of the grant. Kentucky will work with the Hubs to replace that revenue with billable patient interactions or consults.
- **Component 3: Portable and Mobile Dental Care**: The Portable and Mobile Dental Care units will recover their operating expenses through insurance reimbursements, making the program financially sustainable after the initial startup investment phase. The financial investment risk of expanding hygienist capacity to meet demand in LTC settings will be offset by incentive-based payments to encourage LHDs to expand their hygiene programs over the duration of the RHTP grant. The increase in program reach will generate insurance reimbursements and result in collaboration between LHD hygiene units and LTC facilities.
- **Component 4: Intraoral Injection Education for ED Physicians:** ED training will be administered through a "train the trainer" model, such that physicians who participate in the training will receive the necessary materials to train peers. Other team members (including CHW and other ED staff) will also be provided with leave-behind training material which ideally will be incorporated into each facilities' training and onboarding programs.

From Crisis to Care: Integrated EMS and Trauma Response

Kentucky's *From Crisis to Care* initiative has been strategically designed to ensure long-term sustainability after the conclusion of RHTF funding. The Commonwealth is making significant upfront investments in infrastructure, technology, and workforce training to lay a strong foundation for ongoing operations. Throughout the pilot phase, CHFS will review policies and reimbursement pathways to support effective billing of both public and private insurers in order to expand coverage for EMS and CHW services. This approach will help secure stable revenue streams by leveraging existing Medicaid, Medicare, and commercial insurance reimbursements, particularly for non-transport services and CHW follow-ups.

CHFS will actively seek other funding opportunities. For initiatives such as the RMOCC, we will explore tiered participation fee structures. These annual fees, scaled by organization size, will cover a significant portion of operational costs and incentivize broad engagement. In-kind contributions from host health systems, such as physical space and IT support, will further offset costs, especially for rural providers. The EMS initiative will assess opportunities through Kentucky's Medicaid managed care value-based payment initiatives, rewarding EMS agencies for reducing avoidable emergency department visits and improving health outcomes through social determinants of health interventions. In the future, value-based incentives will be explored through Medicaid and commercial plans for improved timely transfers and lower costs. Sustainability will also be reinforced through formal workforce development pipelines for EMS and CHWs, supported by training programs at community colleges and universities. Hospitals and other referral partners will contribute to ongoing EMS provider training and technology, and participation in RMOCC may be incentivized through public reporting and inclusion in state quality programs. Kentucky's *From Crisis to Care* initiative will be maintained through a

balanced mix of insurance reimbursements, participation fees, payer partnerships, and other funding support. This diversified funding model will ensure the continued availability and improvement of EMS services beyond the initial RHTF funding period.

Kentucky's RHTP demonstrates how states can connect people, data, and purpose to renew rural health. The plan transforms fragmented services into a coordinated system where technology, workforce, and community engagement converge. Kentucky stands ready to serve as a national demonstration site for sustainable rural health transformation.

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