GROW: Cultivating Hoosier Health

Growing Rural Opportunities for Well-being

Introduction

Rural Indiana embodies the heart of the state, offering a unique blend of agriculture heritage and community spirit. As the ninth largest farming state in the nation, Indiana takes pride in its rural communities, which contribute billions in agriculture commodities to both the domestic and the global markets. Unfortunately, these same communities face significant and worsening challenges with access to healthcare and health outcomes, which is why Indiana is galvanized by the incredible potential of the Rural Health Transformation Program funding. This is a vital opportunity to spark change through innovative initiatives and locally tailored solutions that will significantly enhance the well-being of our rural populations.

Indiana is poised to seize this opportunity and make a transformative impact on rural health outcomes. Governor Mike Braun's administration has already elevated Hoosier health as a top-tier priority through the launch of the Make Indiana Healthy Again (MIHA) initiative, a bold strategy across rural Indiana that unites government agencies, schools, healthcare providers, and community partners in a shared mission to improve health outcomes, particularly for children and those affected by chronic illness. MIHA serves as a structural backbone for coordinated action, policy alignment, and resource mobilization. Building on this momentum, Indiana Health and Family Services ("HFS," or "Indiana," or "the State") – which includes the Indiana Department of Health ("IDOH"), the Indiana Family and Social Services Administration ("FSSA"), and the Indiana Department of Child Services ("DCS") – respectfully submits this Rural Health Transformation Plan (RHTP) application. Growing Rural Opportunities for Well-being in Health ("GROW"): Cultivating Hoosier Health is a powerful opportunity to amplify MIHA's reach and effectiveness.

By aligning with MIHA's foundational infrastructure and vision, GROW: Cultivating Hoosier Health (GROW) leverages Indiana's strong network of partnerships and existing implementation methods into a strategic and cohesive health strategy. This synergy ensures that the RHTP-funded work will be deeply embedded in Indiana's broader health transformation efforts, accelerating its impact and sustainability beyond the grant end date. The GROW initiatives outlined in this application directly confront the pressing healthcare challenges faced by rural Hoosiers, guided by robust community input, stakeholder collaboration and comprehensive data analysis. See **Appendix A** for a one-page snapshot of all activities and corresponding funding amounts requested as part of GROW.

Section 1: Rural Health Needs and Target Population in Indiana

Rural Demographics

According to the Federal Office of Rural Health Policy (FORHP) and Health Resources and Services Administration (HRSA), Hoosiers living in 64 of Indiana's 92 counties account for 1,846,221 people or 27% of the state's total population (Figure 1 - see **Appendix B** for FIPS codes). These rural counties tend to have smaller, aging populations, with 18% of rural residents older than 65 compared to 15% in urban areas.[1]

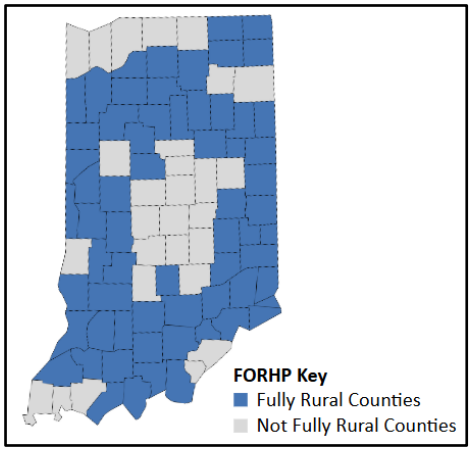

Figure 1- FORHP Rural Counties Map

Rural Hoosiers have worse health outcomes than their urban counterparts, including:

On average, rural counties have a lower life expectancy (see **Appendix C**). There is more than a full decade difference between the county, which is rural, with the lowest life expectancy at 69 years and the suburban county with the highest life expectancy at 80.7 years.

[1] https://mchb.tvisdata.hrsa.gov/Narratives/Overview/d3e37897-c9fb-43e9-b165-128b9035a208

Rural counties have higher obesity, smoking, diabetes and COPD rates (see **Appendix C**). While the overall cancer incidence rate is similar in rural communities compared to the rest of the state, the mortality rate is significantly higher.
Rural counties in Indiana have higher rates of suicide and overdose deaths (see **Appendix C**).
Rural areas of the state experience higher teen births (5.2% to 4.4%) and lower breastfeeding rates (80.7% and 85.4%). Indiana's overall infant mortality rate (IMR) for 2019-2023 was 6.7 (see **Appendix C**). Of the top 10 counties with the highest infant mortality rates, nine are fully rural.

A **survey** of rural Hoosiers' health needs conducted this fall offers further insight into the root causes of these poor outcomes and financial health challenges. Transportation barriers were the most frequently cited concern. Provider shortages and workforce gaps followed closely, reflecting widespread strain on the healthcare system's capacity, followed by a lack of mental health and substance use services, pointing to a growing demand for behavioral health support.

Access Barriers
Travel time significantly affects access to emergency and routine care. As mentioned in **Section 5**, transportation was the respondents' most cited barrier to care.
Nineteen rural census tracts (62,109 residents) are more than 30 minutes from the nearest emergency department (ED), compared to urban residents who are typically within 15 miles
Sixteen counties lack hospital EDs, 13 have no rural health clinic, and 18 lack a (Federally Qualified Health Center (FQHC), impacting more than 543,000 residents
The cost of travel is a major concern: 55.8% of rural residents identified cost of gasoline and financial expense of travel as barriers, compared to 45% of urban residents.[2] Survey respondents indicated that their preference was to have increased access points to healthcare, closer to home, such as a school or a local health department.
GROW Initiatives 1, 2, 4, 7, 8, and 12 are responsive to this challenge

Healthcare Access
Indiana's rural communities must provide acute care to stabilize critically ill patients due to limited access to specialty care. An example is emergency pediatric care. It is estimated that 54 children's lives could be saved annually if all EDs in the state were pediatric ready (able to care for acutely ill and injured children).[3]
In 2021, 47.3% of Hoosiers lived in areas with physician shortages, and Indiana ranks in the 90th percentile nationally for poor primary care physician-to-population ratios.
Of the state's 64 fully rural counties, more than 50 are designated as Medically Underserved Areas (MUAs).
24% of counties, all of which are rural, are classified as maternity care deserts, lacking both obstetric providers and hospitals offering obstetric services. Since 2022, 10 birthing hospitals have ended obstetrics services.

[2] More than one million households without a car in rural America need better transit - Smart Growth America

[3] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2825748

Rural Hoosiers account for 1 in 4 Medicaid enrollees.[4] Indiana Medicaid is administered by the Indiana Health Coverage Programs (IHCP) and covers a heavily managed care population, with 79% of the state's Medicaid population in 2025 enrolled in a type of Medicaid managed care.[5]

Managed Care Program	Population Covered
Healthy Indiana Plan (HIP)	Low-income working adults and most pregnant women covered by Medicaid
Hoosier Care Connect (HCC)	Aged, blind, and disabled members not eligible for Medicare and foster children
Hoosier Healthwise	Children up to age 19 and some pregnant women
Indiana PathWays for Aging	60+ population

GROW Initiatives 4, 5, 6, 7, 8, and 12 are responsive to this challenge

Workforce Shortages
Sixteen out of 64 counties have an inadequate number of primary care providers; some have no primary care physicians at all. By 2030, Indiana will need an additional 817 primary care physicians to address critical physician shortages. However, retention data show 78% of students who complete both medical school and residency in Indiana stay to practice here — exceeding the national average of 68% and outperforming neighboring states.
Geographically, rural counties in Indiana are more likely to have higher ratios or complete absences of psychologists compared to urban counties.[6]

GROW Initiatives 9, 10, 11, and 12 are responsive to this challenge

Rural Facility Financial Health
Since 2015, three rural hospitals in Indiana have closed, and as of July 2025, 16 hospitals (29%) are operating at a financial loss and nine (16%) are at risk of closure.
Analysis from the Cecil G. Sheps Center for Health Services Research at University of North Carolina at Chapel Hill identifies 12 Indiana hospitals as financially at-risk based on two criteria: (1) a high Medicaid payer mix and (2) three consecutive years of negative total margins. All 12 are located in fully rural counties.
A 2025 Purdue University report highlights that while Indiana's Critical Access Hospitals (CAHs) have demonstrated periods of profitability and efficient labor cost management, they also face weaker liquidity, greater financial volatility, and increased dependence on Medicaid and uncompensated care.

GROW Initiatives 7, 8, 9, 10, and 12 are responsive to this challenge

Section 2: Indiana Goals and Strategies

Indiana envisions a future where rural Hoosiers have the same opportunities to thrive as their urban neighbors. In addition to transportation barriers, Hoosiers also **ranked** access to affordable healthy food, health education and literacy, and access to local providers as top needs. To accomplish this vision, Indiana will pursue 12 GROW initiatives, which build upon Indiana's

[4] https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-living-in-rural-areas/
[5] https://www.in.gov/fssa/ompp/files/2025MCPAR-IN-HIP.pdf
[6] https://scholarworks.indianapolis.iu.edu/server/api/core/bitstreams/6dc360d0-ce52-4ab6-9dab-78c9370c82e4/content

MIHA efforts and align perfectly with CMS's goals for the Rural Health Transformation Program. Indiana's first 11 initiatives (details in Section 3) are statewide efforts to support rural communities. Statewide initiatives are crucial for addressing broad issues such as workforce development as they allow for consistency and resource allocation across regions. At the same time, the Make Rural Indiana Healthy Again Regional Grants in Initiative 12 are tailored to engage local stakeholders to identify opportunities for resource sharing and tackle specific community needs, including transportation, where the problems are similar but solutions may be unique to the challenges and partners available within a region. By leveraging both statewide frameworks and local expertise, Indiana can create a more comprehensive and effective approach to problem-solving, ensuring that solutions are tailored to the distinct contexts of different areas. This combination fosters collaboration, optimizes resource use, and ultimately leads to more sustainable solutions. Together, the 12 initiatives both catalyze care reform and directly address all the elements required by statute.

CMS Strategic Goals & Statutory Elements Addressed *(statutory requirements in bold)*	**Key Performance Objectives Targeted** *(see table below for details)*
CMS Goal 1: Sustainable Access INITIATIVE 1**:** Growing Care Coordination: Medical Operation Coordination Center and Alternate Payment Model/Accountable Care Organization (ACO) Feasibility Study INITIATIVE 2**:** Growing Community Connections through Indiana 211	
Improves access through enhanced coordination of operations, technology, preventative care, and emergency services, leveraging **data-driven technology solutions** that improve efficiency and sustainability of long-term access points through centralization of necessary digital hubs, and ultimately **improving health outcomes**	**KPO A:** Chronic Disease Management **KPO B:** ED Diversion **KPO E:** Timeliness and Access to Care
CMS Goal 2: Tech Innovation INITIATIVE 3**:** Growing Improved Patient Outcomes through Enhanced Interoperability and Technology	
Foster use of innovative technology to emphasize prevention and chronic disease management by strengthening the IT infrastructure in rural facilities and addressing long-standing interoperability and cybersecurity gaps, which will contribute to enhanced coordination and **improved outcomes**	**KPO B:** ED Diversion **KPO F:** Data Interoperability
CMS Goal 3: Innovative Care INITIATIVE 4**:** Growing Pediatric & Obstetric Readiness in Rural Emergency Departments INITIATIVE 5: Growing Cardiometabolic Health Standards of Care in Rural Indiana INITIATIVE 6**:** Growing Access to Hospital Post-Discharge Medications INITIATIVE 7**:** Growing Specialty Provider Access through Expanded Teleconsult Capabilities INITIATIVE 8**:** Growing Telehealth Access and Infrastructure	

Improve outcomes related to chronic conditions and address access barriers to both preventative and post-acute care by enhancing pediatric and obstetric readiness in emergency departments, advancing cardiometabolic care standards, improving **timely access** to prescription medications, and strengthening access to digital health tools such as teleconsult and telehealth among rural facilities	**KPO A:** Chronic Disease Management **KPO B:** ED Diversion **KPO C:** Maternal and Infant Health **KPO E:** Timeliness and Access to Care **KPO G:** Telehealth and Teleconsult Expansion
CMS Goal 4: Workforce Development **INITIATIVE 9:** Growing our Rural Health Paraprofessional Workforce **INITIATIVE 10:** Growing Clinical Training and Readiness **INITIATIVE 11:** Growing our Rural Behavioral Health Workforce	
Attract and retain a high-skilled healthcare **workforce** at all levels by investing in early career pipelines, removing credentialing and training barriers for community health workers and peers, and incentivizing rural practice development through physician stipends and rural preceptorships	**KPO B:** ED Diversion **KPO D:** Rural Health Workforce Stability
CMS Goal 5: Make Rural America Healthy Again (MRAHA) **INITIATIVE 12:** Make Rural Indiana Healthy Again Regional Grants	
Drives local **partnerships** and rural health innovations by establishing regional coalitions with joint governance and sustainability plans to improve **financial solvency** through reduced duplication and resource waste. Addresses **root causes** of low volume and bypass of rural providers by allowing rural communities to leverage economies of scale in implementing local, **data-driven solutions** for chronic disease, maternal health, and behavioral health. Targeted local projects, including transportation solutions, **improve access and health outcomes**, powered by the State's health data dashboard. Required local activities include local **workforce** solutions, such as regional deployment of Community Health Workers	**KPO A:** Chronic Disease Management **KPO B:** ED Diversion **KPO C:** Maternal and Infant Health **KPO D:** Rural Health Workforce Stability **KPO E:** Timeliness and Access to Care **KPO F:** Data Interoperability **KPO G:** Telehealth and Teleconsult Expansion **KPO H:** System Integration and Cross-Sector Collaboration

GROW Key Performance Objectives (KPOs)

KPO	Objective	KPO Targets	Initiative Alignment
A	**Chronic Disease Indicators**	Improve chronic disease indicators in rural Indiana by 10 percentage points by 2031 as measured by: Glycemic control (HbA1c <8%) among diabetic patients: increase from 58% to 68.75%. Blood pressure control (BP <140/90) among patients with hypertension: increase from 62% to 72.5%[7]	Initiatives 1, 3, 5, 6, 8, 9, 12
B	**ED Diversion**	Reduce avoidable emergency department visits from 157.4/100,000 enrollees (aged 18-64) to 143.1/100,000.[8]	Initiatives 1, 3, 4, 5, 6, 8, 9, 12
C	**Maternal and Infant Health**	Increase the rate of full-term births and healthy birth weight deliveries in target rural counties by 5% over 2023 baseline levels. Full-term births: Improve from 89.3% in 2023 to 93.8%. Healthy birth weight deliveries: Improve from 92.2% in 2023 to 96.8%[9] Reduce the infant mortality rate in target rural counties by 5% compared to the 2019–2023 average baseline of 6.5 deaths per 1,000 live births. Target rate: Decrease from 6.5 to 6.2 deaths per 1,000 live births (2026-2030)	Initiatives 4, 12

[7] https://data.hrsa.gov/topics/healthcenters/uds/overview/state/IN/table?tableName=Full
[8] https://www.commonwealthfund.org/datacenter/potentially-avoidable-ed-visits-ages-18-64-1000-employer-coverage-enrollees
[9] Indiana State Department of Health Vital Records

D	**Rural Health Workforce Stability**	Create 15 new residency positions serving rural areas and support 200 clinical preceptors for rural healthcare workforce, improving rural retention rates of the behavioral health workforce and expanding training capacity for the healthcare workforce (including physicians, advanced practice providers, pharmacist, CHW, behavioral health, and early career.)	Initiatives 9, 10, 11, 12
E	**Timeliness and Access to Care**	Decrease the average population to physician ratio in rural counties by 4% from 1264.8:1 to 1,214.2:1.[10] And reduce average wait times for primary care appointments by 25%, wait times for specialists by 25%, and unnecessary hospital transfers by 10%.	Initiatives 1, 2, 4, 7, 8, 9, 10, 11, 12
F	**Data Interoperability**	Increase number of rural healthcare entities connected to health information exchange by 450.	Initiatives 2, 3, 4, 7, 8 12
G	**Telehealth and Teleconsult Expansion**	Increase telehealth utilization among rural patients by 50% (baseline of 303,000 Medicaid telehealth encounters conducted in rural counties in SFY25) and establish teleconsult programs in at least three high-need specialties *(e.g.,* cardiology, psychiatry, endocrinology) to reduce out-of-county specialty travel by 30%.	Initiatives 1, 3, 7, 8, 12
H	**System Integration and Cross-Sector Collaboration**	Establish collaboration among rural healthcare entities to demonstrate improvement in health indicators and cost savings through decreased acute healthcare utilization, shared services, sustainable practices, and addressing non-medical drivers of health.	Initiative 1, 3, 4, 5, 6, 8, 9, 10, 11, 12

Regulatory Action & Technical Score Factors

Indiana provides the following data for consideration. See **Appendix D** for additional details.

Factor	Indiana's Response	Score Factors
A.1, A.3-A.6	No additional data needed from Indiana.	Data-Driven: CMS to score
A.2	**Appendix D** contains the requested current list of Certified Community Behavioral Health Clinic (CCBHC) entities within the State as of September 1, 2025; every active site of care associated with each CCBHC entity; and the address of every active site of care.	Data-Driven: CMS to score
A.7	Indiana's % of state hospitals that receive Medicaid Disproportionate Share Hospital (DSH) Payments is 26.43% (46 out of 174 hospitals). See **Appendix D** for further information.	Data-Driven: CMS to Score
B.1	See Sections 3 and 7 for Initiatives **1, 3, 4, 6, 7, 10,** and **12** for pertinent details.	Initiative-Based: CMS to score
B.2	Initiative-Based: see Sections 3 and 7 for Initiatives **5, 8, 9,** and **12** for pertinent details. State Policy Actions: **Appendix D** contains an excerpt of the Indiana **Executive Order (EO) 25-59** (Making Indiana Healthy Again by Promoting the Health and Wellness of Hoosier Students), which also aligns with this technical score factor. This EO includes the Governor's Fitness Test for schools with a reward program for students who demonstrate high performance on the test. Modeled after the Presidential Fitness Test, it promotes the same goals of a healthy, active lifestyle for children.	Initiative-Based (75%): CMS to score State Policy Actions (25%): 100/100
B.3	An excerpt of FSSA's Division of Family Resources' USDA approved State waiver prohibiting the purchase of non-nutritious items in SNAP is included in **Appendix D**. This waiver will go into effect on January 1, 2026.	State Policy Actions: 100/100
B.4	Through engagement with legislators, Indiana has confirmed that by 2028, the State will pass legislation to require Indiana's medical schools to include	State Policy Actions: 100/100

[10] Indiana School of Medicine, Bowen Center for Health Workforce and Research Policy

	nutrition education in the medical curriculum. All medical schools in Indiana have agreed to this requirement while Indiana is seeking a state policy change to support this requirement. Also see **Appendix D** for an excerpt of the governor's **Executive Order 25-57** (Making Indiana Healthy Again by Developing a Comprehensive Diet-Related Chronic Disease Plan), which mandates a comprehensive study related to diet-related chronic disease in Indiana, including analysis of opportunities to improve nutrition education for medical professionals. The Secretary of Health and Family Services shall provide quarterly progress reports and a final written report to the Governor by July 1, 2026, detailing the study's findings and recommendations.	
C.1	See Sections 3 and 7 for Initiatives **2, 3, 4, 5, 6, 7, 10,** and **12** for pertinent details.	Initiative-Based: CMS to score
C.2	See Sections 3 and 7 for Initiatives **1, 3, 4,** and **12** for pertinent details.	Initiative-Based: CMS to score
C.3	Per the report from the Cicero Institute, Indiana received a score of 15, which translates to **75 points** for this technical score factor.	State Policy Actions: 75/100
D.1	See Sections 3 and 7 for Initiatives **10** and **11** for pertinent details.	Initiative-Based: CMS to score
D.2	Per the linked data sources in the NOFO, Indiana should receive a score of **80 points**. This is the average of Physician: 100, Nurse: 100, EMS: 100, Psychology: 100, and Physician Assistant: 0.	State Policy Actions: 80/100
D.3	Per the linked data sources in the NOFO, Indiana should receive a score of **50 points**. This is calculated as the average of PA Score: 50, NP: 50, Pharmacist: 100, and Dental Hygienists: 0.	State Policy Actions: 50/100
E.1	See Sections 3 and 7 for **Initiative 12** for pertinent details.	Initiative-Based: CMS to score
E.2	Initiative-Based: see Sections 3 and 7 for **Initiative 6** for pertinent details. Data-Driven: CMS will calculate a score based on the following components: • Indiana has established a dual contact by MMCO. • Indiana's dual enrollees include both full- and partial-duals. Indiana has individuals enrolled in Program of All Inclusive Care for the Elderly (PACE) and HIDE-SNPs. Indiana's Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP) will be offered through the PathWays Dual Care program which begins 1/1/26. (100 Points) % of Duals Enrolled in an Integrated Plan is 0.3%.	Initiative-Based (50%): CMS to score Data-Driven (50%): CMS to Score
E.3	Indiana confirms that its short-term, limited-duration insurance (STLDI) plans are not restricted in the State beyond the latest federal guidance (see link to **Indiana Code 27-8-5**). This equates to **100 points** for this technical scoring criteria. Additionally, Indiana submits the following supplemental information as requested. • Indiana **does not** have any State restrictions in place that limit STLDI plans beyond latest federal guidance. • Indiana's maximum allowable initial contract term for STLDI is **364 days.** Indiana's maximum allowable total coverage period for STLDI is the greater of **36 months** or the maximum period permitted under federal law.	State Policy Actions: 100/100
F.1	Initiative-Based: see Sections 3 and 7 for Initiatives **1, 2, 7, 8,** and **12** for pertinent details. State Policy Actions: Indiana calculates a score of 60 based on the average of the following based on the Indiana Professional Licensing Agency, Telehealth Regulatory Changes and Termination of Telehealth Certifications for Out-Of-State Practitioners (June 7, 2024). Additionally, an in-state licensing exception exists for professions wherein Indiana is a member of an interstate licensure compact. Indiana is part of the Nurse Licensure Compact, Interstate Medical Licensure Compact, Physical Therapy Licensure Compact, Psychology Inter-jurisdictional Compact, Professional Counseling Compact, Occupational	Initiative-Based (50%): CMS to score State Policy Actions (50%): 60/100

	Therapy Licensure Compact, and the Audiology & Speech Language Pathology Interstate Compact. • Medicaid pay for live video: YES (100 Points) • Medicaid pay for Store and Forward: NO (0 Points) • Medicaid pay for Remote Patient Monitoring (RPM): YES (100 Points) • In-State licensing requirement exception: YES (100 Points) Telehealth License/Registration Process (including special licenses): NO (0 Points)	
F.2	Initiative-Based: see Sections 3 and 7 for Initiatives **1, 3, 7, 10,** and **12** for pertinent details. Data-Driven: per the linked T-MSIS data source in the NOFO Indiana should receive the maximum score of 100.	Initiative-Based (75%): CMS to score Data-Driven (25%): 100/100
F.3	See Sections 3 and 7 for Initiatives **2, 3, 8, 10,** and **12** for pertinent details.	Initiative-Based: CMS to score

Section 3: Proposed Initiatives and Use of Funds

INITIATIVE 1: Growing Care Coordination: Medical Operations Coordination Center and Alternate Payment Model Feasibility Study

Estimated Required Funding: $56.2M over the five-year funding period.
Sustainability: Initial investments in technology and infrastructure. Maintenance will be transitioned to a cost-share agreement with the State.

Main Strategic Goal: Sustainable Access **Use of Funds:** E, F, G, H, I **Technical Score Factors:** B.1, C.2, F.1, F.2	**Key stakeholders:** Indiana Hospital Association, Indiana Rural Health Association, EMS Commission, EMS Division, 911 Board, County Emergency Management Agency, Trauma Care Commission, HealthCare coalitions, Local Health Departments, long-term care, dispatch centers, EMS providers, Crisis Stabilization Centers, Indiana Council of Community Mental Health Centers, local/regional mental and behavioral health providers, local hospitals, FQHCs, Rural Health Clinics (RHC), Community Mental Health Centers, Managed Care Organizations and Commercial Payors
Outcomes: • Improved bi-directional transfer coordination for rural communities • Improve speed, access, and cost to deliver emergency medical services. • Reduced delays in accessing trauma, stroke, psychiatric, and specialty care services	• Transform standard 911 system to direct patients to appropriate location (emergency department, urgent care, psychiatric facility) based on needs • Establish Medical Operations Coordination Center (MOCC) as a centralized 24/7 hub for day-to-day hospital operational reporting, patient transfer coordination, and EMS resource alignment, acting as a single point of contact for referral requests and life-saving resources, enhancing the remote care services infrastructure • Improved coordination and continuity of care across hospitals, primary care, behavioral health, and community-based providers • Identification of data, infrastructure, and policy needs to support potential Medicaid alternate payment model implementation • Enhanced understanding of provider readiness and system capacity for alternate payment participation

Impacted Counties: Requires statewide implementation with all counties contributing, however, Medical Operations Coordination Center-specific grant funding will only be directed to rural communities. Vanderburgh, Marion, Allen, and Lake counties will be omitted due to their urban classification.

Activity 1: Establish a Medical Operations Coordination Center. Indiana's rural counties are experiencing a shortage of EMS providers. EMS is responsible for responding to 911 calls and for transferring patients to higher levels care. 21% of Hoosier trauma encounters resulted in an interfacility transfer for further care in 2023 and unfortunately the % of critical trauma patients who meet the expectation of transfer in 2 hours is less than 20%.[11] Many Hoosier counties are operating with as few as two available ambulances putting patients at risk and potentially delaying care.[12] When a rural hospital has a critical patient to transfer it is frequently the single covered emergency physician contacting multiple hospitals to find a hospital accept their patient, taking their time away from clinical care. Additionally, the default location for 911 calls is to bring patients to the emergency department. The cost of inappropriate ED use is well documented and mental health patients are especially vulnerable to boarding in EDs while they wait for transfer to a psychiatric facility.[13]

To address these growing issues, Indiana seeks to launch a centralized, state-implemented Medical Operations Coordination Center (MOCC), a 24/7 centralized single point of contact for referral requests and life-saving coordination with a strong focus on improving healthcare accessibility for under-resourced rural communities, including interfacility transfers for critical conditions such as trauma, stroke, psychiatric emergencies and OB/GYN complications. Urban centers in Indiana already benefit from the support of MOCCs and this initiative will provide this support to rural communities. The MOCC will work with both the strained EMS system and hospitals to ensure patients are taken to the most appropriate location. The MOCC will develop

[11] Health: Trauma System/Injury Prevention: Indiana Trauma Care Commission
[12] Indiana EMS 2025 Report
[13] ED-report-to-Congress

protocols and integrate with outpatient providers and the behavioral health system, including 988 and Crisis Lifeline, to route patients to the most appropriate care settings such as urgent care and crisis stabilization centers. (see **Appendix E** for access gap maps). The MOCC will address rural hospitals' financial solvency by supporting return of patients to the rural facilities after they are stabilized at the tertiary care center. Finally, MOCCs serve a critical role in the case of mass causality events[14] and development of a MOCC is supported by Indiana's Trauma Care Commission.[15]

Indiana will implement policy to mandate hospitals, inpatient mental and behavioral health facility, and EMS reporting, which will require all hospitals to report daily census, including but not limited to available staffed beds, diversion status and critical staffing shortages, with immediate updates when conditions change. This will allow MOCC staff to make real-time, informed decisions to direct to the most appropriate level of care. Indiana will also leverage AI to identify trends and outliers in transfer times and hospital census to drive quality improvement initiatives for critical conditions such as trauma.

Activity 2: Conduct an Alternate Payment Model Feasibility Study Inclusive of Accountable Care Organization and Bundled Payments for Episodes of Care. Indiana will engage a qualified partner to conduct a study for the potential for alternate payment models including Rural Medicaid Accountable Care Organization (ACO) model and Bundled Payments for Episodes of Care. Nationally, ACO models have demonstrated promising results by aligning provider incentives, enhancing coordination, and strengthening population health management. The study will assess rural providers' ability to collaborate for shared risk, provider readiness, data-sharing capacity, and care coordination mechanisms. It will also examine how an ACO framework could integrate with the state's existing managed care structure and payment systems

[14] (Regional Medical Operations Coordination Centers (RMOCCs) | ACS
[15] Health: Trauma System/Injury Prevention: Indiana Trauma Care Commission

to promote sustainability. Bundled Payments for Episodes of Care align provider payment with incentives to eliminate waste and optimize patient outcomes as it provides a single bundled payment per procedure covering 10 days pre-procedure, the procedure, and 30-days post-procedure. This payment model incentivizes collaboration among providers to share data and avoid pre-procedure duplicate imaging and labs, as well as establish financial incentives post-procedure for patients to receive their medication prior to discharge, home health plan, physical therapy appointments, follow-up office visits, transportation, and medication reviews during the transition to their residence. If a patient avoids readmission, infection, or an ED visit for 30 days post-procedure, the provider makes a greater profit. Otherwise, all procedure-related complication expenses 30-days post-procedure are paid for by the provider.

Findings will help the state assess feasibility and identify potential pathways for advancing value-based care to enhance rural collaboration. This effort may align with **Initiative 12**.

Implementation Timeline	
Stage 0: Thru FY26	• Request for proposal for management, equipment, and technology for the MOCC. • Identify a qualified partner organization to conduct the alternate payment model (ACO and bundled payment) feasibility study and begin identifying study goals and priorities.
Stage 1: FY26 – Q1 FY27	• By the end of Q2 FY27, MOCC is established and begins outreach to hospitals, outpatient providers and behavioral health. Protocols for screening for appropriate location completed. • By Q1 FY27, execute a contractual agreement with the selected ACO study partner and initiate data collection and stakeholder engagement activities.
Stage 2: Q2 FY27 – Q1 FY28	• Pass policy to mandate participation in hospital reporting and data–sharing while maintaining voluntary transfer participation. • By Q4 FY27, MOCC is live and available to assist in the transfer of patients between hospitals. Begin collecting and analyzing data on time to transfer for critical and noncritical patients. • By end of Q1 FY28 MOCC is operational to divert patients to appropriate locations both outpatient, Crisis Receiving and Stabilization Services (CRSS), and other psychiatric centers. Begin collecting and analyzing data on patients diverted from the emergency department. • By Q4 FY27, conclude alternate payment model feasibility study. • Assess study findings to evaluate viability of alternate payment model implementation and share insights with provider networks and state partners. • Establish baseline for time to transfer noncritical patients.
Stage 3: Q2 FY28 - Q1 FY29	• Demonstrate decrease in time transfer noncritical patients by 5%. • Demonstrate increase in percentage of critical patients transferred in an appropriate time by 2% each year after implementation. • Demonstrate increase in percentage of patients diverted to appropriate location by 5% in first year of implementation. By the end of Q1 FY30, identify innovative sustainability pathways including reimbursement models and legislation.

Stage 4: By Q2 FY30	• Demonstrate decrease in time to transfer noncritical patients by total of 10% from baseline. • Demonstrate increase in percentage of patients diverted to appropriate location by 10% by end of RHTP. Indiana MOCC will be fully integrated with required maintenance underway.

Outcome Metrics				
No.	**KPO**	**Metric**	**Data Source, Timing, & Ability to Collect/Analyze**	**Baseline Data & Milestone Targets**
1.1	**E**	Number of appropriate diversions to alternate locations, by county	Baseline is zero, as this is a new program	After implementation, appropriate diversions will increase by 5% by FY28 and total of 10% in FY31
1.2	**B, E, F**	Time to transfer to higher level of care for critical conditions	Statewide Trauma Report, State MOCC partner will track on a monthly basis after implementation	Increase the percentage of critical trauma patients transferred in < 2 hours from 18.5% (2024) to 25%; Establish baseline for time to transfer for other critical patients (stroke, STEMI, OB, sepsis) and develop milestone targets
1.3	**B, F**	Time to transfer for non-critical paper	Statewide Trauma Report, State MOCC partner will track on a monthly basis after implementation	Establish baseline of transfer of non-critical patients and increase by 2% each year for a total 10% decrease by FY31
1.4	**B**	Number of ED visits for psychiatric conditions	Indiana syndromic surveillance data (ESSENCE)	Baseline: ~123,000 ED visits due to mental health (2024). Decrease starting in 2028. Target: 10% decrease ~111,800 visits
1.5	**A, H**	Completion of Alternate Payment Model Feasibility Study	State will monitor vendor progress	Complete by FY28 to determine implementation strategy for realized cost savings
Gray-shaded metrics represent county-level data to demonstrate how impact is distributed.				

INITIATIVE 2: Growing Community Connections through Indiana 211

Estimated Required Funding: $3.3M over the five-year funding period.

Sustainability: Funding will primarily support community engagement and buy-in to bring community-based organization referrals into the existing Indiana 211 system and MCO infrastructure and their payment structures. Coordination network will be self-sustaining.

Main Strategic Goal: Sustainable Access **Use of Funds:** D, F, K **Technical Score Factors:** C.1., F.1., F.3	**Key Stakeholders:** Indiana 211, Indiana Department of Child Services, IDOH Maternal and Child Health Helpline, Partners to support member referral process, CBOs, community health workers (CHW), Clinicians), MCOs, State heath-information exchange (HIE) partner, commercial payers

Outcomes: • Members' needs actively connected with local resources • Removal of administrative burden from clinicians to provide information on available community resources • Support cost savings by streamlining referrals to services for non-medical costs	• Follow-up support is provided to ensure local resources are effectively accessed • Resource information provided to members is tailored to member needs, with additional support provided from care managers for wrap-around member experience • Improved member experience and creation of a sustainable mechanism for continued support • Accountability for services rendered and people served for CBOs
Impacted Counties: Because this initiative will be implemented statewide, it has the potential to impact all counties. However, funding for the purposes of this grant will focus on implementation in rural areas.	

Activity 1: Establish Indiana Community Connect. Indiana 211 is a one-stop-shop number where Hoosiers get connected to community support, such as food pantries, domestic violence shelters or energy assistance programs. While 211 is an asset in our state, the directory-style platform has no mechanism to ensure referrals are completed or patients receive the support they need. This lack of accountability and follow-up contributes to unmet social needs, increased healthcare costs, and poor health outcomes — particularly in rural communities.

Healthcare providers nationwide recognize the significant impact that non-medical factors have on their patients' health outcomes. To address these gaps, Indiana will launch Indiana Community Connect, a coordinated care network that enables hospitals to act as a central community hub bringing together partners to implement strategies that address health related social needs and reduce preventable hospital admissions and emergency room visits. Built on existing infrastructure, this initiative will activate a module within the electronic medical record (EMR) to streamline referrals, enabling providers to direct patients to appropriate services with minimal friction. Consumer-facing technology and care management tools will ensure that member needs are linked to local resources, while CBOs will receive training and support to fully participate in the referral process and close the loop on service delivery. Indiana will evaluate ongoing opportunities, such as addressing service gaps by incorporating emergency shelter care for youth with no place to go, as well as efficiency improvements by leveraging AI.

Implementation Timeline	
Stage 0: By FY26	• Confirm vendor selected to serve as center point of systems integration. • Develop and build customized intake form to be used across systems. • Draft plan for community resource outreach and engagement. • Draft training plan for Community Based Organizations.
Stage 1: FY26 – Q1 FY27	• Commence integration of VisionLink with existing 211 structures. • Engage CBOs/Community Health Workers and potential other partners as identified by FSSA, IDOH, and DCS to conduct training. • Phased CBO integration.
Stage 2: Q2 FY27 – Q1 FY28	• Address question of capturing outcomes data for separate systems. • Continued phased CBO integration. • Begin Pilot program for 211 Enhancement.
Stage 3: Q2 FY28 – Q1 FY29	• Continued phased CBO integration. • Identification of a plan for monitoring CBO performance including leveraging AI. • Begin post-implementation monitoring and oversight for 211 Enhancement.
Stage 4: Q2 FY29 – Q3 FY31	• Implementation of CBO performance monitoring plan. • Finalization of CBO integration.
Stage 5: By Q4 FY31	• CBO integration is complete.

Outcome Metrics				
No.	**KPO**	**Metric**	**Data Source, Timing, & Ability to Collect/Analyze**	**Baseline Data & Milestone Targets**
2.1	**F**	Closed Loop Referrals across Clinicians and CBOs	State will track annually through 211 systems	Baseline 0% prior to implementation. By 2027, increase to 35% clinician CBO engagement. By 2028, 60% clinician CBO engagement
2.2	**E**	Number of unique individuals in rural counties connected to at least 1 Community Connections resource, by county	State will track through Indiana 211 analytics dashboard and reporting tools	Baseline individuals in rural county connections – annually 10% increase year over year
2.3	**E**	Percentage of users reporting satisfaction with referral and follow up support process	State will track through Indiana 211 follow-up and automated outcome surveys	Baseline 68% satisfaction with current 211 resource experience. By 2026, increase to 73%. By 2028, increase to 80%
2.4	**B**	Overall hospital utilization for all Medicaid recipients	State will track annually through FSSA health data systems	Baseline will be established in first year to inform annual milestone targets
Gray-shaded metrics represent county-level data to demonstrate how impact is distributed.				

By leveraging existing systems and enhancing coordination, Indiana will fundamentally reimagine integrated digital infrastructure, improving patient experience, reducing clinician burden, and lowering non-medical healthcare costs —ultimately strengthening access, quality, and outcomes for rural communities across the state**.** This model relies on strong partnerships

among main entities within the rural community: the hospital, primary care and behavioral health clinics, and community-based organizations (CBOs) offering social services.

INITIATIVE 3: Growing Improved Patient Outcomes Through Enhanced Interoperability and Technology	
Estimated Required Funding: $66.5M over the five-year funding period. **Sustainability:** Demonstrated cost savings and efficiency gains will be used to justify reinvestment into system operations from payers.	
Main Strategic Goal: Tech Innovation **Use of Funds:** A, C, D, F, G, H, I, K **Technical Score Factors:** B.1, C.1, C.2, F.2, F.3	**Key stakeholders:** HFS, Indiana Department of Homeland Security, CBOs, FQHCs, skilled nursing facilities, emergency medical services, hospitals, private practices, long-term care facilities, EMS and fire agencies, Ivy Tech Community College, state paramedic programs, academic medical centers, other private & nonprofit organizations (Indiana Hospital Association, Indiana Healthcare Association, Indiana Rural Health Association, IT partners, MCOs, Commercial Insurance)
Outcomes: • Increased awareness of the current technology and infrastructure that are currently utilized by rural health providers	• Increased access to fruits and vegetables in rural areas • Rural provider adoption of new interoperability and HIE infrastructure and enhancements • Increased number of successful Indiana 211 interactions originating from Hoosiers in rural areas. • County-level access across Indiana to at least one Mobile Integrated Health (MIH)/community paramedicine
Impacted Counties: Primarily impact Indiana's 64 rural counties. However, as increased interoperability and infrastructure across rural counties will impact the larger care continuum, benefits of this initiative are likely to affect urban counties as well.	

Activity 1: Rural Health Information Exchange (HIE) Transformation. Indiana's current HIE network connects about 120 hospitals and supports transitions of care between connected providers; however, an estimated 700 rural healthcare facilities are not connected to the current HIE. When healthcare entities are not connected, significant gaps emerge in data sharing and coordination, negatively impacting patient care. Interoperability and access to complete patient data have been shown to decrease adverse events and healthcare costs by reducing repeat testing

and radiology. Interoperability increases provider productivity by minimizing the need to document information from other health providers manually.[16]

Based on assessment outcomes, one-time financial incentives will be provided to rural health systems to support start-up costs associated with the initial implementation of recommended technologies aligned with the recommendations from the **HEA 1003-2025 Feasibility Study**, including provider EMR integration. A cost sharing model for these one-time incentives will be determined to ensure rural health systems invest in determined upgrades.

Through this initiative, the State will connect about 450 rural healthcare facilities, including CAHs, rural hospitals, private practices, FQHCs, community mental health centers (CMHCs), Certified Community Behavioral Health Clinics (CCBHCs), child welfare providers, skilled nursing facilities, health departments, correctional facilities, and EMS.

The State will modernize the provider portal from within the HIE that allows connected providers and State partners to access the suite of integrated health data. This includes exploring the potential for integrating AI technologies to enhance the functionality of the HIE, ensuring a thorough evaluation of its feasibility and benefits in areas such as:

Ability to reduce medical error by evaluating for drug interactions
Natural language processing to inform clinical decisions and reduce clinician burden of chart search
Predictive analytics for population health and disease states
Evaluating outcomes and quality of services to inform value-based decisions
Develop individualized tailored treatment plans
Decrease healthcare utilization (radiology, labs, testing) through clinical decision tools

It will integrate mobile integrated health (MIH) and Community Paramedicine Programs into HIE to support development and availability of critical dashboards and coordination between EMS and other provider types. This will strengthen the rural health care ecosystem by addressing long-standing data gaps within the current HIE, including through the development of targeted dashboards to boost service speed and quality. The system will lead to enhanced care

[16] Interoperability: A call to action. HCI-DC 2014 | West Health

coordination, improved health/public health outcomes for chronic diseases, infant mortality, mental/behavioral health, and cut overall costs.

Activity 2: Feasibility Study for Double Up Indiana Program Expansion to Retailers.

Access to nutritious food remains a persistent challenge in rural Indiana communities without full-service grocery stores. The Supplemental Nutrition Assistance Program (SNAP) current systems do not fully leverage technology to promote healthy eating. To drive healthy food decisions by those eligible for assistance programs, the Double Up Indiana Program enables SNAP recipients to receive a SNAP match for buying fruits and vegetables at participating locations. Indiana's Double Up program is already available at farmers markets but has limited retail access.

To address these challenges, Indiana will commission a comprehensive study to assess the feasibility of integrating nutrition incentives directly onto the Hoosier Works Electronic Benefits Transfer (EBT) card. If the study demonstrates strong health outcomes impact and compelling return on investment, eventual tech enhancement implementation would serve as a companion to the approved Indiana SNAP Waiver that restricts the EBT purchases of candy and soda, which also is key to Make Indiana Healthy Again. Key technological enhancements:

EBT System Modifications	Real-time tracking and redemption of nutrition incentives, with automated accrual based on eligible purchases (*e.g.*, fruits and vegetables).
Retail Point-of-Sale (POS) Integration	Upgraded POS systems to process incentive transactions and securely transmit data to state systems.
State Agency Infrastructure	Improved benefit management systems to support incentive calculations and reporting.

A Rural Engagement and Technical Assistance (TA) Team will provide ongoing consultative and technical support to ensure that rural providers connect to the HIE and utilize its features to maximize health outcomes. Indiana would dedicate six contract employees (one Project Manager and one Business Analyst for HIE Modernization and TA, one Initiative Program Manager and three vendors for HIE Modernization, HIE Environment Assessment, and Double Up Indiana

Feasibility Study respectively) to this initiative who would be committed to carry out the following:

Implementation Timeline	
Stage 0: By FY26	• Conduct robust Technology and Security assessment of the current state of interoperability in the State. • Establish Rural Engagement and Technical Assistance (TA) Team. • Begin roll out of Technology/Security SNAP incentive program.
Stage 1: FY26 – Q1 FY27	• Launch competitive procurements supporting HIE Transformation. • Launch feasibility study of Double Up Indiana EBT Nutrition Incentive activities. • Pending results of the feasibility study, potentially begin onboarding of vendors and initial contractor activities.
Stage 2: Q2 FY27 – Q1 FY28	• Continue design, development, and implementation (DDI) for HIE Provider Portal.
Stage 3: Q2 FY28 – Q1 FY29	• Continue development activities for the HIE Provider Portal including AI for clinical decision making. • Prepare for HIE Provider Portal launch, support implementation through TA Team.
Stage 4: Q2 FY29 – Q3 FY31	• Launch HIE Provider Portal to targeted pilot groups and continue implementation support.
Stage 5: by Q4 FY31	• Complete statewide roll out of HIE Provider Portal, including behavioral health providers. • Engage in comprehensive program evaluation and enact sustainability plans.

Outcome Metrics				
No.	**KPO**	**Metric**	**Data Source, Timing, & Ability to Collect/Analyze**	**Baseline Data & Milestone Targets**
3.1	**F**	Number of rural providers adopting new interoperability and data exchange infrastructure and enhancements, by county	State's HIE system will provide data on a quarterly basis	An est. 700 healthcare facilities in rural counties are not connected to statewide HIE. Participation est. at 35% for hospitals and 20% for FQHCs/PCPs (primary care physicians). Goal to connect an additional 450 healthcare entities to the HIE
3.2	**F, G**	Number of patient encounters where statewide clinical data is viewed in rural counties	State's HIE system will provide data on a quarterly basis	Baseline will be set in the first year; Number of encounters viewed increased by 15% by end of year 3, and by 25% by end of year 5
3.3	**F**	Completion and utilization of the HIE provider portal with AI enabled decision making	State's HIE vendor will report on completion milestones	By FY27, complete assessment of needs related to the provider portal. By FY29 completed development of provider portal with AI enabled decision making. By FY31 complete statewide rollout of provider portal; 100% of connected providers have access

3.4	**A, F, H**	Completed feasibility study and associated implementation plan for Double Up Indiana Retail Expansion	State will identify vendor – vendor will provide quarterly progress reports; landscape scan and assessment complete in Year 1; implementation plan and initial project initiation in Year 2	Feasibility report with recommendations submitted by end of Year 1. Implementation plan complete by end of Year 2. Identify rural retailers for implementation by end of Year 2
Gray-shaded metrics represent county-level data to demonstrate how impact is distributed.				

INITIATIVE 4: Growing Pediatric & Obstetric Readiness in Rural Emergency Departments

Estimated Required Funding: $45.4M across the five-year funding period.
Sustainability: Readiness equipment and capacity-building investments are one-time only. Ongoing maintenance and training costs will be evaluated as part of a value-based cost analysis, targeting demonstrated return on investment (ROI) for integration into participating hospital operating budgets.

Main Strategic Goal: Innovative Care **Use of Funds:** A, D, G, J, K **Technical Score Factors:** B.1, C.1, C.2	**Key stakeholders:** Medical Operations Coordination Center, Indiana Department of Homeland Security, Indiana Hospital Association, Maternal Mortality Review Director and Committee, Indiana Perinatal Quality Improvement Collaborative, Hospitals, MCOs, and Commercial Insurers
Outcomes: • Improve the overall delivery of care in rural EDs across Indiana and decrease pediatric and OB morbidity and mortality • Establish a network connecting the Emergency Care Coordinators (ECCs) across the state • Increased PECC participation in the National Pediatric Readiness Quality Initiative (NPRQI) • Increase in stabilization and successful transfers of OB emergent patients	• Increased connection with perinatal centers, their affiliates, and non-birthing facilities regarding emergency obstetric care • Boost workforce through recruitment of Pediatric Readiness Coaches (PRCs) to improve readiness and build sustainability within hospital sites • Standardized resources to communicate to EMS or receiving hospital regarding maternal, neonatal or pediatric patient • Increased Pediatric Readiness Score (PRS) across sites • Decreased ED length of stay for critical OB and pediatric patients • Improved readiness, recognition, response, and reporting for the OB and pediatric populations that report to EDs for care
Impacted Counties: Targets Indiana's 64 rural counties first (see Appendix B for full list); however, this initiative's outcomes will impact all Indiana counties.	

Activity 1: Pediatric Readiness. Low pediatric patient volume can make it challenging for rural facilities to maintain the capacity and skills to care for emergency situations involving pediatric patients. Pediatric Readiness encompasses the presence of pediatric-specific clinical champions, competencies, protocols, equipment, and other essential resources across EMS and emergency departments (EDs). Evidence from EDs indicates that high levels of Pediatric

Readiness are associated with a reduction in pediatric mortality risk by up to 76%. Aligned with the Emergency Medical Services for Children (EMSC) National Pediatric Readiness Project (NPRP), this initiative will prioritize rural hospitals, including Critical Access Hospitals (CAHs), hospitals with EDs, and freestanding EDs.

Indiana will partner with Indiana Emergency Medical Services for Children (IEMSC) to conduct a needs assessment, provide technical assistance, training, and programmatic oversight and administration of grant funding to help hospitals attain Pediatric Ready ED status.

The Indiana Department of Homeland Security (IDHS) EMS will conduct a similar needs assessment to determine gaps in equipment and training for EMS partner agencies and assist EMS entities with becoming Prehospital Pediatric Ready to improve prehospital care for acutely ill and injured children as outlined by the National Prehospital Pediatric Readiness Project (PPRP). Hospitals must fulfill criteria across seven domain areas to reach "Pediatric Ready" designation as outlined by the PPRP and EMSC.

Pediatric Ready Required Domain Areas	
1. Administration and Coordination 2. Health Provider Standards 3. Quality Improvement 4. Patient Safety	5. Policies, Procedures, and Protocols 6. Support Services 7. Equipment

Activity 2: OB Readiness. As hospital closures and the loss of inpatient obstetric services continue to affect rural communities across Indiana, many residents face travel times exceeding 30 minutes to access critical OB care. In these areas, EDs may serve as the only point of care for pregnant or postpartum women and their infants, underscoring the urgent need for enhanced readiness. Indiana will collaborate with key stakeholders to assess and support obstetric readiness, through the delivery of targeted simulations and training, and equipping rural EDs with essential supplies in alignment with **Initiative 1**. EDs will implement American College of Obstetrics and Gynecology (ACOG) Emergency Department Algorithms for obstetric emergencies in non-obstetric settings and perform continuous quality improvement. These

algorithms include **Cardiovascular Disease** and **Acute Hypertension** in pregnancy and the postpartum period, and an **Eclampsia Algorithm**. IDHS will conduct a similar needs assessment to determine gaps in equipment and training for EMS partner agencies and assist EMS entities with becoming obstetric ready to improve prehospital care for pregnant and postpartum women.

To improve sustainability and support future financial solvency, a component of both activities will be the establishment of lifecycle management for equipment, so it does not expire and go to waste. Examples of equipment:

Pediatric	Neonatal Warmers; Neonatal Resuscitation Program and Supplies; Neonatal Pulse Oximetry; Umbilical Catheter; Various Sized Infant Monitor Leads; Infant Supplies including Premature
Obstetric	Portable Ultrasound Machine; OB Hemorrhage Cart with Supplies; Uterine Tamponade or Vacuum-Induced Uterine Tamponade Device; Quantified Blood Loss Scale; Emergency Obstetrical Delivery Kits; Rapid Infuser

By strengthening pediatric readiness in rural acute care facilities and for EMS and obstetric and neonatal preparedness in non-birthing facilities and EMS, the program promotes reliable, time-sensitive care and reinforces regional referral networks with an outcome goal of reduced morbidity and mortality in children, moms and babies.

Implementation Timeline	
Stage 0: By FY26	• Establish project governance structure and stakeholder engagement plan. • Formalize partnerships with IEMSC, IDHS EMS, OB readiness subrecipient, and rural hospitals networks. Develop statewide OB Readiness frameworks aligned with NPRP and ACOG guidelines. Select subrecipient for each activity to complete assessments.
Stage 1: FY26 – Q1 FY27 (first-year milestones)	• Conduct Pediatric and OB Readiness needs assessments across rural hospitals and EMS agencies. • Begin technical assistance and training for Pediatric Ready ED and Prehospital Pediatric Ready criteria. • Launch OB simulation training and distribute initial equipment kits to priority EDs. • Implement ACOG ED Algorithms in pilot sites. • Begin data collection for baseline metrics.
Stage 2: Q2 FY27 – Q1 FY28	• Expand Pediatric and OB Readiness training statewide. • Support hospitals in meeting domain criteria for Pediatric Ready designation. • Continue OB equipment distribution and simulation training. • Begin continuous quality improvement cycles for both Pediatric and OB programs. • Conduct competency validation training across rural counties for ED and EMS staff and refine the training curriculum.
Stage 3: Q2 FY28 -Q1 FY29	• Evaluate progress toward Pediatric Ready and OB Readiness benchmarks. • Conduct mid-cycle feasibility studies to assess sustainability and ROI. • Refine lifecycle management systems based on equipment usage and maintenance data.

	• Adjust training and technical assistance based on feedback and performance metrics.
Stage 4: Q2 FY29 – Q3 FY31	• Achieve Pediatric Ready designation for majority of targeted EDs and EMS agencies. • Institutionalize OB Readiness protocols and equipment lifecycle management. • Expand referral networks and integrate with broader maternal-child health initiatives.
Stage 5: By Q4 FY31	• Transition Pediatric and OB Readiness programs to permanent operational status. • Embed readiness standards into state-level assessments and funding mechanisms. • Publish final evaluation report and disseminate best practices. • Ensure ongoing funding streams and policy support for equipment lifecycle and training refreshers.

Outcome Metrics

No.	KPO	Metric	Data Source, Timing, & Ability to Collect/Analyze	Baseline Data & Milestone Targets
4.1	**C, H**	Percentage of specified rural emergency departments determined to be OB ready through training, use of equipment, and use of ACOG emergency protocols, by county	State partner will track on a quarterly basis	Baselines will be set in first year. By year 3, at least 50% of specified emergency departments will report being OB ready. By year 5, 90% of specified emergency departments will report being OB ready
4.2	**C**	Percentage of rural EDs achieving Pediatric Ready designation, by county	State Partner will complete Pediatric Readiness assessments and designations	Baseline 5%, increase by 18%, on average, annually. By year 3, 50% Hospitals with ED, Freestanding ED and CAH are Pediatric Ready. By year 5, 90% of Hospitals with ED, Freestanding Eds and CAH are Pediatric Ready
4.3	**B, E**	Percentage of prehospital agencies assessed and determined to be pediatric ready and OB ready including skills-checking on use of pediatric and OB equipment	IDHS EMS completion data source	Baseline will be set in first year. By year 2 50% assessments completed in prehospital agencies located in rural counties (as identified in RHTPG application). By year 5, 80% of prehospital agencies assessed and determined to be pediatric ready
4.4	**B, E**	Percentage of facilities with lifecycle-managed pediatric/OB equipment	To be determined through initial readiness assessments	Baseline will be set in first year. By year 5, 100% OB and Pediatric ready designated facilities will have adopted a lifecycle management program for OB/ped equipment

Gray-shaded metrics represent county-level data to demonstrate how impact is distributed.

INITIATIVE 5: Growing Cardiometabolic Health Standards of Care in Rural Indiana

Estimated Required Funding: $15.3M over the five-year funding period.
Sustainability: Funding will be used to stand up a cardiometabolic care model with regional sites. Ongoing staffing and training costs will be evaluated as part of a cost analysis, targeting demonstrated ROI through decreased hospitalizations and healthcare costs.

Main Strategic Goal: Innovative Care **Use of Funds:** A, C, E, G **Technical Score Factors:** B.2, C.1	**Key stakeholders:** Rural providers and community health centers, Rural hospitals, Local Health Departments (LHD), MCOs, and Commercial Payers
Outcomes: • Improved health outcomes • Reduced hospitalizations and readmissions • Reduced burden of obesity and chronic disease	• Enhanced patient experience • Increased early identification of cardiometabolic risk factors like early signs of obesity, heart disease, and prediabetes or diabetes • Clinician certifications in cardiometabolic care to enhance rural workforce
Impacted Counties: All eight regional partnerships who will be required to participate as defined in **Initiative 12**.	

Activity 1: Regional Cardiometabolic Health Program and Centers of Excellence.

According to the Trust for America's Health 2025 The State of Obesity Report, Indiana ranks as the sixth most obese state, seventh highest rate of diabetes, and tied for 10th highest rate of hypertension. Cardiometabolic care focuses on managing conditions like obesity, diabetes, and cardiovascular disease through a comprehensive, including nutrition and physical activity, team-based approach to improve patient outcomes and reduce health risks. A to-be-determined technical assistance organization will provide consulting services, conduct gap analyses, and offer proprietary materials to support model implementation. Additionally, a rural healthcare system who has already demonstrated success with cardiometabolic care in their rural community will serve as a Cardiometabolic Center of Excellence, deploying dedicated personnel to assist clinic staff in developing care models. The collaboration will launch a statewide collaborative care model tailored to rural communities. Each of Indiana's eight Rural Health Regions, described in **Initiative 12**, will be required to participate, with one implementation site per region.

Activity 2: Lifestyle Medicine Training for Indiana's Rural Health Workforce. The MAHA report places a strong emphasis on lifestyle medicine as a foundational strategy to reverse chronic disease and restore national health. This activity directly aligns with MAHA priorities by equipping Indiana's rural health workforce with Lifestyle Medicine education,

embedding preventive care into clinical practice and empowering communities to manage chronic illness through sustainable behavior change. **This activity will implement a policy to mandate all Indiana medical students to receive comprehensive nutrition education.**

MAHA/MIHA in Action: Indiana will pursue state policy change to require nutrition education in medical school curricula, ensuring future clinicians are equipped to center food as a fundamental component of chronic disease treatment and management. This effort aligns with MAHA's emphasis on Food is Medicine and bolsters Indiana's proposed Lifestyle Medicine training initiative by embedding nutrition into the foundation of clinical education and expanding the reach of prevention-focused care. This policy change also supports Governor Braun's Executive Order 25-57, which directs IDOH to develop a comprehensive diet-related chronic disease plan – including exploration of strategies to improve nutrition education for medical professionals.

Additionally, it will expand access to evidence-based Lifestyle Medicine (LM) to about 6,000 individuals across Indiana's rural health workforce. The goal of these efforts is to reduce the burden of chronic illness, improve patient outcomes, and lower long-term healthcare costs, positioning Indiana as a national leader in addressing chronic disease through evidence-based lifestyle medicine education. Up to 2,000 eligible clinicians will receive Lifestyle Medicine Board Certification, embedding LM leaders across Indiana's rural health system regions.

Activity 3: Feasibility Study of Food is Medicine Logistics in Rural Indiana: This study will evaluate the end-to-end logistics of implementing a rural Food is Medicine (FIM) model in Indiana, with a focus on sourcing and distributing Hoosier-grown foods to **support nutrition-based interventions for rural populations**. Aligned with the MAHA movement and the state-implemented MIHA initiative, the study will assess procurement pathways, storage and delivery infrastructure, and clinical integration for services such as medically tailored meals, produce prescription, and disease-specific nutrition therapy. This includes evaluating infrastructure needs for telehealth-based medical nutrition therapy, identifying viable public and private payer reimbursement pathways, and supporting program design and delivery models tailored to rural settings. The funding is solely for infrastructure and will not be used to purchase food. One Technical Assistance contract staff will oversee this activity.

Implementation Timeline

Stage 0: By FY26	• Identify Cardiometabolic TA vendor and lead rural healthcare system for this initiative. • Identify organizations to serve as regional implementation sites. • Outline a phased implementation approach with benchmarks for recognition and excellence designation. • Launch FIM study, hire contractor, and create workplan.
Stage 1: FY26 – Q1 FY27	Prepare detailed project plan and assign staff across clinical, educational, and administrative domains. Initial implementation efforts will begin, including: • Develop clinical workflow models based on guideline-directed medical therapy (GDMT), population health, and quality strategies. • Establish a framework for educational forums, provider training sessions, and observation opportunities to be hosted at MHP. • Formally contract with partners. • Establish and deliver Year 1 lifestyle medicine (LM) training plan.
Stage 2: Q2 FY27 – Q1 FY28	• Deliver targeted guideline-directed medical therapy (GDMT) education to clinical providers. • Pilot referral pathways and consultation services between organizations and local community partners. • Launch structured data collection to support quality improvement efforts and prepare for recognition benchmarks. • Establish and deliver Year 2 LM training plan. • Execute FIM study – produce report/recommendations to demonstrate value to all payers by developing return-on-investment and cost savings projections.
Stage 3: Q2 FY28 – Q1 FY29	• Host regional observation opportunities for physicians to view healthcare partner's population health workflows and care models. • Establish and deliver Year 3 LM training plan. • Explore FIM implementation pathways and provide ongoing TA.
Stage 4: Q2 FY29 – Q3 FY31	• Establish a network of regional centers positioned for recognition in blood pressure and diabetes care. • Provide structured educational forums, clinical consultation, and research advisement across Indiana counties. • Establish and deliver Year 4 LM training plan. • FIM implementation and ongoing TA.
Stage 5: By Q4 FY31	• Produce measurable state outcomes in cardiometabolic care, prevention, and disease management. • Enable regional centers to demonstrate improved performance on quality measures. • Position Indiana as a national leader in cardiometabolic prevention and treatment. • Establish and deliver Year 5 LM training plan. • FIM implementation and ongoing TA.

Outcome Metrics				
No.	**KPO**	**Metric**	**Data Source, Timing, & Ability to Collect/Analyze**	**Baseline Data & Milestone Targets**
5.1	**A, B**	Number of rural residents with access to cardiometabolic centers of excellence, by county	State will track on an ongoing basis	Baseline: ~88,000 Target by year 5: increase access to approximately 500,000 rural residents

5.2*	**A, B, H**	Percentage of patients achieving improved HbA1c control (<8% for diabetics) or blood pressure control (<140/90 for hypertensive patients), by county	Participating providers will submit clinical outcome EHR data at baseline, 6 months, and 12 months	Baseline percentage of patients with glycemic control is 58% and Blood pressure control is 62%. By Year 5, increase percentage of patients with glycemic control to 68.75% and blood pressure control to 72.5%
5.3	**A, B**	Number of individuals trained on Lifestyle Medicine	State training partner will report numbers of newly trained individuals and certified clinicians quarterly	Year 1: 1,200 individuals trained, and 400 clinicians certified. Year 3: 3,600 individuals trained, 1200 clinicians certified. Year 5: 6,000 individuals trained, and 2000 clinicians certified
5.4	**A**	Completed Feasibility Report with Implementation Plan for Food is Medicine plan	State will identify vendor; vendor will provide progress updates	Data collection phase completed by end of Year 1. Report and implementation plan submitted by end of Year 2

Metric overlaps between this initiative and another. For narrative justification, please see **Section 6: Metrics & Evaluation Plan. Gray-shaded metrics represent county-level data to demonstrate how impact is distributed.*

INITIATIVE 6: Growing Access to Hospital Post-Discharge Medications

Estimated Required Funding: $11.0M over the five-year funding period.
Sustainability: The barrier is funding to update the technology in the EMR and developing logistics. Sustained through payment and realized cost savings through decreased readmissions and ED visits.

Main Strategic Goal: Innovative Care **Use of Funds:** A, F, I, K **Technical Score Factors:** B.1, C.1, E.2	**Key stakeholders:** Rural hospitals, Insurance carriers, Hospital and pharmacy associations, IT system vendors, Individual healthcare providers (pharmacists, nursing staff, social workers, case management providers, and other stakeholders), MCOs, and commercial payers
Outcomes: • Initiative launch and number of participating hospitals	• Reduced hospital readmission rates • Increased post-discharge medication adherence rates • Decreased ED utilization post discharge

Impacted Counties: Targets Indiana's 64 rural counties first (see **Appendix B** for full list); however, this initiative's outcomes will impact all Indiana counties.

Activity 1: Increase Access to Hospital Post-Discharge Medications. Growing Access to Hospital Post-Discharge Medications will provide patients with their prescribed medication before they leave the hospital. A study in the **Journal of the American Pharmacists Association** found that a discharge prescription program reduced seven-day readmissions by 20% and 30-day readmissions by 16%. The medication will be charged at outpatient prices

despite dispensing of the medication in the hospital setting, effectively bringing the retail pharmacy to the patient's bedside eliminating access and transportation barriers. A clinician (nurse, pharmacy liaison, pharmacist, physician, etc.) will work with the patient to help them understand their medication, ensuring that the patient is well-equipped to focus on recovery upon discharge.

Operationalization of Growing Access to Hospital Post-Discharge Medications will require upfront investment, logistic operations, and electronic health system updates to build standard discharge flows, training, and hospital buy-in through ongoing stakeholder engagement. Once fully implemented, Growing Access to Post-Discharge Medications will be scalable and sustainable year-to-year. In addition to this infrastructure approach, Indiana may consider other ways to meet the goals of a predischarge medication delivery program, including a pharmacy staff training model. Two contract employees will oversee this initiative.

Implementation Timeline	
Stage 0: By FY26	• Conduct project planning including stakeholder engagement planning, finalizing governance structure and internal staffing.
Stage 1: FY26 – Q1 FY27	• Meet with stakeholders to generate hospital buy–in and overcome barriers. • Begin collaboration with MCO and other partners to identify process and coding changes.
Stage 2: Q2 FY27 – Q1 FY28	• Execute electronic medical record system coding changes. • Train Pharmacist Laison and standard operating procedures to address logistic barriers. • Program becomes fully operational by October 1, 2027, in rural hospitals.
Stage 3: Q2 FY28 – Q1 FY29	• Program meets halfway point of the target outcomes with ongoing adjustments made in alignment with feedback from stakeholder engagement.
Stage 4: Q2 FY29 – Q3 FY31	• Achieve more than 75% of outcomes in rural areas. • Generate significant buy–in from hospitals for cost–sharing, potentially targeting rural health systems with high readmission penalties under CMS first.
Stage 5: by FY31	• Fully implement the initiative across the state, meeting outcomes that can be reported to present compelling data to justify ongoing financing. • Growing Access to Post-Discharge Medications is financially sustainable.

Outcome Metrics				
No.	**KPO**	**Metric**	**Data Source, Timing, and Ability to Collect/Analyze**	**Baseline Data & Milestone Targets**

6.1	**A, B, H**	Percentage of rural hospital participation in Hospital Post-Discharge Medication program, by county	State will track on a quarterly basis through participation data	Baselines will be set in the first year. By year 5, increase the total percentage of rural hospital participation to 80%
6.2	**A, B, H**	Number of 30-day hospital readmission rates for participants in program	Participating hospitals will be required to report readmission and discharge data quarterly	Baselines will be set in the first year. Target to be determined with a goal of decreasing readmissions year over year
6.3	**A, B, H**	ED utilization 30 days post hospitalization	Participating hospitals will be required to report data quarterly	Baselines will be set in the first year. Target to be determined with a goal of decreasing ED utilization year over year
6.4	**A, B, H**	Percentage of discharged patients in participating hospitals who receive all prescribed medications before discharge	Participating hospitals will be required to report quarterly	Baselines will be set in the first year. Target to be determined with a goal of increasing number of patients served
Gray-shaded metrics represent county-level data to demonstrate how impact is distributed.				

INITIATIVE 7: Growing Specialty Provider Access through Expanded Teleconsult Capabilities

Estimated Required Funding: $2.6M over the five-year funding period.
Sustainability: Maintained by organizations through payment and realized cost savings.

Main Strategic Goal: Innovative Care **Use of Funds:** C, G, H, K **Technical Score Factors:** B.1, C.1, F.1, F.2	**Key stakeholders:** Higher education organizations, Rural primary care providers, Rural primary care clinics, Representative organizations (Indiana Rural Health Association, Indiana Primary Health Care Association, Indiana American Academy of Pediatrics, Indiana State Nurses Association, Specialty care providers across the state and their respective associations), MCOs, and commercial payers
Outcomes: • Completed needs assessment to understand teleconsult landscape • Improved health outcomes due to timely care	• Increased access to specialty care for our rural communities • Increased ability to treat and discharge inpatient patients and avoiding transfers due to telespecialty consultation • Improved access to high-demand/low supply providers
Impacted Counties: All 64 rural counties (see Appendix B) who face the greatest access challenges.	

Activity 1: Provider Network and Needs Assessment. Indiana will competitively select a partner to conduct a provider network assessment to understand what infrastructure may already exist, as well as to evaluate specific specialty needs and location of target specialty providers. This activity will happen in tandem with expansion activities for other programs happening

within the state delivering teleconsultation in high-need specialties, such as psychiatry and behavioral health.

Activity 2: Teleconsultation Systems Solution. A teleconsultation network requires a systems solution capable of hosting secure video and teleconferencing and text communication. Indiana anticipates addressing present barriers such as credentialing and the appropriate payment incentives. Recognizing that many communities and hospitals are already embarking on this effort, Indiana plans to issue a competitive solicitation to identify one or more shelf-ready solution partners to support roll-out across our rural communities in alignment with **Initiative 12**, with participating organizations expected to be responsible for ongoing maintenance costs after the funding period. The State will focus on recruitment of known specialty provider gaps, including behavioral and psychology specialties, and support provider outreach to encourage uptake. The State will also evaluate opportunities to leverage AI for analysis of consultation needs, including to adjust and right size availability by specialty and time, and to identify gaps in knowledge for education for opportunities. One contract employee will oversee this initiative and will be committed to carrying out the following and more:

Implementation Timeline	
Stage 0: By FY26	• Identify partner to conduct provider network and needs assessment. • Identify participating hospital primary care entities and providers and participating local and distant specialty providers. • Identify rural hospitals and clinics who have not yet utilized or who are estimated to be underutilizing the teleconsult network. • Evaluate technological challenges and best practices to inform systems solution solicitation.
Stage 1: FY26 – Q1 FY27	• Develop and enhance targeted educational programs, outreach practices, and network practices to best overcome barriers and meet educational and resource needs. • Create specific guidelines for providers such as appropriate consultations, necessary patient demographic information and medical information templates. • Competitive procurement for system solution(s) launched.
Stage 2: Q2 FY27 – Q1 FY28	• Continued targeted outreach and education to rural hospitals and clinics, assess impact, and work with stakeholders. • Shelf–ready system solution partner or partners selected and collaborative rollout underway.
Stage 3: Q2 FY28 – Q1 FY29	• Conduct targeted outreach and provide TA on usability with systems solution partner(s) collaborating with provider network and needs assessment partner. • Roll out by specialty and/or region.

Stage 4: Q2 FY29 – Q3 FY31	• Assess impact and work with stakeholders to revise as indicated. • Ongoing evaluation of impact on time to care, avoided hospital transfers for specialty care, avoided hospital admissions, and hospital length of stay. • Leverage AI to evaluate consultation needs to adjust and right size availability by specialty and time, and to identify gaps in knowledge for education for opportunities.
Stage 5: By Q4 FY31	• Network utilization is anticipated to be routine and evolve in capability as rural providers increase knowledge and capacity to provide behavioral health care. • Continued evaluation of ROI and partnership with payers on realized cost savings for sustainment.

Outcome Metrics				
No.	**KPO**	**Metric**	**Data Source, Timing, & Ability to Collect/Analyze**	**Baseline Data & Milestone Targets**
7.1	**E, F, G, H**	Number of interfacility transfers	The teleconsult vendor system will provide monthly reporting	Baselines will be set in the first year with a goal to reduce year over year
7.2	**E, F, G, H**	Wait time and travel for an appointment with a specialist, by county	The teleconsult vendor system will provide monthly reporting	Baselines will be set in the first year with a goal to decrease year over year
7.3	**F, G H**	Number of specialists available via teleconsult	The teleconsult vendor system will provide monthly reporting	Baselines will be set in the first year with a goal to increase year over year; both statewide access, and through intra-hospital/ network access
7.4	**G, H**	Utilization rate for providers	The teleconsult vendor system will provide monthly reporting	Baselines will be set in the first year with a goal to increase utilization year over year
Gray-shaded metrics represent county-level data to demonstrate how impact is distributed.				

By building the collaboration and infrastructure necessary to conduct secure interactive video and teleconferencing delivery of acute care, Indiana can expand the reach of and access to critical specialty provider types that are largely congregated in urban areas, and in turn decrease unnecessary care and turnaround time for specialty care for patients that truly need it.

INITIATIVE 8: Growing Telehealth Access and Infrastructure

Estimated Required Funding: $28.9M over the five-year funding period.
Sustainability: Payments from MCOs and commercial payor.

Main Strategic Goal: Innovative Care **Use of Funds:** A, C, F, G, H **Technical Score Factors:** B.2, F.1, F.3	**Key stakeholders:** LHDs, Indiana Broadband Office (IBO), FQHCs, RHCs, Women, Infants, and Children (WIC) Clinics, Providers, Birthing hospitals that serve rural populations, MCOs, and Commercial Payors

Outcomes:	
• Improved access to clinical care, both primary and specialty/subspecialty • Improved access to preventive services and prenatal and postpartum care	• Improved health outcomes through expanded health coaching access; such as, BMI, cholesterol, hypertension, etc. • Improved timeliness of access to appropriate care, by county • Number of patients served through telehealth solutions
Impacted Counties: Targets Indiana's 64 rural counties first (see Appendix B for full list)	

Activity 1: Feasibility Study & Regional Health Grant Collaboration. Indiana will first identify a partner to conduct a feasibility study of the existing rural provider landscape to understand what systems are in place, what utilization looks like in those cases, what connectivity and scheduling interoperability will need to be addressed, and what regional specific challenges exist, such as lack of appropriate equipment. As part of the study, Indiana seeks to evaluate the impact of wearable electronics such as biometric monitoring devices and how remote health monitoring enables health tracking to decrease clinician burnout, improve patient monitoring, and lower healthcare costs. This partner will be expected to share findings and collaborate with the regional coalitions selected through Initiative 12 to meet each region's specific readiness needs.

Activity 2: Telehealth Systems Solution that Addresses Rural Challenges. This activity aims to bridge existing gaps through a unified systems solution. The State will issue a competitive procurement to identify a telehealth vendor, with the expectation new technology capable of using cellular over wi-fi for connectivity is included in their solutions proposal. Telehealth vendors who are leveraging AI to improve outcomes, support clinical decision tools, and enhance customer service are preferred. The feasibility study will inform target locations for rollout staging. One contract employee will oversee this initiative:

Implementation Timeline	
Stage 0: May 2026 – Q4 FY26	• Identify a partner to conduct a feasibility study and connect said partner with awarded Regional Health Grant awarded Regional Coalitions.

Stage 1: Q4 FY26 – Jan 2027	• Establish contractual relationship with identified feasibility study partner and begin targeted outreach and engagement to inform the study. • Identify target communities within the 8 rural regions and their unique telehealth infrastructure needs in collaboration with awarded regional coalitions. • Launch telehealth systems request for proposal.
Stage 2: Jan 2027 – Q4 FY27	• Conclude feasibility study. • Award telehealth systems vendor.
Stage 3: Sep 2027 – Q1 FY29	• From January 2028 – December 2028, state-led telehealth system launches. • Technical assistance for participating facilities, education, and outreach begins.
Stage 4: Q2 FY29 – Q1 FY30	• Expand telehealth system statewide. • Refine interoperability and scheduling tools. • Leverage AI to support clinical decision tools, identify efficiencies and enhance customer service. • Continue training and stakeholder engagement. • Begin sustainability planning.
Stage 5: By Q1 FY30	• Achieve full operationalization across Indiana. • Conduct statewide evaluation of outcomes and cost savings. • Evaluate effectiveness of AI. • Finalize long-term sustainability model.

Outcome Metrics				
No.	**KPO**	**Metric**	**Data Source, Timing, and Ability to Collect/Analyze**	**Baseline Data & Milestone Targets**
8.1	**F, G, H**	Number of telehealth encounters (incl. teleconsultation, virtual urgent care, and remote patient monitoring)	Providers will submit quarterly telehealth utilization reports documenting encounter types, patient locations, and clinical specialties	Increase telehealth utilization among rural patients by 50% (baseline of 303,000 Medicaid telehealth encounters conducted in rural counties in SFY25)
8.2*	**A, G, H**	Percentage of patients achieving improved HbA1c control (<8% for diabetics) or blood pressure control (<140/90 for hypertensive patients), measured at county level	Participating providers will submit clinical outcome EHR data at baseline, 6 months, and 12 months. Regional coalitions will collect blood pressure data through telehealth platforms. State Medicaid claims data for covered populations	Baseline percentage of patients with glycemic control is 58% and Blood pressure control is 62%. By Year 5, increase percentage of patients with glycemic control to 68.75% and blood pressure control to 72.5%
8.3	**E, F, G**	Timeliness of access to appropriate care, by county	State partner will report timeliness data quarterly	Baseline will be set in the first year; improvement milestones to determine
8.4*	**B, F, G, H**	Preventable ED visit rates for ambulatory care-sensitive conditions measured at county level	Syndromic surveillance data; Programs will submit monthly encounter data through hospital reporting systems, with county-level analysis and validated against State data. EMS agencies will report transport volume and diversion outcomes	As of 2023, preventable ED visit rates for ambulatory care-sensitive conditions in rural areas average 58 ED visits per 1,000 population annually, significantly higher than urban rates of 42 per 1,000; By end of year 3, reduce preventable ED visits for ambulatory care-sensitive conditions by 15%, and by 25% by end of program

Metric overlaps between this initiative and another. For narrative justification, please see Section 6: Metrics & Evaluation Plan. Gray-shaded metrics represent county-level data to demonstrate how impact is distributed.

INITIATIVE 9: Growing our Rural Health Paraprofessional Workforce

Estimated Required Funding: $11.8M over the five-year funding period.
Sustainability: Creation of career pathways and stipends will build a rural workforce that serves rural communities beyond the timeframe of this grant. Also, Community Health Workers (CHWs) have demonstrated return on investment in their role in supporting families in healthcare and social need navigation.

Main Strategic Goal: Workforce Development **Use of Funds:** A, E, H **Technical Score Factors:** B.2	**Key stakeholders:** Rural health paraprofessional member associations, rural health paraprofessional certification and training vendors, employer community where rural health paraprofessionals are integrated into care teams (rural hospitals, primary care clinics, FQHCs, CMHCs, CCBHCs, school-based health centers, and CBOs), Indiana Community Health Worker Association, current certification vendors, funding and sustainability task force, the Community Health Workforce Development Institute, CHW employers, MCOs, and Commercial Payers
Outcome: • Increase in the number of Certified CHWs	• Increase in the number of students pursuing a healthcare credential • Increase in the number of credential health care workers in rural counties
Impacted Counties: All 64 rural counties across the state.	

Activity 1: Certified Community Health Workers (CCHWs) Training: CCHWs are uniquely positioned to understand and provide services that support the health-connected needs of Hoosiers and the communities in which they live. CCHWs help fill important gaps by providing follow-up support to patients, allowing physicians and licensed clinicians to focus on the provision of care. CCHWs increase residents' knowledge of behaviors promoting health, such as lifestyle changes, education on physical activity, and/or proper nutrition, and increase access to community resources that prevent and manage chronic disease to improve health outcomes. The impact of integrating CCHWs in healthcare and community-based settings is well-documented, showing a 28% reduction in hospitalizations following a CHW intervention in a population earning lower incomes with multiple chronic conditions and significantly improved clinical markers of people living with chronic diseases.[17] To grow the number of CCHWs in rural

[17] Indiana community health workers: challenges and opportunities for workforce development

areas, Indiana will pay for initial certification trainings to remove barriers to entry for individuals residing and working in rural counties and provide financial assistance for additional training to ensure that CCHWs that require upskilling are able to access those additional trainings. The CCHW training activity serves as a valuable opportunity to connect SNAP recipients with educational work pathways to support their communities' health and well-being.

Activity 2: Create Career Pathway Programming for Rural High School Students.

Understanding that early career exposure is key to socializing careers available in the healthcare and behavioral health sectors, Indiana, in partnership with a state-wide university system, will create a comprehensive early-career program that specifically targets high-school students. High school students will have the opportunity to begin gaining education towards general health education or an LPN (licensed practical nurse), EMT, and or CNA. Indiana will collaborate with an in-state university system to launch the following:

1. Healthcare Academy program	An 8-week summer program with demonstrated success that high school students can participate in at no cost to them, while earning college credit.
2. Incentive Stipend	A $1,000 stipend will be made available to graduating rural high school seniors who participated in the Healthcare Academy and are pursuing a healthcare credential at a university located in one of the eight regions within the university system.
3. Rural Healthcare Stipend	A $10,000 stipend offered for up to four consecutive semesters to any Hoosier residing in a rural county pursuing a credential in a healthcare field in one of the eight regions and committed to five-year requirement.

Implementation Timeline	
Stage 0: Nov 6, 2025 -- Q1 FY26	• Finalize approach for the CCHW certification and upskilling training. • Conduct outreach to rural healthcare providers to identify partners and begin planning for the Healthcare Academy kick-off.
Stage 1: Q2 FY26 -- Q1 FY27	• Recruit students for the Summer 2026 Healthcare Academy, conduct the first year of the Healthcare Academy program, make Initiative Stipends available to high school students attending the program. • Begin paying for certification training and ongoing training for CCHW upskilling.
Stage 2: Q1 FY27 – Q1 FY28	• Monitor and report enrollment of students in the Healthcare Academy and Incentive Stipend programs; begin planning for Summer 2027 activities and conduct the Summer 2027 Healthcare Academy Program. • Provide certification training and ongoing training for CCHW upskilling.
Stage 3: Q1 FY28 – Q1 FY29	• Rural Healthcare Stipends offered to students pursuing a credential in a healthcare field at the partner university system in academic year 2028-2029.

	• Monitor and report enrollment of students in the Healthcare Academy and Incentive Stipend programs; begin planning for Summer 2028 activities and conducting the Summer 2028 Healthcare Academy Program. • Provide certification training and ongoing training for CCHW upskilling.
Stage 4: Q1 FY29 – Q1 FY30	• More than three–fourths (¾) of outcomes have been achieved. • Monitor and report enrollment of students in the Healthcare Academy and Incentive Stipend programs; begin planning for Summer 2029 and Summer 2030 activities and conducting the Summer 2029 and Summer 2030 Healthcare Academy Programs. • Provide certification training and ongoing training for CCHW upskilling.
Stage 5: Q1 FY30 – Q1 FY31	• Monitor and report enrollment of students in the Healthcare Academy and Incentive Stipend programs; begin planning for Summer 2031 activities and conduct the Summer 2031 Healthcare Academy Program. • Finalized metrics report for all initiative activities.

Outcome Metrics				
No.	**KPO**	**Metric**	**Data Source, Timing, & Ability to Collect/Analyze**	**Baseline Data & Milestone Targets**
9.1	**D, E, H**	Number of CHWs recruited and trained across rural communities, by county	As submitted by the identified training program	2024 est. baseline of approximately 150-200 CHWs in rural areas; By the 4-year mark, train an additional 150, and by year 5, 200 new CHWs across rural regions
9.2	**D, E, H**	Percentage of CHWs integrated into clinical and community care teams and long-term healthcare planning	Regional coalitions will submit quarterly reports on CHW data; State will validate with professional certification data	By the 5-year mark, achieve 85% retention rate of trained CHWs
9.3	**A, D**	Number of students enrolled annually in the Healthcare Academy	Enrollment will be measured through vendor's enrollment portal prior to the start of the Academy each summer	Over the course of the grant, vendor's goal is to enroll a total of 850 high school students in the Healthcare Academy (annually, this will include 475 high school students)
9.4	**D**	Number of students who go on to complete certifications (LPN, EMT, CNA, etc.) as result of the Healthcare Academy	Completion/certification will be measured by vendor and reported yearly.	Baseline to be determined by vendor with the expectation to increase year over year
Gray-shaded metrics represent county-level data to demonstrate how impact is distributed.				

INITIATIVE 10: Growing Clinical Training and Readiness

Estimated Required Funding: $83.0M over the five-year funding period.
Sustainability: Long-term sustainability will rely on partnerships with key stakeholders to maintain residency training capacity and integrate successful models into rural workforce policy and planning. Ongoing program evaluations and research on the GME initiative and temporary preceptor stipend will assess impact on rural workforce retention, using results to justify continued state investment or legislative appropriations.

Main Strategic Goal: Workforce Development **Use of Funds:** E **Technical Score Factors:** B.1, C.1, D.1, F.2, F.3	**Key stakeholders:** IDOH, Indiana GME Board, Health Workforce Council, institutions providing graduate medical education (GME), healthcare providers and organizations (clinicians, RHCs, FQHCs, CCBHCs, and other provider health organizations), professional associations (Indiana Rural Health Association, Indiana State Medical Association, and other professional physician groups)
Outcomes: • Increased total number of residency programs operating within the state	• Increased number of available rural or underserved rotations offered to residents • Total length of service commitments in rural and underserved areas • Increased number of participating preceptors
Impacted Counties: This initiative will be implemented state-wide and has the potential to impact all counties within the state. However, funding for the purposes of this grant will focus on implementation in rural areas.	

Activity 1: GME Enhancement. The state's Graduate Medical Education (GME) capacity will be enhanced to keep pace with growing demands for physicians and support the health care career education infrastructure, particularly in rural and underserved communities. Indiana will identify a partner to collaborate for a Rural GME development plan, which will inform grant disbursement through partnership with the Commission for Higher Education (CHE) Graduate Medical Education (GME) Board to administer targeted grants for expansion of residency programs in rural communities to fund the development and initiation of new positions.

Activity 2: Physician Stipends. To bolster Indiana's rural workforce and ensure physicians are incentivized to practice in rural communities, Indiana will provide stipends to recruit and retain physicians in key disciplines: primary care, pediatrics, OBGYN, and general surgery. Studies show that one physician carries a $32 million boost to the local economy, including bringing along six or seven new jobs. Indiana's Health Workforce Council will assist in identifying what disciplines each community needs. New physicians willing to move their practice to a rural community for five years, or new graduates who commit 100% of their clinical hours for five years in the designated rural area, will receive a stipend. Indiana has not had a physician default on similar programs but contracts with physicians will require a payback if the

physician in unable to complete the five-year commitment. Indiana will dedicate two personnel to oversee this program.

Activity 3: Rural Preceptorship Stipend. Clinical preceptors are practicing health professionals that teach students clinical skills to help prepare them for a career in the medical field, and act as a critical tenet of healthcare workforce development. To encourage rural workforce expansion, which is heavily threatened by the shortage of clinical preceptors, a temporary preceptor stipend program will be used as an incentive to recruit and retain clinical preceptors. A stipend amount of up to $10,000 will be provided to participating clinicians who will be required to commit for the five-year period in alignment with the NOFO; stipend amount will depend on the number of rotations and the profession of the preceptor (physicians will be eligible for higher stipends than LSWs and RNs.) Stipends increase with a higher number of rotations and will be capped at 10 rotations. For example, a rural general surgeon who provides 10 months of precepting for general surgery residents would receive $1,000 per rotation for a total of $10,000.

A study looking specifically at Family Medicine residency training found a 5- to 6- fold increase in subsequent rural practice after completing a rural rotation.[18] **To further support provider training, Indiana will pass a policy, by 2028, requiring that Indiana medical schools will require one rural rotation for medical students, exposing students to the unique aspects of rural healthcare.** Both of Indiana's medical schools have committed to implementation by 2030.

Activity 4: Rural Preceptorship Database. Indiana healthcare students report difficulty in identifying preceptors to meet their training requirements. Indiana will develop a preceptor database for healthcare students to identify and connect with clinical preceptors in rural

[18] https://pubmed.ncbi.nlm.nih.gov/35991106/

communities. As mentioned, exposure to rural healthcare increases the likelihood of future practice and provides an opportunity for rural healthcare entities to recruit students.

Implementation Timeline	
Stage 0: By end of Q2 FY26	• Procure and initiate rural graduate medical education development plan research and participation.
Stage 1: Q3 FY26 – Q4 FY26	• Create infrastructure to begin technical assistance collaborative. • Create infrastructure for preceptor database. • Increase rural residencies and rotations by onboarding 5 additional locations. • Administer physician rural health training temporary stipend.
Stage 2: Q4 FY26 - Q1 FY27	• Increase rural residencies and rotations by onboarding 5 additional locations. • Administer physician rural health training temporary stipend to at least 30 recipients up to a maximum of $300,000 with agreement to practice in a rural area for 5 years. • Register clinical preceptors to document and establish availability.
Stage 3: Q2 FY27 – Q1 FY28	• Increase rural residencies and rotations by onboarding 5 additional locations. • Targeting by 2028, legislation or regulatory action will be implemented to require Indiana's two medical schools to include nutrition education in medical curriculum. • Targeting by 2030, legislation or regulatory action will be implemented to require Indiana's two medical schools to include one rural rotation requirement. • Launch preceptor stipend program for supporting rural rotation for healthcare students.
Stage 4 & 5: Q2 FY28 – Q1 FY30	• Program managers to complete yearly program evaluations. • Continue preceptor stipend program. • Evaluate usefulness of preceptor database and outcomes for where students choose to practice after completing training.

Outcome Metrics				
No.	**KPO**	**Metric**	**Data Source, Timing, & Ability to Collect/Analyze**	**Baseline Data & Milestone Targets**
10.1	**D, E**	Number of registered rural clinical preceptors	State will track through preceptor database on a quarterly basis	Years 1: Register 200 clinical preceptors. Years 2 – 5: Register an additional 50 preceptors each year
10.2	**D**	Percentage of individuals utilizing the state-implemented preceptor database	State will track through preceptor database on a quarterly ongoing basis	Years 3 – 5: Ensure that 50% of Indiana colleges and universities are utilizing the state-implemented preceptor database to encourage rural clinical experience. Track utilization and expand communication
10.3	**D, E, H**	Number of rural residencies and rotations	State partner will track on a quarterly basis	Create 15 new residency positions serving rural areas and support 200 clinical preceptors for rural healthcare workforce
10.4	**D, E, H**	Population to physician ratio in rural counties	Bowen Center reports annual data	By year 5, Decrease the average population to physician ratio in rural counties by 4% from 1264.8:1 to 1,214.2:1
Gray-shaded metrics represent county-level data to demonstrate how impact is distributed.				

INITIATIVE 11: Growing our Rural Behavioral Health Workforce	
Estimated Required Funding: $5.3M over the five-year funding period. Sustainability: Behavioral career pathway programming will ensure communities have a trained workforce.	
Main Strategic Goal: Workforce Development **Use of Funds:** E, H **Technical Score Factors:** D.1	**Key stakeholders:** FSSA Division of Mental Health and Addiction (DMHA), DCS, IDOH, Indiana GME Board, Health Workforce Council, Indiana high schools, colleges and universities, Peers Recovery Community Organizations, Indiana Council of Community Mental Health Centers
Outcomes: • Increased local hire rate in rural communities of program graduates	• Increased behavioral health workforce in target rural sites • Increased program completion and credential attainment rate • Increased retention and community service impact of behavioral health workforce
Impacted Counties: 64 rural counties and targeted efforts will be aligned with corresponding educational institutions (*e.g.*, Ivy Tech Community College) in the rural community.	

Activity 1: Grow Your Own Workforce. To promote workforce retention, support rural provider recruitment, and encourage new professionals to enter and remain in behavioral health settings, Indiana will partner with local universities to create rural-focused behavioral health certificate and degree programs for mental health technicians and nurses and offer scholarships and stipends to rural students who commit to working locally post-graduation for the required five-year period. To encourage entrance into behavioral health fields early on, Indiana will implement a pathway program to introduce mental health and substance use career opportunities to high school students. These approaches guide critical funding decisions to keep more talented Hoosier students and professionals active, successful and local in their respective fields.

Activity 2: Behavioral Health & Peers Workforce. This activity will promote replication of evidence-based practice initiatives to increase workforce pipeline and retention in rural counties and communities, with a specific focus on midlevel professionals. Building on the high school pathways program described in Activity 1, Indiana will implement a pathway for clinical training for college students studying mental health and substance use-related disciplines in rural communities, in addition to sustaining current internship programs that offers stipends to

incentivize interns, especially in rural areas, and who commit to work locally after they complete the end of their internship.

The State will support the rural peer workforce by supporting Certified Peer Support Specialist (CPSP) trainers to provide 12 more opportunities per year for CPSP certification trainings. Also, the State will work with a vendor to provide continued education training opportunities, with priority to CPSPs in rural areas, to meet the certification requirements to increase retention of peers in the workforce of rural communities.

Activity 3: Behavioral Health Threat Assessment and Management Workshop. This workshop will equip rural health paraprofessionals employed by community mental health centers, particularly in crisis response teams and leadership, in best practice behavioral health assessment and management to engage, assess, intervene, and provide treatment to those at risk for engaging in violent behavior. One contractor will serve as a program director.

Implementation Timeline	
Stage 0: By Q3 FY26	• Secure academic partnerships. • Design curriculum and career pathways.
Stage 1: By Q4 FY26	• Develop course materials. • Hire program staff.
Stage 2: Q4 FY26 – Q1 FY27	• Launch recruitment campaign. • Finalize cohort selection.
Stage 3: Q1 FY27 – Q1 FY29	• Deliver instruction and disburse stipends.
Stage 4: Q2 FY29 – Q1 FY30	• Provide clinical placements.
Stage 5: By Q1 FY30	• Monitor retention, placement, and service.

Outcome Metrics				
No.	**KPO**	**Metric**	**Data Source, Timing, & Ability to Collect/Analyze**	**Baseline Data & Milestone Targets**
11.1	**D, E, H**	Number of individual rural patients receiving psychology services per month	State partner will track monthly	Baseline will be set in the first year with the expectation to increase year over year
11.2	**D, E, H**	Number of different rural counties who have residents receiving psychology services, by county	State partner will track monthly	By FY31: ≥ 85% completion/credentialing rate within normal program duration

11.3	**E**	Percentage of enrolled students who complete the certificate/degree within the expected timeframe and obtain credential	State partner will track annually	By FY31: ≥ 75% placement within 12 months
11.4	**D, E, H**	Percentage of program graduates employed at a participating rural facility within 12 months of graduation	State partner will track annually	By FY31: ≥ 65% retention at 24 months
Grey-shaded metrics represent county-level data to demonstrate how impact is distributed.				

INITIATIVE 12: Make Rural Indiana Healthy Again Regional Grants

Estimated Required Funding: $604.2M total over the five-year program period (FY27-FY31), with approximately $75M distributed annually across the eight Regional Coalitions.
Sustainability: Each region and their projects are required to demonstrate their own sustainability plan. Funding is to be utilized to implement the 5 core areas of the RHTP: Access, Technology Innovation, Workforce Development, MRAHA, and Innovative Care.

Main Strategic Goal: Make Rural America Healthy Again **Use of Funds:** A, C, D, F, G, H, J, K **Technical Score Factors:** B.1, B.2, C.1, C.2, E.1, F.1, F.2, F.3	**Key stakeholders:** Healthcare Delivery Organizations (CAHs, FQHCs, rural health clinics, behavioral health organizations, EMS), Public Health and Community Organizations (LHDs), Educational and Workforce Development Entities (clinical training programs and preceptorship sites), State Agencies and Support Organizations (IDOH, FSSA including Medicaid, Department of Children's Services, State Office of Rural Health, Indiana Hospital Association, Indiana Rural Hospitals Association), Patients and Community Members (patient advisory councils, community advisory boards, chambers of commerce), Medicaid MCOs, commercial payers and members of the Indiana General Assembly (IGA)
Outcomes: • Identification of duplication of services and gaps in care to right size healthcare delivery in rural Indiana • Increased care of pregnant women, through increasing percentage of women with first trimester care and completing all pre and postnatal visits	• Increased access to preventive services and connection to appropriate primary or specialty care through engagement with telehealth and teleconsult, mobile integrated health, hub and spoke models, and other innovative care delivery models • Improved blood pressure and diabetes control through engagement in cardiometabolic programs • Increased workforce recruitment and retention though development of rural preceptorships • Improved hospital health • Leveraging the collective of healthcare providers in rural Indiana, rather than bolstering singular entities there will improve system integration and sustainability

Impacted Counties: The eight regions will collectively serve approximately all rural counties across Indiana, representing ~2.5-3 million rural residents. Counties may have overlapping service from multiple regions where border communities naturally connect to more than one healthcare delivery region. All funded activities must be implemented in rural areas as defined by FORHP/HRSA rural designation criteria.

This initiative duplicates the federal RHTP at the state level. Similar to the sentiment of the federal program, Indiana recognizes that rural communities across the state have unique insight into their own needs which strengthens their ability to implement specific local solutions. Indiana

has previously demonstrated success in empowering local communities to utilize data to identify areas of greatest opportunity and then draw upon the resources and stakeholders already in their community to address them.

Indiana's Success with Regional Model
Health First Indiana is state appropriated public health funding for counties that require local public health and stakeholder collaboration. Additionally, statue requires counties to address core public health outcomes such as chronic disease and trauma and injury prevention by utilizing county specific data (provided from IDOH, Health: Public Health Data Navigator) to identify the drivers of poor health outcomes and then leverage local resources and stakeholders to apply solutions. Counties are held accountable through key performance outcome tracking and robust data collection.
IDOH had worked to address the state's infant mortality rate (IMR) for decades with moderate success. It wasn't until Indiana invested in local solutions to the specific leading causes of IMR (substance use disorder, smoking in pregnancy, prenatal care access) in each community that we began to see meaningful results. Secondary to Indiana's shift to an intentional locally driven approach, in 2024 Indiana had its lowest infant mortality rate since data started to be collected in 1900.
Indiana's READI program is an economic development regional grant that encourages neighboring communities across the state to work collaboratively to develop a bold vision for their future that attracts, develops and retains talent in Indiana. About 92% of the 398 funded projects continued beyond initial funding because regional partnerships evolved into self-sustaining collaboratives.

Building on the success of Health First Indiana, Indiana's historic infant mortality decrease, and the READI program, the Regional Grant program is aligned with the objectives of the RHTP. The State will issue and award competitive, regional grants targeting rural health innovations, collaboration for shared cost savings across entities, new access points to promote preventive health, outcomes-driven chronic disease prevention and management, a trained and ready rural workforce and technological innovations. Participation and access to funding will be contingent upon the entities engaged in the grant fully participating in the expectations set in other components of Indiana's GROW initiatives.

This $600 million investment over five years employs a Regional Coalition grant model as a deliberate strategy to transform rural health delivery in ways that single-institution or state-directed approaches cannot achieve. The grants will require collaboration across hospitals, federally qualified health centers (FQHCs), mental health providers, community-based

organizations, local health departments, schools, the business community, and other key players in the delivery of local healthcare.

Indiana is divided into 10 emergency preparedness regions (**Appendix F**) that closely align geographically with patient care and referral areas. This map serves as a starting point for identifying the eight regions that will serve as the regions for the Make Rural Indiana Again Regional Grant, as two of the 10 regions (1 and 5) are largely urban and suburban. These regions already work together for trauma care and preparedness.

Each region will be required to submit one single, unified regional application that demonstrates evaluation of health outcomes leveraging community needs assessment and local health data provided by IDOH (**Appendix F**). The application must address duplication of services, opportunities for shared cost savings, describe how gaps are filled and provide service delivery innovations. By requiring regions to submit one application encompassing the full scope of rural initiatives and partners, these relationships will outlast the grant because they become the foundation for ongoing regional health planning. Funding, however, will be distributed directly to the individual entities carrying out initiatives. Rural providers understand their communities' unique challenges better than state officials and rural patients don't experience healthcare in organizational silos — they navigate disconnected providers and services. Entities will be required to convince other healthcare entities in their region how investment in their infrastructure will serve the greater needs of Hoosiers in the community and not their individual interests. When organizations don't coordinate, there are higher healthcare costs through service duplications and patients fall through the gaps.

Regional Grant Oversight Governance: The State will implement rigorous, multi-layered oversight balancing accountability with flexibility that rural communities need to innovate. At each stage of the grant-making process, HFS will ensure sub-grantees are compliant with all

NOFO terms and any future CMS guidance regarding allowable/unallowable expenses, expenditure timelines, and sub-grantee reporting, as well as all State rules pertaining to grant agreements. The State will provide public data reporting through dashboards and KPO tracking to foster transparency and community accountability for the success of each region's activities.

Governor Braun							
State Executive Oversight (approved by the Governor's Office)							
Regional Grant Steering Committee (approved by the Executive Oversight Committee)							
Region 2 Coalition	**Region 3 Coalition**	**Region 4 Coalition**	**Region 6 Coalition**	**Region 7 Coalition**	**Region 8 Coalition**	**Region 9 Coalition**	**Region 10 Coalition**
Regional Committee	Regional Committee	Regional Committee	Regional Committee	Regional Committee	Regional Committee	Regional Committee	Regional Committee
Note: Regions 1 and 5 in Appendix F are omitted due to being primarily urban.							

The **Executive Oversight Committee** will consist of leadership and subject matter expertise from the Health and Family Services vertical and the Governor's office. The executive committee has final decision-making capacity for applications, funding amounts, and oversight into reporting, budget and key performance outcomes. The State Executive Oversight Committee will maintain oversight throughout the life of the grant and retain the ability to adjust funding amounts year after year based on compliance and outcomes.

Regional Grant Steering Committee, chaired by the State Executive Oversight Committee, will be approved by the Governor's office and include community and legislative leadership, many who serve on the RHTP working group. The committee will meet quarterly to review updates on the Regions' activities, data, and outcomes. It will provide guidance and direction and assist in addressing opportunities for scale and further collaboration.

Regional Committees will consist of stakeholders within the individual region and have 11 regional members, approved by the State Executive Oversight body. They will represent key rural health stakeholders, utilizing subject matter expertise to assess potential beneficiaries of the regional grants, thus ensuring an equitable distribution of funds and accountability. The Regional

Committee must meet at least quarterly to provide oversight, strive for collaboration, drive accountability, and review the budget. Each Committee must include:

• 1 Member of the Indiana General Assembly • 1 Provider Representative • 1 Non-Provider Medical Workers Representative • 1 Patient Representative • 1 Pharmacy Representative	• 2 Regional Business Community Representatives • 2 Community-based Organizations Representatives • 1 Local Health Department Representative • 1 Medicaid Managed Care Representative

Regional Application Development. HFS will develop the Make Rural Indiana Healthy Again Regional Grant Application in direct adherence to the NOFO and RHTP parameters. The comprehensive application will give clear direction to applicants regarding how to address the needs of rural communities to ensure rural health advancement in line with CMS' overall strategic goals, emphasizing data-driven solutions, exceptional partnership strength, innovation, and sustainability planning. HFS will contract with a vendor experienced in grant-making to support application development, evaluation design (the State will make all award decisions), grant agreement development, and expectations for outcomes and financial reporting.

Indiana Regional Grant Application Timeline	
Date	**Milestone**
March 2026	Request for Applications released to public
March – July 2026	Technical assistance available for coalition formation and application development
July 1, 2026	Applications due to State
July – September 2026	Application review, scoring, and award determinations
October 1, 2026	Grant agreement period begins, and funding distributed to individual entities

Pre-Application Expectations: The Regional Coalitions are encouraged to begin identifying partners, convening discussions about shared regional rural priorities, conducting joint needs assessments, and exploring data sharing agreements. Regional Coalitions demonstrating preliminary planning and established governance will be better positioned to rapidly deploy funding upon contract award.

Regional Application Requirement: Each Regional Coalition must submit **one unified application** to the State inclusive of all funding requests. Applicants will be required to submit a

comprehensive needs assessment illustrating both the health and technology needs of the region, letters of support from stakeholders and partners, a sustainability plan, and clear acknowledgement that they understand and agree to comply with the grant requirements for funds usage and reporting and state requirements. All applications must connect projects to measurable KPOs and describe how progress on the below goals will be demonstrated annually.

- Increased access to prenatal care
- Increased access to chronic disease prevention programs
- Increased access to oral health providers
- Improved patient quality and safety
- Improved community health worker workforce expansion and interoperability
- Increased telehealth and community paramedicine utilization to reduce preventable ED visits
- Improved transportation access
- Increased access to healthcare
- Increased regional collaboration
- Improved sustainability indicators

Additional metrics that Regional Coalitions may be required to report are dependent on the optional activities they pursue, and examples can be found in **Appendix F.**

Funding Categories and Required Investments: Regional coalitions will be able to apply for funds within the following categories informed by the State survey, direct stakeholder conversations, Indiana's assessment of the rural landscape, the NOFO priorities, and expectations to participate in state-implemented initiatives.

Overview of Funding Categories	Participation Expectations
Technology Innovation and Capital Project Work collaboratively to identify capital and tech needs to increase services. Capital costs are restricted to a maximum of 20% of total regional budget and electronic medical record (EMR) system expenditures are restricted to a maximum of 5% of total regional budget. Explore opportunities to leverage AI to improve outcomes through collaborative quality efforts.	**Required Participation in State-Implemented Initiatives**
	Must participate in Initiative 3 defined as: Regional coalitions must collaborate with state-implemented HIE vendor to support provider engagement and uptake efforts.
	Examples of Potential Regional Activities
	Example Activity 1: Health entities collaborating for EMR updates, AI use for clinical decision-making tools, and community engagement communication platforms. **Example Activity 2:** Leverage regional economies of scale for investment in cybersecurity upgrades and other cost sharing savings. **Example Activity 4:** Regionally agreed upon capital investments in minor renovation to a rural hospital to fill a gap in healthcare delivery for that region. For example, to provide dental services.
Sustainable Access	**Required Participation in State-Implemented Initiatives**

Coordinate to provide preventive programs (cardiometabolic programs, prenatal care, screenings) and address non-medical needs impacting overall health. All regional applications must address the following: expanding access to prenatal care, supporting the community health workforce through investment in recruiting, training, and sustainment. Regional Coalitions will be required to select one of the evidence-based interventions provided by IDOH or seek approval from IDOH before implementation. IDOH will provide significant technical assistance to regional grantees before and during implementation.	**Must participate in Initiative 5 defined as:** Regional Coalition membership must include the implementation site identified for participation in the state-implemented rural collaborative cardiometabolic care model. **Must participate in Initiative 8 defined as:** Regional Coalition must include in their initial needs assessment a landscape of patient-to-provider telehealth solutions currently in use in their region and evaluation of gaps (*e.g.*, teledentistry, remote biometric monitoring solutions, etc.) to be shared with the awarded solutions vendor in **Initiative 3**. **Must participate in Initiative 1 defined as:** Regional Coalition must collaborate with state Medical Operations Coordination Center in supporting roll-out for their region. **Must participate in Initiative 9 defined as**: Regional Coalition must collaborate with the State in identifying suitable employers of rural health paraprofessionals within their region.
	Other Required Activities
	Regional Coalitions MUST: **Address Prenatal Care Access and Infant Mortality Opportunities:** Implement innovative care models and solutions to address access to prenatal care and leading causes of infant mortality. **Address Geriatric Populaiton:** Address the growing rural geriatric population through geriatric specific activities in prevention, outreach and/or enhanced training on the needs of geriatric patients. **Address Non-medical Drivers of Health:** Identify partners and implement solutions to address leading non-medical drivers of health, such as transportation and access to healthy food.
	Examples of Potential Regional Activities
	Example Activity 1: Regional transportation coordination such as non-emergency medical transportation vouchers, volunteer driver programs, and partnerships with rural transit authorities to address healthcare access. **Example Activity 2:** Incorporate comprehensive health assessment, results review, and personalized health plan in youth office visits with pediatrician or primary care physician to address growing obesity epidemic in youth. **Example Activity 3:** Incorporating training on the Beers Criteria of inappropriate medications for older adults and implementing region wide clinical protocols for clinicians to minimize risk of polypharmacy and adverse drug interactions.
Innovative Care Models Require participating health care providers to engage in initiatives proven to decrease healthcare costs and utilization through appropriate diversion of emergency department services, medication-assisted treatment to inpatient beds transitions, mobile integrated health, hospital at home programs, and palliative care access expansion. Regions will be required to participate in the cardiometabolic health	**Required Participation in State-Implemented Initiative**
	Must participate in Initiative 6 defined as: All hospitals must participate and align with Growing Access to Post-Discharge Medications model, including EMR updates if needed. **Must participate in Initiative 7 defined as:** Regional Coalition must include in their needs assessment a landscape of provider-to-provider teleconsult solutions currently in use in their region, including evaluation of gaps (geographic, specialties, system capabilities, etc.). For identified facilities experiencing gaps, initial start-up cost of systems adoption must be covered.
	Other Required Activities
	Regional Coalitions MUST: **Address opportunities for financial solvency**: Region must work together to identify and report cost-savings achieved through shared service models.
	Examples of Potential Regional Activities

program (as described in Initiative 5).	**Example Activity 1:** Hospital at home (including long-term care facilities) program enabling acute care delivery in patients' homes with remote monitoring, coordinated across regional hospitals and home health agencies. **Example Activity 2:** Using Mobile Integrated Health to improve outcomes and decrease hospital utilization for post-discharge patients, new mothers, and high frequency utilizers.
Workforce Development All coalitions must invest in building a trained and ready rural healthcare workforce, including strategies for recruitment, training, retention, and support of clinical and non-clinical health professionals.	**Required Participation in State-Implemented Initiative**
	Must participate in Initiative 10 defined as: Regional Coalition must support identification of providers to host clinical preceptor rural rotations and facilitate connection between regional providers and clinical preceptors. **Must participate in Initiative 4 defined as:** Regional Coalition must participate in training clinicians to obtain Pediatric and OB readiness.
	Examples of Potential Regional Activities
	Example Activity 1: Community Health Worker deployment to serve as bridges between healthcare systems and communities. **Example Activity 2**: EMS and paramedic training and utilization as clinicians in hospital to provide continued supervised training, support income and leverage additional clinical support in rural hospitals. **Example Activity 3:** Recruiting and leveraging advanced practice providers to provide access points in remote communities.

State Grant Evaluation, Allocation, and Competitive Scoring

Investment Structure: Five-year, $600 million investment ($120 million annually) grants will be distributed across eight Regional Coalitions beginning October 1, 2026. Individual regional awards will range from approximately $8 million to $25 million annually based on population served and application quality scoring, resulting in total five-year regional awards ranging from $40 million to $100 million per region. Cross-regional activities will be encouraged and supported if they align with the expectations of the grant. Specific budget and funding needs will be defined by the region in the application. HFS will grant funding directly to the individual entities completing the activity or program. Funding amounts are expected to be adjusted yearly based on compliance and outcome improvements.

Evaluation Methodology and Process: Actual award amounts will be determined through a competitive review process and will be proportional to the number of rural lives served within each region's catchment area, with additional funding allocated to coalitions demonstrating

exceptional partnership strength, innovation, and sustainability planning. While all eight regions are anticipated to receive funding, awards will be sized based on:

Population served: # of residents within catchment area, with attention to populations experiencing access barriers	**Application quality:** Regional Coalitions demonstrating innovation, compliance with required elements, strong partnerships, and sustainable approaches receive enhanced allocations

Applications will be reviewed by the Executive Oversight and Steering Committee and their designees using a competitive scoring rubric assessing Regional Coalition demonstration of collaboration, shared data systems, coordinated care models, right sizing healthcare services, addressing gaps and duplication in services. Joint projects will be favorably positioned.

Regional Technical Support: A dedicated contracted HFS regional grant team will support the day-to-day operations, including regular engagement with the regional coalitions, technical assistance for public health interventions, tech innovations, and workforce training. This team includes six dedicated professionals: Program Director (CMS liaison), two Program Managers (technology/telehealth and workforce/care delivery), Data Analyst, Compliance Officer, and Technical Assistance Coordinator. The team will engage subject matter expertise impeded across HFS for additional support.

The Regional Technical Support Team will conduct regular cross-regional learning facilitations to catalyze success across the state. Quarterly convenings of all eight coalitions facilitate peer learning, problem-solving, compliance training and coordination. Monthly Regional Coalition Leadership Network check-in meetings will maintain communication. Additionally, the Regional Technical Support Team will host bi-monthly communities of practice meetings organized by project type (example, growing prenatal care access) to share implementation lessons. A dedicated Technical Assistance Coordinator will provide ongoing consultation, webinar series, resource library access, and peer mentoring. When monitoring identifies challenges, HFS will deploy targeted technical assistance within 30 days. HFS will

provide cooperative agreements and ongoing technical assistance to each regional sub-recipient, beginning prior to grant start and continuing throughout the agreement duration.

HFS will contract external technical assistance providers for implementation support, cross-regional learning facilitation, and independent evaluation including analysis of return-on-investment and cost savings.

Oversight Components: HFS will conduct rigorous oversight of each regional grant component at every phase.

Additional Oversight Components	
Oversight Component	**Detail**
Pre-Award	HFS Technical Support Team and subject matter experts will conduct pre-award site visits to verify partnership authenticity and governance structures. Budget review confirms 20% capital and 5% EMR expenditure cap compliance. HFS shares scoring methodology and award recommendations with CMS before finalizing awards.
Financial	Quarterly financial reports documenting expenditures by category, cap compliance, sub-granting details, and budget variances. Annual independent audits follow federal Single Audit requirements. Monthly desk reviews examine expense samples using risk-based sampling. Pre-approval required for capital expenditures over $100,000 or EMR purchases. Funds disbursed quarterly on reimbursement basis following report approval, with payment holds for non-compliance.
Programmatic	Quarterly programmatic reports with detailed outcome progress, implementation milestones (Stage 0-5 framework), partnership documentation, and county-level service data. Annual site visits to each coalition include governance meetings, implementation site visits, partner/patient interviews, and progress assessment. Centralized data dashboard tracks key metrics monthly (telehealth volumes, community paramedicine visits, Community Health Worker deployments, HIE participation) enabling early identification of underperforming regions. Data quality audits verify accuracy of self-reported data.
NOFO	Semi-annual compliance reviews verify alignment with NOFO permissible uses of funds. Annual certification from each coalition confirms compliance with non-negotiables. As CMS issues new guidance, HFS immediately disseminates interpretation, reviews activities for alignment, and requires corrective action if needed. CMS project officer calls address compliance questions.
Risk-Based Differentiated	Oversight intensity varies based on financial management, programmatic performance, compliance, and organizational capacity. Low-risk Regional Coalitions receive annual site visits and submit quarterly reports. Medium-risk coalitions receive semi-annual visits and accelerated reporting. High-risk coalitions receive quarterly visits, monthly reporting, expenditure pre-approval, and mandatory technical assistance. Regions can graduate to lower tiers with strong performance.
Progressive	Non-performance triggers progressive consequences, including informal remediation through technical assistance, formal corrective action plans with monthly reporting, payment suspension until issues resolve, scope reduction for underperforming projects, and grant termination as last resort with fund reallocation. All enforcement includes due process with written notice and opportunity to respond.

Implementation Timeline	
Stage 0: Q2 FY26	• Lay the foundation for grant–making with stakeholders during application development. • Meet with regional partners to support coalition building efforts. • Develop all Make Indiana Healthy Again Grant application components.
Stage 1: Q3 FY26 – Q4 FY26	• By Q3 FY26: Release the grant application. • In Q4 FY26: Technical assistance for coalition formation and application development. • In July 2026: grant applications due to the State.
Stage 2: Q4 FY26	• Applications are reviewed and award determinations are made. • Grant agreement period begins.
Stage 3 & 4: Q2 FY27 -- Q1 FY29	• Regional District progress continually evaluated by State. • Annual award amount released.
Stage 5: Q2 FY29 – Q1 FY30	• Evaluate progress and metrics for future learning.

The Make Rural Indiana Healthy Again Regional Grants initiative will be evaluated using the following quantifiable metrics. Additional metrics that Regional Coalitions may be required to report are dependent on the optional activities they pursue, and examples can be found in **Appendix F**.

Outcomes				
No.	**KPO**	**Metric**	**Data Source, Timing, & Ability to Collect/Analyze**	**Baseline Data & Milestone Targets**
12.1	**C, H**	Percentage receiving prenatal care in the first trimester, measured at county level	Participating providers will submit quarterly data; State health data systems (IDOH Vital Records) will provide validation and county-level granularity	As of 2023, rural first-trimester prenatal care average is ~74%, with county-level variation ranging from 44% to 89%; By end of year 3, increase first trimester prenatal care initiation to 80% in funded regions, and to 85% by end of program
12.2	**A, D, G, H**	Number of new access points to provide primary and preventative care and No. of people served	Reported directly from the regions and would include MIH, school-based clinics, telehealth, remote satellite locations for prenatal or primary care, etc.	Baseline: Access has been diminishing in rural communities, growth in innovative ways that are sustainable and match the population size will be a value add to health outcomes. Target that 80% of the population live within 30 minutes of access to primary and prenatal healthcare
12.3	**A, E, H**	Percentage of residents with access to essential non-medical drivers of health such as	Reported directly from the regions on how they are expanding and adding access. Expectation that there is coordination throughout region to not duplicate services and to fill in gaps	Baseline to be established in each region. Target to be determined. Will work with Medicaid, MCOs, and commercial payors

		transportation and nutritious food		
12.4	**A, H**	Cost savings through shared services, collaborative purchasing, care coordination, etc.	Reported directly from the regions	Target to achieve a 15% reduction in operating costs by the conclusion of the RHTP program
12.5*	**B, F, H**	Preventable ED visit rates for ambulatory care-sensitive conditions measured at county level	Syndromic surveillance data; Programs will submit monthly encounter data through hospital reporting systems, with county-level analysis and validated against State data. EMS agencies will report transport volume and diversion outcomes	As of 2023, preventable ED visit rates for ambulatory care-sensitive conditions in rural areas average 58 ED visits per 1,000 population annually, significantly higher than urban rates of 42 per 1,000; By end of year 3, reduce preventable ED visits for ambulatory care-sensitive conditions by 15%, and by 25% by end of program
**Metric overlaps between this initiative and another. For narrative justification, please see Section 6: Metrics & Evaluation Plan. Gray-shaded metrics represent county-level data to demonstrate how impact is distributed.*				

Section 4: Implementation Plan and Timing

Indiana will leverage the Governance Structure (Figure 2) to conduct program-wide project management and oversight in collaboration with identified partners. GROW will be led by HFS and the lead RHTP Grant Director (Principal Investigator), see **Appendix H** for their resume.

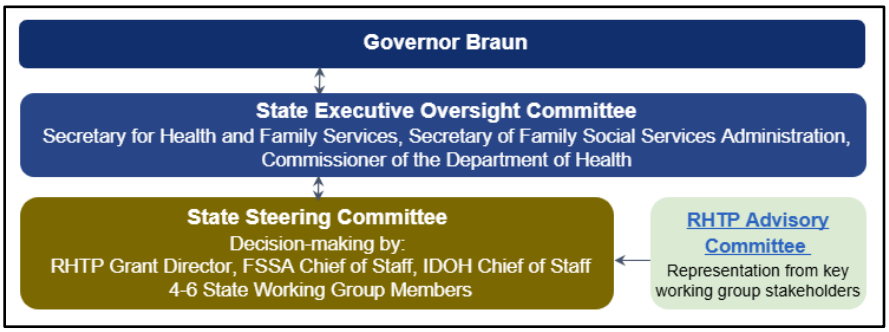

Figure 2 – Indiana's GROW Governance Structure

Of note, the State Steering Committee structure will ensure speed, scalability, and sustainability through consistent stakeholder input on key decisions, while maintaining central accountability as the State will make all determinations on policy direction and funding

mechanisms. The State Steering Committee will ensure implementation progress keeps pace with the timelines set forth, particularly achievement of first-year milestones. For more information on how the State will coordinate among health agencies and with external stakeholders, please see **Section 5**. Operationally, targeted efforts may be strategically outsourced to regional coalitions as outlined in **Initiative 12**, and other state-implemented initiatives will follow the timelines contemplated in **Section 3**.

Section 5: Stakeholder Engagement

GROW is based on a foundation of collaboration and dialogue with the rural communities it aims to serve. Through structured consultation, direct feedback and building on lasting partnerships, Indiana has ensured that rural residents, providers and provider organizations, community leaders, and healthcare organizations are active participants in shaping the vision, priorities and implementation of this plan. Additionally, stakeholder engagement is the cornerstone of the Make Rural Indiana Healthy Again Regional Grants. Through the requirements of the collaborative grants, rural communities will be engaged with implementation of Indiana's GROW initiatives.

Initial Engagement

In preparing this application, Indiana conducted extensive stakeholder engagement to inform the development of our plan, including public Working Group sessions, a survey targeting all rural areas, and intake of initiative proposals from diverse stakeholders, which together informed both the priority goals and specific initiatives of GROW.

The Indiana RHTP Grant Application Working Group (**Appendix I**) convened state agencies, legislators and rural health leaders over the course of four sessions beginning in late August 2025 to identify barriers to care, explore funding priorities, and provide feedback on emerging program decisions. Buy-in generated from these key stakeholders are demonstrated in the Letters

of Support included in **Appendix J**. The meetings were open to the general public and published to a dedicated **website** for Indiana's RHTP. This collaborative process established the plan's framework and ensured alignment between state objectives and local needs.

In parallel, Indiana issued a survey in fall 2025 to hear directly from rural Hoosiers. More than 2,100 responses were received from across the state, representing citizens, local and state-wide elected officials, business owners, and community-based organizations across all 92 counties. The survey results reflect a strong desire for locally tailored, flexible and sustainable models that meet people where they are — physically, culturally and economically. Across all survey sections, several recurring themes emerged that highlight the most pressing health-related challenges facing Indiana communities, detailed in **Appendix G**. Indiana also established a dedicated inbox for GROW and received over 50 initiative proposals from a wide range of stakeholders offering specific, actionable ideas that directly informed initiative design.

Ongoing Engagement

Indiana's commitment to stakeholder engagement extends beyond the development of this application and will remain a defining feature throughout implementation. Indiana will continue to rely on structured collaboration to ensure that rural perspectives guide decision-making, performance monitoring, and continuous improvement. To maintain this dialogue and partnership, Indiana will continue to convene the Working Group at regular intervals throughout the grant period. These sessions will serve as a forum for discussion, feedback and information sharing among partners, with an emphasis on tracking progress and exploring strategies to support the sustainability of successful initiatives. Key stakeholders will also have a place in Indiana's Governance Structure as detailed in **Section 4** to advise on implementation decisions and to facilitate input from other partners. The State will continue to field questions and feedback through the designated GROW inbox to ensure timely responses to stakeholder needs. In parallel with the formal engagement processes established through the Governance Structure, the initial

and ongoing efforts outlined below will foster collaboration with impacted communities and partners whose existing infrastructure will be leveraged during initiative work. These entities were consulted during the application development and planning and will continue to be engaged quarterly throughout implementation to ensure alignment and collaboration.

Key Stakeholder	Initial and Ongoing Engagement Efforts
Indiana Office of Community and Rural Affairs (OCRA)	Initial consultation to ensure that Indiana's proposed initiatives are separate but complementary to the federally funded programs that OCRA currently supports, with continued collaboration as needed.
Indiana Department of Transportation (INDOT)	Consultation to align rural transportation and infrastructure planning with healthcare access goals to address mobility barriers.
Indiana Department of Homeland Security (IDHS)	Collaboration to integrate emergency preparedness, disaster response, and facility readiness planning into goals and consultation to ensure coordinated response.
Indiana Native American Indian Affairs Commission	Engagement to ensure activities align with the priorities and needs of Native communities, incorporating tribal input into planning and implementation of healthcare delivery.
The Pokagon Band of Potawatomi Indians	Direct consultation with Indiana's one federally recognized tribe to strengthen tribal health access, ensuring initiatives reflect the community's unique healthcare and infrastructure needs.
Managed Care Organization (MCO)	Partnership to identify value-based strategies, data-sharing opportunities, and care coordination models that enhance rural healthcare delivery for Medicaid beneficiaries.
Key external stakeholders that have participated in initial planning efforts through the formal working group and will continue to be engaged in ongoing working group sessions: • Indiana Rural Health Association (IRHA) • Indiana Hospital Association (IHA) • Indiana State Medical Association (ISMA) • Community Health Network • Purdue University • Local Health Departments	

Indiana will also draw on successful collaborative frameworks, such as those established by the Indianapolis Coalition for Patient Safety, to inform strategies for hospital network coordination and shared approaches to improving patient outcomes across rural regions.

Initiative-Specific Engagement

Alongside program-wide structures, Indiana will sustain focused stakeholder engagement at the initiative level to ensure each component of the plan remains aligned with local priorities and needs. Patients, providers, community organizations and public health partners will continue to offer input through regional workshops, advisory councils and collaborative forums that maintain direct feedback between implementation teams and those in the community.

Engagement will be tailored to each initiative's focus. For additional detail, a full list of stakeholders consulted and planned for continued engagement throughout initiative activities is provided in **Appendix K.** These efforts will ensure that stakeholders remain active partners throughout implementation, enforced by project governance intentionally structured to reflect the communities being served through patient and provider representation in decision-making and feedback processes.

Section 6: Metrics and Evaluation Plan

Indiana will identify and contract with a grant-wide program evaluation partner for the full funding period. The evaluation partner will collect, track, and report GROW metrics, including for Regional Coalitions, and will be responsible for reporting back to the Regional and State Steering Committees to track and measure success. Additionally, each metric's baseline will be further validated or developed in Year 1 of the RHTP.

The following outcome metrics overlap across one or more initiatives:

Metric	Justification
Percent of patients achieving improved HbA1c control (<8% for diabetics) or blood pressure control (<140/90 for hypertensive patients), measured at county level	Reducing chronic disease indicators requires a comprehensive, multi-pronged approach. While numerous initiatives contribute to this goal—reflected in its designation as a key performance objective (KPO)—Initiatives 5 and 8 are especially aligned with driving measurable impact. Indiana is committed to achieving a significant improvement in health outcomes, targeting over a 10% increase in the number of patients reaching disease control. This goal is supported by the complementary strengths of Initiatives 5 and 8. Initiative 5 introduces a new cardiometabolic model of excellence, with dedicated rural sites designed to expand access to high-quality care in underserved areas. Initiative 8 enhances telehealth capabilities, enabling broader access to disease management services and the integration of biometric monitoring technologies.
Percent reduction in preventable ED visits, measured at county level	Indiana is committed to a reduction in preventable ED visits. ED visits are among the most expensive forms of care, often used by rural families when timely, preventive services are unavailable. This reduction will be achieved through a multi-pronged strategy that leverages the complementary strengths of Initiatives 8 and 12: Initiative 8 expands telehealth capabilities statewide, offering virtual access to disease management and urgent care services. This helps rural families avoid costly ED visits by providing earlier, more convenient interventions. Initiative 12 focuses on increasing physical access points for care in regions where services can be more effectively and proactively delivered. Through the work of Regional Coalitions, Indiana will identify gaps in care and implement locally tailored solutions that bring preventive and primary care closer to the communities that need it most.

Section 7: Sustainability Plan

GROW will usher in a bold transformation of rural healthcare across the state, building resilient systems designed to deliver lasting, sustainable impact for generations. To drive lasting impact beyond the grant period, this plan:

✓ Tackles the root causes of financial instability among rural healthcare systems, including low patient volume, high levels of uncompensated care and outdated payment models, through a strategic redesign of services and cross-sector partnerships.
✓ Prioritizes investments in infrastructure, workforce development, and training, alongside career pathway programs that strengthen the local talent pipeline.
✓ Builds on feasibility studies to assess viability before significant implementation, providing critical data to guide evidence-based decisions and reduce risk.
✓ Embeds sustainability into each Regional Grant proposal from the outset. The collaborative partnership model reduces service duplication and fosters resource-sharing, creating more efficient systems that are built to last.

Sustainability is not an afterthought. It is a foundational element of program design. Each initiative includes a detailed plan for maintaining activities, partnerships and resources beyond the grant period to ensure lasting impact across Indiana's rural lands.

GROW Sustainability Plan by Initiative		
	Capacity Building through One-time Investments	**Demonstrated ROI to inform Ongoing Cost Absorption**
	Activities leverage strategic, one-time investments to build value by strengthening capacity or embedding new functions in systems to ensure sustainability without ongoing financial inputs	*Activities will rely on measurable ROI and cost-saving outcomes to demonstrate value and enable continued cost absorption for sustained operations*
Initiative 1: Growing Care Coordination: Medical Operations Coordination Center and Alternate Payment Model Feasibility Study	Investments in the Medicaid ACO Model feasibility study will inform long-term decisions on ACO viability and future implementation.	Targets cost-sharing agreements with hospitals for Medical Operations Coordination Center initiative based on utilization and demonstrated efficiency in patient transfer coordination.
Initiative 2: Growing Community Connections through Indiana 211	Funding will support the initial activation of the module and related community engagement efforts, leveraging the existing Indiana 211 system and MCO infrastructure to develop an integrated, self-sustaining coordination network built	Demonstrate value to all payers by developing return-on-investment and cost savings projections for each initiative across the state and prepare a value proposition report per payor type: Medicaid, Medicare, cash-paying patients, Commercial.

	on community resources and current payment mechanisms.	
Initiative 3: Growing Improved Patient Outcomes Through Enhanced Interoperability and Technology	Initial one-time investment connecting rural healthcare entities to the HIE and integrating into EMR. Also, a feasibility study to evaluate opportunities for expanding the Double Up Indiana program to grocery retailers will build a pathway for implementation to support Hoosier families well beyond the timeframe of the RHTP grant.	Demonstrated cost savings and efficiency gains will be used to justify reinvestment into system operations and inform development of a permanent, blended funding model.
Initiative 4: Growing Pediatric & Obstetric Readiness in Rural Emergency Departments	Supports the purchase and installation of obstetric and pediatric equipment to establish lasting hospital infrastructure and emergency readiness protocols, while ongoing training, skills validation, and equipment checks will be integrated into existing accreditation and preparedness frameworks.	Implementation of life cycle management with partnering tertiary care partners decreases equipment cost. Cost analyses will quantify efficiency and outcome improvements, supporting integration of ongoing equipment maintenance and training costs into hospital operating budgets.
Initiative 5: Growing Cardiometabolic Health Standards of Care in Rural Indiana	Stands up new care models and CCE sites with the expectation that hospitals will maintain training and best practices after implementation.	Demonstrate value to all payers by developing ROI and cost savings projections for each initiative across the state and prepare a value proposition report per payor type: Medicaid, Medicare, cash-paying patients, commercial.
Initiative 6: Growing Access to Hospital Post-Discharge Medications	One time investment in hospital infrastructure, policy development, and implementation rollout will continue well beyond the timeframe of this grant program.	Targets cost-sharing between hospitals and health system partners based on documented outcome improvements, particularly around readmission reductions.
Initiative 7: Growing Specialty Provider Access through Expanded Teleconsult Capabilities	Establishment of a more robust, integrated, and streamlined specialty-care consultation network for rural providers to utilize to improve local care delivery in critical specialty areas including behavioral and maternal and infant health.	Targets shared funding among participating insurance carriers to sustain teleconsultation services through demonstrated ROI
Initiative 8: Growing Telehealth Access and Infrastructure	Investments in feasibility studies, broadband, and Telehealth equipment to establish durable capacity for virtual care delivery.	Demonstration of measurable ROI related to cost savings, local revenue gains, provider efficiency, and patient outcomes, providing an evidence base for ongoing investment and integration into existing telehealth infrastructure and MCO offerings.
Initiative 9: Growing our Rural Health Paraprofessional Workforce	Creation of career pathways and incentive stipends will build a rural workforce that serves rural communities well beyond the timeframe of this grant.	Community Health Workers have demonstrated return on investment in their role in supporting families in healthcare and social need navigation.

Initiative 10: Growing Clinical Training and Readiness	Initial investments in training efforts will establish the foundation for long-term sustainability by supporting partnerships with rural health clinics, FQHCs, and Critical Access Hospitals to maintain residency training capacity and embed successful models into workforce planning across the state.	Throughout the RHTP will assess opportunities for continued funding through healthcare entities, foundations, philanthropy, economic development and private business investment.
Initiative 11: Growing our Rural Behavioral Health Workforce	Behavioral career pathway programming, including peers, and targeted workshop roll-out, will ensure communities have a trained workforce infrastructure beyond the timeframe of this grant.	Behavioral career pathway programming, including peers, and targeted workshop roll-out, will ensure trained workforce infrastructure beyond the grant timeframe.
Initiative 12: Make Rural Indiana Healthy Again Regional Grants	Funds infrastructure and equipment purchases, as well as train-the-trainer models to sustain education and readiness efforts. New partnerships, processes, and shared services will help support sustainment.	Demonstrated ROI from grant-funded initiatives will motivate health systems to maintain successful programs, with some models becoming ongoing requirements for participation or certification.