MISSISSIPPI

RURAL HEALTH TRANSFORMATION PROGRAM

OPPORTUNITY NUMBER: CMS-RHT-26-001

PROJECT NARRATIVE

RURAL HEALTH NEEDS AND TARGET POPULATION

Challenges Addressed by the Mississippi RHT Program Plan

Rural Mississippi faces significant gaps in healthcare access and workforce capacity. As of 2025, seven counties have no hospital, and more than half of the counties, 51.2%, are maternity care deserts, lacking obstetric providers [1]. Transportation barriers and provider shortages force residents in some areas to travel 50 to 75 miles for primary care and other essential services [1]. Nearly all rural counties are designated as Health Professional Shortage Areas (HPSAs) for primary care [32]. Workforce shortages compound these challenges, with some areas **having over 2,000 residents per primary care physician** [1]. Recruitment and retention are further hindered by low reimbursement rates and limited rural training pipelines [4], leaving communities without adequate primary care, nursing, and behavioral health support.

Mississippi faces more than $1 billion in unmet rural health needs, and with its largely rural population, strong community networks, and unique demographic profile, the state provides an ideal testing ground for practical, scalable solutions to improve healthcare access and outcomes.

Behavioral health and maternal care deficits remain critical concerns, with high rates of untreated mental illness, substance use disorders, and maternal vulnerability persisting in rural regions [5]. Mississippi has **one of the highest maternal mortality rates in the nation, and more than half of its counties lack obstetric services** [5]. Many rural hospitals are operating at a loss, necessitating consideration of service reductions or closures [6], and **high rates of uncompensated care, totaling 5.54%,** exacerbate the situation [1]. **More than half of the hospitals in the state rely on DSH payments,**

according to our 2021 DSH Audit. Social and economic barriers, including the **nation's highest hunger rate, with 18.8% of children** going to bed hungry most nights [7], further contribute to chronic disease prevalence and poor health outcomes across rural communities [8].

The Mississippi RHT Program will prioritize Mississippi's most underserved rural communities, targeting counties facing provider shortages and high poverty, to improve access for children, pregnant women, and residents with chronic or behavioral health conditions.

Rural Demographics

Mississippi defines rural areas using a combination of federal and state criteria. The U.S. Census Bureau considers **areas outside urbanized zones with populations under 50,000 rural [12],** while HRSA/FORHP uses RUCA codes and population density for federal program eligibility[3]. At the state level, Mississippi classifies counties with fewer than 50,000 residents, fewer than 500 people per square mile, or municipalities with populations under 15,000[4].

Population Size and Density: Mississippi has a total population of approximately 2.94 million, **with 53.2% residing in rural areas**, equating to roughly 1.56 million rural residents. The State spans **46,924 square miles**, resulting in an average population density of 62.6 people per square mile, though rural counties often fall below 30 people per square mile [1],[13].

Mississippi's rural demographics reflect a population that is older, poorer, less educated, increased instances of comorbidities, and more reliant on public health programs than their urban counterparts.

Income Levels: Mississippi's median household income is **$54,203**, but many rural counties report per capita incomes **below $30,000**.

Mississippi ranks **50th in the nation for poverty**, with **19.5% of residents living below the poverty line**, including **26.4% of children and nearly 16% of seniors**[38].

Employment Sectors and Unemployment Rates: Rural Mississippi's economy is historically rooted in agriculture, forestry, and manufacturing, but these sectors have seen declining employment due to automation and population loss. Over the past three years, Mississippi has experienced a record low in unemployment. However, when viewed over a 10-year period, the **State's unemployment rate has averaged 5.35%**, indicating that while recent years have shown remarkable progress, the long-term trend remains moderate [39].

Educational Attainment: In Mississippi's rural counties, **15.5% of adults did not complete high school,** and only **20.2% have a college degree.** [40]. The **high school dropout rate was 8.5%** in the 2023-2024 school year, almost double the national rate [41].

Health Insurance Coverage: Approximately **12.1% of Mississippians are uninsured**, with higher rates in rural areas. **Medicaid plays a critical role in rural health access, with over 27% of rural residents relying on it for coverage.** Gaps remain in behavioral health, maternal care, and specialty services, particularly in counties designated as Health Professional Shortage Areas (HPSAs) [1].

Frontier and Remote: Approximately **5% of Mississippi's population resides in a zip code designated as a Frontier and Remote (FAR) Area Code level 2** by the USDA, based on data from the 2010 decennial census [16].

Health Outcomes

Chronic Conditions in Rural Mississippi: Leading chronic conditions among adults include **hypertension at 49.5%, obesity at 39.6%, arthritis at 35.2%, mental illness at 20.2%, diabetes at 13.1%, and cardiovascular disease at 10.0%** [17]. Counties in the Delta region report the highest rates of stroke and heart disease mortality, **with stroke death rates reaching 140 per 100,000 and heart disease mortality exceeding 700 per 100,000 in some areas.** These conditions contribute to high rates of disability, premature death, and avoidable hospitalizations, particularly in rural counties[18].

Mississippi carries one of the highest burdens of chronic disease in the nation, with rural communities disproportionately affected.

Child Health Outcomes: Mississippi consistently ranks **among the lowest states in the nation for child well-being and health outcomes**[19]. Key indicators include **low-birth weight, affecting 12.5% of newborns**; a **child and teen death rate of 53 per 100,000 for ages 1–19**; **child obesity affecting over 42% of adolescents aged 10–17**; and **6% of children lacking health insurance**, with rural areas reporting higher rates[20], [21].

Maternal Health Outcomes: Mississippi has the **highest maternal mortality rate in the nation**[21], [22]. Nearly **20% of mothers receive late or inadequate prenatal care**[24], [25]. More than **51% of counties lack birthing facilities or obstetric providers** [26].

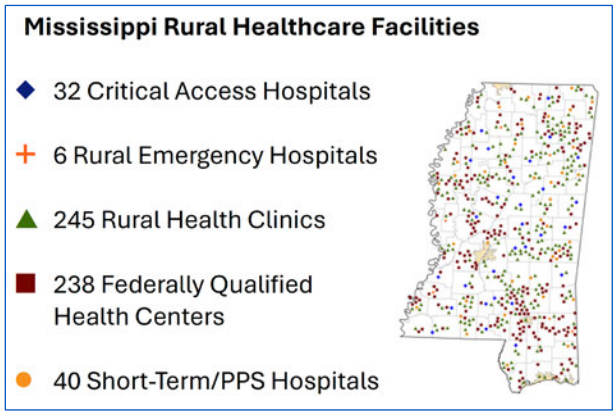
Healthcare Access

Average Distance to Nearest Hospital or Primary Care Clinic: In many rural areas, drive times to access **primary and maternal healthcare regularly exceed 30 minutes** [42]. In the Delta, some travel **up to 75 miles for primary care services** [27], [28].

Availability of Healthcare Providers: Approximately 50% of Mississippians live in underserved counties with greater than 2,000 persons per primary care physician [28]. **Nearly all rural counties in Mississippi are designated as Health Professional Shortage Areas (HPSAs) for primary care**[32].

Availability of Public Transportation: Public transportation in rural Mississippi is **present but far from sufficient**. While regional transit providers deliver over five million trips each year through programs such as Delta Rides, SMART, and TRANS-CON, **service remains limited and uneven**. Many communities still face long travel distances, minimal infrastructure, and unreliable funding. For seniors and individuals with disabilities, accessibility barriers persist, leaving **large areas of the state without consistent or practical transportation options.**

Health Care Facility Numbers and Distribution: Mississippi's rural health infrastructure includes **32 Critical Access Hospitals, 6 Rural Emergency Hospitals, 245 Rural Health Clinics, 238 Federally Qualified Health Centers, and 40 Short-Term/PPS Hospitals** [31]. However, these facilities are unevenly distributed. **Seven counties lack any hospital presence**, and over half of Mississippi's counties are classified as maternity care deserts [31].



Rural Facility Financial Health

Rural Hospital Closures: According to the Center for Healthcare Quality and Payment Reform, as of mid-2025, **more than half of the State's rural hospitals are at risk of closure**. High rates of **uncompensated care, totaling 5.54%**, and **more than half of hospitals in the State receiving DSH payments**, exacerbate financial instability[1]. Closures would **disproportionately affect counties already designated as HPSAs or maternity care deserts**. Rural hospitals serve as major employers in their communities, and closures have **ripple effects on local economies**, workforce stability, and emergency response capacity [36].

Mississippi is experiencing one of the most severe rural hospital crises in the nation.

Utilization & Volumes: Rural hospitals face lower patient volumes and higher per-patient costs due to limited local utilization, with **occupancy rates often below 50%**[36]. **Rural emergency departments commonly serve as the primary access point for non-emergency care**, resulting in high volumes of non-urgent visits and increased levels of uncompensated care [1].

RURAL HEALTH TRANSFORMATION PLAN: GOALS AND STRATEGIES

By 2031, every rural Mississippian will have reliable access to high-quality healthcare services, both in-person and through telehealth, supporting increased access points and healthier communities across the State. The strategy prioritizes access, measurable improvements in health outcomes, workforce development, financial

Mississippi has designed a plan that directly supports the RHT Program's five strategic pillars: Make Rural America Healthy Again, Sustainable Access, Workforce Development, Innovative Care, and Technology Innovation.

sustainability, scalable care delivery models, and the strategic application of health technology.

EXPAND ACCESS AND IMPROVE OUTCOMES

Mississippi is tailoring our initiatives to include expanding access and improving outcomes in rural settings. Programs designed to recruit and retain doctors, nurses, and other allied health professionals, while simultaneously launching pilots for expanded services like obstetrics, mental health care, and value-based care initiatives, can significantly strengthen healthcare delivery, particularly in underserved areas. By integrating telehealth and remote patient monitoring, these programs extend clinical reach beyond physical facilities, enabling timely interventions and chronic disease management. Regionalized systems of care, featuring nurse navigation and closed-loop referrals to social services, will ensure patients receive coordinated medical and non-medical support, reducing gaps in care and improving compliance with treatment plans. Collectively, these strategies expand access to essential services, enhance continuity of care, and foster better health outcomes through earlier detection, proactive chronic disease management, and streamlined pathways across providers and community resources.

HARNESS TECHNOLOGY AND DATA

With RHT Program funds, Mississippi will develop a comprehensive statewide Health Information Exchange network, allowing for bi-directional sharing of patient records and facilitating coordination of transfers, sites of care selection and care coordination efforts. The State will also use funds to improve integrated technology at provider sites, including upgrades and module additions to electronic health record systems, cybersecurity, telehealth and remote patient monitoring capabilities.

BUILD PARTNERSHIPS AND STRENGTHEN WORKFORCE

Mississippi is implementing initiatives to build partnerships through technology and integrated systems of care and strengthen the rural workforce through incentives, expanded training opportunities, and focused educational outreach. The statewide Health Information Exchange will connect providers in new and innovative ways and help facilitate clinically integrated efforts and value-based care opportunities. Facilities and clinicians will be able to share resources and expertise through expanded telehealth capabilities and wraparound social services.

Mississippi will also use RHT Program funds to strengthen the rural clinical workforce through financial incentives (retention awards and "earn while you learn" programs), while also expanding the number of physician residencies, nurse preceptor programs, and allied health training opportunities in rural markets.

ENSURE FINANCIAL STABILITY AND ADDRESS ROOT CAUSES

Mississippi will use RHT Program funds to upgrade healthcare facilities to improve access and close gaps in care. These improvements will facilitate the opening of necessary service lines in rural markets, such as chronic disease management, obstetrics, neonatal intensive care, and psychiatric emergency services. Pilot programs will be launched to address early intervention for chronic conditions to better address root causes.

Other Required Components

PROGRAM KEY PERFORMANCE OBJECTIVES

By the end of the funding period in FY 2031, the State expects the RHT Program to establish a more integrated, data-informed, and sustainable rural health system, improving access, quality, workforce capacity, care coordination, technology adoption, virtual care,

behavioral health services, and infrastructure across the State. These objectives reflect the State's intended outcomes and may evolve as programs are designed and implemented.

The **Statewide Rural Health Assessment** will provide a foundational roadmap. By project completion, **100% of planned assessment activities**—including data collection, stakeholder engagement, analysis, and reporting—will be executed. The assessment will engage ≥150 **stakeholders** across hospitals, FQHCs, EMS, behavioral health, and community representatives. It will identify ≥5 **major service, workforce, or infrastructure gaps statewide** and deliver a **data-driven roadmap with recommendations aligned with assessment findings**, prioritized by urgency, impact, and feasibility.

The **Coordinated Regional Integrated Systems (CRIS) Initiative** will strengthen regional care networks and patient care continuity. By the end of Year 5, CRIS is designed to reduce **low-acuity ER visits by ≥10%** through nurse navigation and treat-in-place interventions, engage **≥50% of rural hospitals and clinics** in coordinated care networks, and ensure **≥35% of high-risk patients have completed care plans within 7 days of discharge**, resulting in a **≤20% 30-day readmission rate** for high-risk patients.

The **Workforce Expansion Initiative (WEI)** will expand and sustain the rural healthcare workforce. By FY 2031 the State intends to recruit and retain **≥150 clinicians, allied health professionals, and support staff** in rural areas for at least 5 years, with **≥20% of program participants remaining in rural practice 5 years post-completion**. WEI is designed to create and fill **≥35 new residency or training positions** and engage **≥50 preceptors or mentors** to provide high-quality supervision.

The **Health Technology Advancement and Modernization (HTAM) Initiative** will modernize rural provider systems and support digital health. HTAM seeks to have, by Year 5, **≥90% of funded providers have upgraded, interoperable EHR systems**, **≥75% of eligible providers will actively share data through the statewide HIE**, **≥50% of applicable provider staff will complete cybersecurity or IT training**, and **≥40% of patients will actively engage with digital tools**, including patient portals, telehealth, and remote monitoring.

The **Telehealth Adoption and Provider Support (TAPS) Initiative** will increase virtual care access and capacity. By Year 5, TAPS is structured to: **increase by ≥40%** telehealth visits **among funded providers**, **enroll and sustain ≥50% of eligible providers in telehealth service delivery for at least two consecutive years**, **≥85% of funded sites will achieve full operational readiness**, and **≥50% of applicable provider staff will complete telehealth competency training within the first year**.

The **Building Rural Infrastructure for Delivery, Growth, and Efficiency (BRIDGE) Initiative** will improve rural behavioral health access and infrastructure. BRIDGE is structured to, by Year 5, have **≥3 Psychiatric Emergency Services (PES) units** established, and **≥100 Community Health Workers and clinical staff** will be trained and deployed. By Year 5, **≥25 rural capital projects** will be completed, contributing to **≥15% increases in service capacity**, a **≥15% reduction in patient travel distances**, and a **≥15% reduction in preventable ER visits** in pilot program areas. **≥50% of pilot programs** will show measurable improvements, and BRIDGE will reach **≥100,000 rural residents statewide**.

Collectively, these initiatives create a resilient, well-connected rural health system by FY 2031, guided by evidence, measurable outcomes, and coordinated stakeholder engagement. Each objective has defined numeric targets and baseline measurements where available, ensuring progress can be monitored and evaluated consistently.

LEGISLATIVE OR REGULATORY ACTION

Mississippi is committed to taking steps to align with CMS policy and support the goals of the Rural Health Transformation Program. The State plans to make certain changes to legislation and regulation to improve access, quality, and cost-effectiveness of care in rural communities. The chart below details our current policies, committed actions, timeline and expected impact on rural health for each State Policy Action Factor.

Technical Score Factor	Current Policy	Committed Action and Timeline	Expected Impact on Rural Health
B.2 Health and Lifestyle	Mississippi does not require schools to reestablish the Presidential Fitness Test	✓ Mississippi will require schools to reestablish the Presidential Fitness Test that is aligned with federal guidance associated with Executive Order 14327 before the beginning of the 2026/2027 school year	Promote physical activity and healthy habits Support chronic disease prevention and population health
B.3 SNAP Waivers	No pending or approved USDA SNAP food restriction waiver prohibiting the purchase of non-nutritious items or no pending State bill requiring a food restriction	✓ Mississippi will have a USDA approved State waiver prohibiting the perchance of non-nutritious	Improve dietary intake and clinical indicators associated with long-term disease in

Technical Score Factor	Current Policy	Committed Action and Timeline	Expected Impact on Rural Health
	waiver be submitted to USDA	items in SNAP by Jan 1, 2027	rural populations
B.4 Nutrition Continuing Medical Education (CME)	No requirement for nutrition to be included in CME for physicians as well as no pending State bill requiring nutrition to be included in CME for physicians	Mississippi will continue engaging with stakeholders regarding the potential inclusion of nutrition in CME requirements for physicians	
C.3 Certificate of Need	Mississippi has a CON score of 90	Mississippi is contemplating CON reforms in the next legislative session and will keep CMS updated on any developments	
D.2 Licensure compacts	✓ IMLC Member State serving as SPL ✓ NLC state ✓ Licensure compact member of the EMS Compact ✓ PSYPACT participating No active legislation to become a PA Compact member		
D.3 Scope of Practice	PA: Reduced Scope of Practice NP: Reduced Scope of Practice Pharmacists: Restricted Authority Dental Hygienist: Restricted Scope of Practice	Mississippi does not currently believe changes to our scope of practice regulations are appropriate for the State; however, we remain open to	

Technical Score Factor	Current Policy	Committed Action and Timeline	Expected Impact on Rural Health
		new information and will consider adjustments in the future	
E.3 Short-Term, limited duration insurance	✓ STLDI plans are not restricted in the State beyond the latest federal guidance.		
F.1 Remote care service	✓ Medicaid payment for at least one form of live video ✓ Medicaid payment for Store and Forward [37] ✓ Medicaid payment for Remote Patient Monitoring ✓ Limited In-State licensing requirement exception ✓ Telehealth License/ Registration Process		

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

As of September 1, 2025, Mississippi does not have any Certified Community Behavioral Health Clinics (CCBHCs). The Mississippi Department of Mental Health received a federal planning grant in 2023 to create standards for certification, and several Community Mental Health Centers are interested in becoming CCBHCs. Mississippi will be applying for the CCBHC Demonstration Grant as soon as it is released.

MEDICAID DISPROPORTIONATE SHARE HOSPITALS

According to our 2021 DSH Audit, the State provided DSH payments to 63 out of 114 hospitals.

PROPOSED INITIATIVES AND USE OF FUNDS

Statewide Rural Health Assessment

Content Category	Description
	Mississippi has built a strong foundation for its RHT Program through collaboration with healthcare providers, community leaders, and rural stakeholders, shaping a clear vision to strengthen access, workforce capacity, and service delivery. To ensure effective and sustainable use of funds, the State will engage a third-party to conduct a comprehensive statewide assessment of rural health needs. This assessment will validate and enhance the existing plan, confirming that proposed investments address critical gaps and deliver measurable, long-term impact. **The Statewide Rural Health Assessment will:** • Build upon prior stakeholder engagement by reviewing existing input, data, and feedback gathered through statewide outreach efforts. • Identify any remaining gaps or emerging opportunities to optimize the use of RHT Program resources. • Refine and prioritize investment strategies to ensure maximum impact, sustainability, and alignment with federal program objectives. • Develop a data-driven roadmap that confirms the best use of RHT Program funds for long-term transformation of rural health in Mississippi. • Through this process, Mississippi is taking a responsible and evidence-based approach, leveraging the extensive input already gathered while ensuring no critical perspective or opportunity is overlooked. This deliberate step will position the State to invest RHT Program funds wisely, achieving lasting improvements in access, quality, and outcomes for rural communities statewide. **Potential use of funds could include:** • **Contracted Firm Fees** - Hiring a qualified consulting firm to conduct statewide data analysis, stakeholder engagement, and strategic planning. • **Data Collection & Analysis** - Acquiring and analyzing population health, workforce, and clinical infrastructure data to identify gaps and opportunities. • **Stakeholder Engagement** - Conducting listening sessions, focus groups, and interviews with providers, local health departments,

Content Category	Description
	community organizations, and patients; including venue rental, materials, and participant incentives. • **Travel and Site Visits** - Covering travel, lodging, and per diem for project staff and consultants visiting rural facilities and communities. • **Technical Tools and Analysis** - Licensing software for data analysis, mapping, and secure data management. • **Reporting and Deliverables** - Preparing professional reports, dashboards, and presentations to guide State decision-making and program implementation. • **Project Management and Administration** - Coordinating assessment activities, scheduling meetings, managing deliverables, and communication costs.
Main Strategic Goal	Sustainable Access
Use of Funds	I. Innovative Care K. Fostering Collaboration
Technical Score Factors	B.1 Population health clinical infrastructure C.1 Rural provider strategic partnerships F.2 Remote care services
Key Stakeholders	Rural hospitals, FQHCs, primary care clinics, EMS services, behavioral health providers, State Office of Rural Health, MSDH, Mississippi Division of Medicaid, maternal health providers, universities, residency programs, and workforce training institutions, high schools and college
Potential Outcomes (not exhaustive)	• Confirmation that the State's proposed initiatives align with the most urgent and impactful rural health needs. • Identification of service, workforce, infrastructure, and technology gaps across rural Mississippi. • Actionable guidance from providers, community leaders, and patients to ensure investments are responsive and equitable. • A data-driven plan outlining where and how funding should be allocated for maximum sustainability and impact. • Strengthened partnerships and communication channels to support long-term rural health system sustainability. • Establishment of benchmarks and metrics to measure success of RHT Program-funded projects over time.
Impacted Counties	All Rural Counties

Content Category	Description
Estimated Required Funding	$ [redacted]
Process and Criteria for Selecting Subgrantees	State will conduct procurement and comply with all applicable state and federal procurement laws and regulations, including 2 CFR Part 200.
Examples	

Coordinated Regional Integrated Systems Initiative (CRIS)

Content Category	Description
	The Coordinated Regional Integrated Systems (CRIS) Initiative is designed to transform rural healthcare delivery across Mississippi by creating a connected, data-driven network of emergency, clinical, and community-based services. CRIS strengthens the State's rural health infrastructure by integrating EMS, hospitals, public health entities, and social service providers into Regional Healthcare Districts, ensuring patients receive timely, coordinated, and continuous care. This initiative supports the Mississippi RHT Program's goals of expanding access, improving quality, and enhancing the sustainability of healthcare services in rural areas. CRIS is comprised of the following projects: **Regionalized EMS Systems in Rural Healthcare Districts -** CRIS establishes regionalized EMS systems within defined Rural Healthcare Districts to create a coordinated emergency response network across Mississippi's rural counties. These regional systems align EMS operations with local hospital resources, standardize protocols, and improve dispatch efficiency. By sharing data and resources across jurisdictions, the initiative enhances patient outcomes, reduces unnecessary hospital transports, and strengthens surge capacity during high-demand periods or public health emergencies. District-level dashboards track key performance metrics such as response times, transport patterns, and patient outcomes to guide continuous improvement and resource allocation, ultimately fostering resilient, connected care networks across the State. **EMS Treat In Place Pilot Program -** The Treat In Place Pilot Program is designed to build on Mississippi's Triage, Treat, and Transport to Alternative Destination Act, which went into effect on July 1, 2024. Treat

Content Category	Description
	In Place empowers EMS providers to deliver safe, protocol-driven care in the field for patients with low-acuity conditions that do not require hospital transport. Supported by telehealth consultation and clinical decision tools, EMS clinicians can assess, stabilize, and treat patients on-site or connect them to follow-up care. This model reduces unnecessary emergency department visits, eases hospital capacity pressures, and increases patient satisfaction while ensuring that rural residents receive timely care. Over time, this pilot supports the development of sustainable reimbursement pathways and positions EMS as a fully integrated component of Mississippi's rural healthcare system. **Clinical Integration and Post Discharge Care Coordination -** CRIS promotes continuity of care through clinical integration and post discharge care coordination, ensuring patients, particularly those with chronic or complex conditions, remain connected to services after hospital discharge. Nurse navigators and care managers collaborate with clinically integrated primary care and specialty providers and community organizations to monitor recovery, follow treatment plans, and coordinate follow-up appointments. These coordinated efforts reduce readmissions, improve patient outcomes, and strengthen the local provider network. By integrating electronic health records and referral tracking tools, Mississippi can ensure seamless information exchange and build capacity for outcome-based reimbursement and long-term care quality improvement. **Remote Medical Assistance and Nurse Navigation Lines -** The Remote Medical Assistance and Nurse Navigation Program provides Mississippi's rural communities with 24/7 access to clinical guidance. Patients, EMS, and local providers can receive real-time support for symptom assessment, treatment planning, and care coordination. These nurse navigation lines reduce unnecessary emergency visits, promote equitable access to care, and ensure patients remain connected to the appropriate clinical and community services. Integrated with regional data systems, this program also generates insights into resource planning, public health monitoring, and system-wide quality improvement. **AI and Algorithmic Decision Support Pilot Program for EMS -** The AI and Algorithmic Decision Support Pilot Program equips EMS providers with advanced tools to guide triage, routing, and treatment decisions. Using predictive algorithms, the system considers patient data, dispatch information, and hospital capacity to recommend optimal care pathways. For Mississippi's rural EMS workforce, these tools improve clinical decision-making, enhance field efficiency, and ensure

Content Category	Description
	consistent, high-quality care. The pilot also provides performance monitoring data to refine protocols and inform statewide emergency response strategies. **Closed-Loop Referral and Wraparound Social Services -** Through closed-loop referral and wraparound social services, CRIS connects patients to critical non-clinical supports, including transportation, housing, food assistance, and behavioral health services, using digital platforms. Systems like this ensure referrals are completed and outcomes are tracked, strengthening accountability and improving whole-person care. By linking social services with clinical care, Mississippi can address social determinants of health, close service gaps, and promote community resilience, particularly for vulnerable populations in rural regions. **Public Safety Answering Point Integration -** Integration with public safety answering points ensures seamless communication between 9-1-1 dispatchers, EMS, hospitals, and community providers. This connected system enables timely, coordinated responses, reduces delays in patient transport, and ensures resources are allocated efficiently. Data from PSAPs feeds into statewide dashboards to track performance metrics, support continuous quality improvement, and guide workforce planning. PSAP integration reinforces transparency, accountability, and operational efficiency across Mississippi's rural healthcare system. **Potential uses of funds could include:** *Regionalized EMS Systems in Rural Healthcare Districts* • Development and implementation of standardized EMS protocols across districts. • Investment in communication and dispatch infrastructure to enable cross-jurisdiction coordination. • Creation and maintenance of district-level dashboards for performance monitoring (response times, transport patterns, outcomes). • Training and workforce development for EMS personnel in integrated regional operations. • Purchase and maintenance of vehicles, equipment, and technology to support coordinated EMS response and surge capacity. *EMS Treat In Place Pilot Program* • Telehealth platforms and mobile connectivity tools for EMS clinicians in the field.

Content Category	Description
	• Clinical decision support tools and protocol development for low-acuity patient treatment on-site. • Training programs for EMS providers in on-scene assessment, stabilization, and follow-up care coordination. • Data collection and evaluation systems to measure patient outcomes, resource utilization, and cost savings. • Development of reimbursement models for non-transport EMS care services. *Clinical Integration and Post-Discharge Care Coordination* • Hiring and training nurse navigators and care managers to coordinate post-discharge follow-up. • Integration of electronic health records (EHRs) across hospitals, clinics, and community providers. • Referral tracking and population health management software to monitor patient care continuity. • Tools for outcome-based reimbursement modeling and long-term quality improvement programs. • Educational programs for patients and caregivers to support chronic condition management. *Remote Medical Assistance and Nurse Navigation Lines* • Establishment of 24/7 nurse navigation call centers or telehealth lines. • Technology infrastructure to connect patients, EMS, and local providers to real-time clinical guidance. • Development of protocols for symptom assessment, triage, and care coordination. • Data analytics platforms to monitor call volume, patient outcomes, and service gaps. • Staff training on telehealth delivery, patient communication, and system integration. *AI and Algorithmic Decision Support Pilot Program for EMS* • Utilize ongoing research at the University of Mississippi Medical Center to implement AI and algorithmic decision support systems for EMS triage and routing, with procurement of additional tools considered as needed to support full pilot deployment and integration into EMS operations. • Data integration tools to combine patient, dispatch, and hospital capacity information. • Training for EMS personnel on interpreting and using AI recommendations in the field.

Content Category	Description
	• Monitoring and evaluation infrastructure to refine algorithms and measure clinical impact. • Research and development for predictive modeling and performance optimization. *Closed-Loop Referral and Wraparound Social Services* • Digital platforms to track referrals and social service engagement. • Staff and coordinators manage referral networks for housing, transportation, food, and behavioral health services. • Training for clinical and social service providers on using integrated referral systems. • Analytics measure referral completion, service utilization, and population health outcomes. • Community engagement and outreach programs to ensure awareness and access to support services. *Public Safety Answering Point (PSAP) Integration* • Technology upgrades to integrate PSAPs with EMS, hospitals, and community providers. • Real-time data dashboards for statewide monitoring of emergency response metrics. • Workforce training for dispatchers and EMS staff on integrated communication systems. • Maintenance and cybersecurity of communication networks. • Performance evaluation and continuous quality improvement programs informed by PSAP data. **Other considerations:** • Funding for provider payments is subject to restrictions described in funding policies and limitations. • Funding for capital expenditures and infrastructure is subject to restrictions described in funding policies and limitations. • Limit direct payments to individual providers or facilities without alignment to CRIS initiative. • Arrangements/affiliations should not be contingent on or influence ownership and/or independence of participating providers.
Main Strategic Goals	Make Rural America Healthy Again; Sustainable Access; Innovative Care
Use of Funds	A. Prevention & chronic disease D. Training and technical assistance F. IT advances G. Appropriate care availability

Content Category	Description
	H. Behavioral health I. Innovative care J. Capital expenditures and infrastructure K. Fostering collaboration
Technical Score Factors	B.1 Population health clinical infrastructure B.2 Health and lifestyle C.1 Rural provider strategic partnerships C.2 EMS
Key Stakeholders	Rural hospitals, FQHCs, primary care clinics, EMS services, behavioral health providers, State Office of Rural Health, MEMA, Hospital Associations, PCPs, community health workers, faith-based and nonprofit organizations, schools
Possible Outcomes (not exhaustive)	• Increased EMS coverage and response efficiency across rural Healthcare Districts. • Reduced unnecessary hospital transports through Treat In Place EMS protocols. • Expanded 24/7 access to clinical guidance and nurse navigation for rural residents. • Improved availability of specialized care through coordinated regional networks. • Reduced hospital readmissions through post-discharge care coordination. • Improved clinical outcomes for chronic and complex conditions via integrated care and follow-up. • Higher patient satisfaction due to faster, more personalized, and coordinated care. • Data-driven decision making, leading to consistent, evidence-based EMS and clinical protocols. • Enhanced EMS and clinical workforce skills through training and AI decision support tools. • Better retention and engagement of rural health professionals by providing integrated support and resources. • Expanded role of EMS as part of a fully integrated healthcare system, improving job satisfaction and professional scope. Integration of EHRs and real-time dashboards for continuous monitoring and quality improvement. • Deployment of AI and predictive analytics for EMS triage, routing, and care prioritization. • Improved interoperability between hospitals, EMS, public health, and social service providers.

Content Category	Description
	• Improved access for vulnerable populations, including elderly, low-income, and isolated residents. • Strengthened community engagement and trust in local healthcare systems.
Impacted Counties	All Rural Counties
Estimated Required Funding	$ [redacted]
Process and Criteria for Selecting Subgrantees	The State will establish a transparent process to solicit, review, and award subgrants. Applications will be evaluated based on demonstrated need, service to priority populations, organizational capacity, and commitment to responsible use of funds. Subgrantees will comply with all reporting and accountability requirements under 2 CFR Part 200, and performance will be monitored to ensure alignment with program goals. If procurement is required, the State will follow all applicable state and federal procurement laws.

Workforce Expansion Initiative (WEI)

Content Category	Description
	The Workforce Expansion Initiative (WEI) is designed to strengthen the healthcare workforce in rural areas, improving access, continuity, and quality of care. Through targeted programs, WEI addresses recruitment, retention, training, and career pathway development for a wide range of healthcare professionals, including doctors, nurse practitioners, midwives, pharmacists, social workers, therapists, paramedics, certified nurse assistants, patient navigators, community health workers, dental providers, and essential support staff such as lab technicians, health IT and cybersecurity professionals, and billing/coding personnel. WEI also aligns local high schools and community colleges with rural hospitals and nursing homes to build a pipeline of students and early-career professionals into rural healthcare roles. **Workforce Recruitment & Sustainable Ecosystem Development**: This program strengthens Mississippi's rural healthcare workforce by attracting and retaining clinicians, dentists, allied health professionals, EMS personnel, and support staff. Partnerships with local schools, community colleges, and vocational programs create clear career pathways, offering mentorship, clinical rotations, and telehealth

Content Category	Description
	training. Financial incentives, including retention awards, signing bonuses, and relocation support, encourage long-term service in high-need areas. By linking workforce development directly to education pipelines and community networks, this program builds a resilient, sustainable rural workforce, expands access to care, and improves continuity and quality of services across the State. **Residency Program Expansion Grant:** The Residency Program Expansion Grant supports the growth of graduate medical and dental education opportunities in rural regions. By increasing residency slots and program capacity, the initiative fosters the development of new providers who are more likely to remain in these communities after training. **Preceptor Expansion Program:** This program enhances clinical training capacity by expanding the number of qualified preceptors available to supervise students and residents. By strengthening mentorship and hands-on learning opportunities, it ensures that emerging healthcare professionals gain the experience needed to succeed in rural and high-need settings. **Secondary Education Medical Career Outreach:** Targeting high school students, this outreach program introduces young people to healthcare careers—including nursing and allied health professions—through education, mentorship, and experiential opportunities. Early exposure to healthcare pathways encourages students to pursue postsecondary training in medical fields, supports completion of relevant coursework, and helps increase high school graduation rates by demonstrating clear pathways to meaningful careers. **Earn While You Learn:** This program allows individuals to gain practical healthcare experience while earning a stipend, with a focus on Community Health Workers (CHWs). By combining on-the-job training with financial support, participants can build skills, advance their careers, and contribute immediately to improving community health outcomes. **Potential uses of funds could include:** *Workforce Recruitment & Sustainable Ecosystem Development* • Retention awards, signing bonuses, and relocation support for clinicians, allied health professionals, and support staff committing to a minimum of 5 years of service spent in a rural area. • Development of partnerships with high schools, community colleges, and vocational programs to create allied health career pipelines.

Content Category	Description
	• Retention incentives, such as milestone bonuses for continued service in high-need areas. • Marketing and outreach to promote program awareness among eligible professionals. • Investments in an integrated ecosystem where hospitals, schools, small businesses, and local governments all benefit from lower costs, stronger care access, and improved economic vitality. *Residency Program Expansion Grant* • Funding for additional residency or training slots for physicians, nurse practitioners, pharmacists, dentists, and therapists. • Salaries or stipends for residents and fellows during training, tied to at least 5 years of service spent in a rural area. • Recruitment and onboarding of faculty, preceptors, and administrative support for expanded programs. *Preceptor Expansion Program* • Stipends or salary supplements for preceptors supervising trainees across multiple professions. • Professional development and training for preceptors to strengthen mentorship skills. • Travel or telehealth equipment for remote supervision and support. • Administrative support for scheduling and program coordination. *Secondary Education Medical Career Outreach* • Career workshops, job shadowing programs, and summer immersion experiences for high school students. • Marketing materials, outreach campaigns, and partnerships with schools. • Mentorship program coordination, including stipends for mentors. • Educational supplies, digital resources, or lab equipment to enhance experiential learning. *Earn While You Learn* • Stipends or hourly wages for participants, including Community Health Workers, all allied health workers, and other support staff, tied to at least 5 years of service spent in a rural area. • Training and certification fees (e.g., CHW credentialing, basic clinical skills, or IT training). • Program coordination, supervision, and mentoring for participants. • Personal protective equipment (PPE), uniforms, or tools required for hands-on work. **Other considerations:** • Funding for provider payments is subject to restrictions described in funding policies and limitations.

Content Category	Description
	• Financial incentives should include a requirement for the provider or healthcare worker to commit at least 5 years of service in a rural community to receive the benefits. • Limit direct payments to individual providers or facilities without alignment to WEI. • Arrangements/affiliations should not be contingent on or influence ownership and/or independence of participating providers.
Main Strategic Goal	Workforce Development
Use of Funds	D. Training and technical assistance E. Workforce K. Fostering collaboration
Technical Score Factors	D.1 Talent recruitment C.1 Rural provider strategic partnerships
Key Stakeholders	Rural hospitals, FQHCs, medical schools, residency programs, professional associations, schools, nursing homes, hospitals, dental schools
Possible Outcomes (not exhaustive)	• More clinicians, dentists, allied health professionals, and support staff (e.g., nurses, CHWs, lab techs, IT specialists) practicing in rural and underserved areas. • Expansion of residency and training slots leads to a pipeline of providers committed to staying in these regions. • Expanded pipeline of students entering healthcare professions through school-based training and mentorship programs. • Higher retention rates for healthcare staff due to retention awards, stipends, and professional development incentives. • Greater availability of qualified preceptors and mentors across multiple professions. • Improved quality of clinical and hands-on training for students, residents, and support staff. • Expanded training in health IT, cybersecurity, and allied health roles strengthens rural infrastructure and service readiness. • High school and early education outreach programs create pipelines for future healthcare professionals in rural communities. • Increased enrollment in healthcare training programs for underrepresented populations. • Participants in “Earn While You Learn” programs gain skills while contributing to local healthcare delivery.

Content Category	Description
	• Reduced provider shortages lead to shorter wait times, broader service availability, and better continuity of care. • More comprehensive care teams, including social workers, pharmacists, therapists, and support staff, improve patient outcomes. Establishment of long-term mechanisms for recruitment, retention, and training that continue beyond the RHT Program period. • Stronger collaborations between rural providers, educational institutions, and community organizations. • Data from program outcomes informs future workforce planning and policy decisions. • Indirect improvements in population health indicators due to better access and continuity of care. • Increased utilization of preventive services, chronic disease management, and coordinated care. • Enhanced community trust and engagement with local healthcare providers.
Impacted Counties	All Rural Counties
Estimated Required Funding	$ [redacted]
Process and Criteria for Selecting Subgrantees	The State will establish a transparent process to solicit, review, and award subgrants. Applications will be evaluated based on demonstrated need, service to priority populations, organizational capacity, and commitment to responsible use of funds. Subgrantees will comply with all reporting and accountability requirements under 2 CFR Part 200, and performance will be monitored to ensure alignment with program goals. If procurement is required, the State will follow all applicable state and federal procurement laws.

Health Technology Advancement & Modernization Initiative (HTAM)

Content Category	Description
	The Health Technology Advancement and Modernization Initiative (HTAM) is designed to modernize rural healthcare systems by strengthening the digital backbone that supports high-quality, coordinated, and secure care. Through grants and targeted support,

Content Category	Description
	HTAM helps rural providers adopt and upgrade health IT systems, enhance cybersecurity, and participate in statewide Health Information Exchange (HIE) efforts. The initiative ensures that technology infrastructure supports efficient care delivery, data-driven decision-making, and improved health outcomes. **Rural Provider Technology Grant Fund:** This program supports small and rural providers in acquiring, upgrading, or maintaining technology systems essential for modern care delivery. Funding helps bridge the digital divide by enabling providers to implement telehealth, data-sharing, and analytics solutions that improve patient outcomes and operational efficiency. **Small Rural Provider EHR Replacement Grant Fund**: This program provides financial assistance to rural health and mental health providers seeking to replace outdated or non-interoperable electronic health record (EHR) systems. By promoting adoption of interoperable, certified systems, the initiative enables seamless exchange of clinical information, supports quality reporting, and strengthens participation in value-based care. **Cybersecurity and Technology Modernization for Rural Healthcare Providers including FQHCs:** This initiative enhances the cybersecurity posture and IT infrastructure of rural healthcare providers including Federally Qualified Health Centers (FQHCs). Investments help protect sensitive patient data, prevent service disruptions, and ensure compliance with federal security standards through improved network infrastructure, staff training, and risk management systems. **Health Information Exchange (HIE) Implementation:** This program supports statewide HIE assessment, design, and implementation to enable real-time, secure data sharing among healthcare providers. By establishing a connected health data environment, this program improves care coordination, reduces duplication of services, and provides a foundation for population health management and analytics. **Potential uses of funds could include:** *Rural Provider Technology Grant Fund* • Purchase or upgrade of IT hardware and software (EHRs, telehealth platforms, secure networks • Implementation support, including vendor selection, integration, and staff training • Ongoing technical assistance for maintenance and optimization *Small Rural Provider EHR Replacement Grant Fund* • Replacement of outdated or non-certified EHR systems • Data migration, interoperability testing, and system customization

Content Category	Description
	• User training and workflow redesign to optimize EHR utilization *Cybersecurity and Technology Modernization for healthcare providers including FQHCs* • Implementation of cybersecurity software and network protections • Staff cybersecurity training and awareness programs • Development of security policies, risk assessments, and incident response plans *Health Information Exchange (HIE) Implementation* • HIE system assessment and design, including stakeholder engagement • Development and implementation of the HIE infrastructure • Provider onboarding, data standardization, and training • Governance and sustainability planning for long-term HIE operations **Other considerations:** • Funding for provider payments is subject to restrictions described in funding policies and limitations. • Funding for capital expenditures and infrastructure is subject to restrictions described in funding policies and limitations. • Limit direct payments to individual providers or facilities without alignment to HTAM initiative. • Arrangements/affiliations should not be contingent on or influence ownership and/or independence of participating providers.
Main Strategic Goals	Tech Innovation; Innovative Care
Use of Funds	C. Consumer tech solutions D. Training and technical assistance F. IT advances J. Capital Expenditures and Infrastructure K. Fostering Collaboration
Technical Score Factors	B.1 Population health clinical infrastructure C.1 Rural provider strategic partnerships F.1 Remote care services F.2 Data infrastructure F.3 Consumer-facing technology
Key Stakeholders	Rural hospitals, FQHCs, IT vendors, State Office of Rural Health, provider networks
Outcomes	• Increased adoption of interoperable EHRs among rural and critical access providers. • Upgraded capacity supporting telehealth and digital health services. • Reduction in downtime or technical barriers to care delivery.

Content Category	Description
	• Active participation of rural providers and FQHCs in statewide HIE. • Enhanced ability to track patient outcomes and manage chronic conditions through shared data. • Reduction in duplicative tests, errors, and administrative inefficiencies. • Improved cybersecurity resilience of FQHCs and small providers against threats. • All participating organizations meet or exceed federal security and privacy standards. • Greater patient trust due to strengthened data protection. • Increased use of telehealth and remote monitoring services in rural communities. • Reduced travel burden and increased convenience for patients, especially those with chronic conditions or mobility challenges. • Integration of consumer-facing technologies that enhance engagement and self-management. • More complete, timely, and accurate data available for state-level analysis. • Improved ability to identify health disparities, allocate resources, and measure health outcomes. • Foundation established for future value-based care and population health initiatives. • Long-term partnerships formed among providers, vendors, and State agencies. • Ongoing support and maintenance plans ensure systems remain current and secure. • Increased technical literacy and workforce readiness among rural health staff.
Impacted Counties	All Rural Counties
Estimated Required Funding	$[redacted]
Process and Criteria for Selecting Subgrantees	The State will establish a transparent process to solicit, review, and award subgrants. Applications will be evaluated based on demonstrated need, service to priority populations, organizational capacity, and commitment to responsible use of funds. Subgrantees will comply with all reporting and accountability requirements under 2 CFR Part 200, and performance will be monitored to ensure alignment with program goals. If procurement is required, the State will follow all applicable state and federal procurement laws.

Telehealth Adoption and Provider Support (TAPS) Initiative

Content Category	Description
	The Telehealth Expansion and Access Initiative strengthens rural healthcare by increasing virtual care access, supporting providers in adopting telehealth, and exploring innovative payment models. Investments enhance connectivity, technology, and diagnostic tools to enable real-time remote care. The initiative also provides training for providers and community outreach to help patients use telehealth effectively. By integrating services into schools, it expands preventive, primary, and behavioral care for students while educating families on telehealth use. **Telehealth Adoption Incentives:** This program supports providers in adopting and sustaining telehealth services by offsetting reimbursement gaps and promoting payment model innovation. Funding enables rural and small providers to deliver virtual care without financial loss while exploring alternative payment approaches that better reflect the value of telehealth in improving access, efficiency, and patient outcomes. **Telehealth Hub Connectivity / Telehealth Equipment:** This program improves connectivity, equipment availability, and technology capacity for providers and community-based telehealth hubs. Investments support the purchase and installation of high-quality telehealth platforms, secure connections, and diagnostic equipment to enable real-time remote care and consultations across the State. **Telehealth Education (Provider and Patient Community Outreach):** This program enhances understanding and effective use of telehealth among both providers and patients. It includes training for providers on clinical workflows and technology use, as well as community outreach and education to help patients navigate telehealth platforms, address privacy concerns, and increase utilization of virtual care services. **School-Based Telehealth & Nursing Expansion:** This program increases the number of school nurses and integrates telehealth services directly into schools, ensuring students have timely access to preventive, primary, and behavioral healthcare. Investments support hiring and training school nurses, establishing telehealth stations, and connecting students with off-site providers for routine and urgent care. The program also provides educational resources for families to understand and use telehealth, improving health outcomes and reducing missed school days due to illness.

Content Category	Description
	Possible uses of funding could include: *Telehealth Adoption Incentives* • Reimbursement supplements for rural providers to offset reduced telehealth payment rates • Pilot projects testing alternative or value-based payment models for virtual care • Development of billing and coding guidance for telehealth reimbursement • Technical assistance to integrate telehealth into existing workflows and clinical practices *Telehealth Hub Connectivity / Telehealth Equipment* • Purchase of telehealth carts, cameras, monitors, and diagnostic peripherals • Broadband upgrades or connectivity enhancements for clinics and community hubs • Installation and integration of telehealth platforms or video conferencing systems • Ongoing maintenance, software licensing, and technical support services *Telehealth Education (Provider and Patient Community Outreach)* • Provider training on telehealth delivery, technology use, and compliance • Patient outreach campaigns to increase awareness and comfort with telehealth • Development of multilingual educational materials and online tutorials • Community workshops and demonstration events on telehealth access and benefits • Evaluate curriculum and course work requirements across all healthcare fields to ensure adequate education and training is provided to students to maximize the utilization of telehealth services. *School-Based Telehealth & Nursing Expansion* • Recruit and train school nurses and telehealth coordinators • Telehealth equipment • Infrastructure upgrades to improve internet connectivity, private spaces, and data security • Contracts with physicians, behavioral health providers, and specialists to deliver virtual care • Development of materials and outreach to help families navigate telehealth and understand available school-based services.

Content Category	Description
	Other considerations: • Funding for provider payments is subject to restrictions described in funding policies and limitations. • Funding for capital expenditures and infrastructure is subject to restrictions described in funding policies and limitations. • Limit direct payments to individual providers or facilities without alignment to TAPS initiative. • Arrangements/affiliations should not be contingent on or influence ownership and/or independence of participating providers.
Main Strategic Goals	Tech Innovation; Make Rural America Healthy Again
Use of Funds	B. Provider payment C. Consumer tech solutions D. Training and technical assistance E. Workforce F. IT advances I. Innovative care J. Capital Expenditures and Infrastructure K. Fostering Collaboration
Technical Score Factors	B.1 Population health clinical infrastructure C.1 Rural provider strategic partnerships E.1 Medicaid provider payment incentives F.1 Remote Care Services F.3 Consumer-facing technology
Key Stakeholders	Rural hospitals, FQHCs, telehealth vendors, community health centers, State Office of Rural Health
Possible Outcomes (not exhaustive)	• Increased telehealth visits across rural and underserved communities. • Reduced geographic and transportation barriers for patients. • Expanded access to specialty care through remote consultation models. • More providers offering telehealth services without financial loss. • Successful testing and implementation of new telehealth payment models. • Sustained adoption of virtual care after the incentive period ends. • Increased number of fully equipped telehealth hubs across the State. • Improved broadband connectivity and IT readiness among rural providers.

Content Category	Description
	• Reliable, secure, and interoperable telehealth platforms supporting continuity of care. • Higher telehealth utilization among patients due to improved awareness and comfort. • Providers demonstrate improved confidence and competency in telehealth delivery. • Increased patient satisfaction and engagement with virtual care options. • Improved access to follow-up care and preventive services through telehealth. • Better care continuity and adherence to treatment for patients with chronic conditions. • Data-driven monitoring and evaluation of telehealth outcomes to inform future policy. • Increased access to care for students. • Improved chronic disease management. • Reduced absenteeism. • Expanded behavioral health support,
Impacted Counties	All Rural Counties
Estimated Required Funding	$[redacted]
Process and Criteria for Selecting Subgrantees	The State will establish a transparent process to solicit, review, and award subgrants. Applications will be evaluated based on demonstrated need, service to priority populations, organizational capacity, and commitment to responsible use of funds. Subgrantees will comply with all reporting and accountability requirements under 2 CFR Part 200, and performance will be monitored to ensure alignment with program goals. If procurement is required, the State will follow all applicable state and federal procurement laws.

Building Rural Infrastructure for Delivery, Growth and Efficiency Initiative (BRIDGE)

Content Category	Description
	The BRIDGE Initiative is designed to strengthen rural healthcare infrastructure by improving access to specialized care, closing care gaps, and supporting innovative pilot programs that enhance service

Content Category	Description
	delivery. BRIDGE focuses on building physical, operational, and programmatic capacity to address unmet needs, improve care coordination, and foster sustainable rural healthcare systems. **Psychiatric Emergency Services (PES) Development:** This program supports the establishment and enhancement of psychiatric emergency services in rural hospitals and community health centers. By expanding crisis response capabilities, PES Development improves timely access to mental health care, reduces emergency department bottlenecks, and provides specialized support for patients experiencing acute psychiatric episodes. **Rural Capital Project Care Gap Closure**: This program funds infrastructure projects that address care gaps in rural communities, such as facility upgrades, clinic expansions, and equipment acquisition. Investments are targeted at increasing service capacity for underserved populations, supporting critical access hospitals, and enhancing operational efficiency to reduce barriers to care. **Pilot Programs:** BRIDGE includes targeted pilot programs to test innovative approaches to care delivery and coordination. Examples include implementing legislative task force recommendations for early intervention programs; years 4–9 focused interventions for autism spectrum disorder (ASD); care management programs; value-based care (VBC) initiatives; Community Health Worker (CHW) reimbursement pilots; and the development of evidence-based strategies to provide mental health services to emergency responders coping with on-the-job trauma, including exploration of crisis response teams, peer support programs, trauma debriefing training, and financial support for uncompensated outpatient mental health therapy. These pilots allow for scalable solutions to systemic rural health challenges. **Possible uses of funding could include:** *Psychiatric Emergency Services (PES) Development* • Facility renovation or expansion to accommodate PES units • Purchase of specialized psychiatric equipment and telepsychiatry technology • Staff recruitment, training, and retention for PES teams • Development of crisis protocols and care coordination pathways *Rural Capital Project Care Gap Closure* • Construction, renovation, or expansion of clinics, hospitals, or community health facilities • Purchase of diagnostic, imaging, and treatment equipment to fill service gaps

Content Category	Description
	• Facility maintenance and upgrades to ensure safe, efficient operations • Implementation of workflow improvements to optimize service delivery *Pilot Programs* • Design, implementation, and evaluation of early intervention and ASD-focused programs. • Hire and train additional early intervention specialists or support staff to meet program goals. • Fund assessment tools, screening kits, and therapeutic materials for children. • Provide training and technical assistance for providers and families on new EI processes. • Develop and implement age-appropriate intervention programs for children with ASD ages 4-9. • Assess and implement a program to strengthen support services for children and adults with intellectual development disabilities and mental health needs. • Develop and adopt evidenced-based statewide protocols for juvenile drug courts and mental health courts and pilot such diversion courts in financially challenged and underserved areas in the State. • Explore and fund the adoption of evidenced-based enhanced recovery surgical protocols in rural settings to transform surgical care delivery with the goal of reducing complications, readmissions and opioid use. • Develop evidence-based strategies, including awareness campaigns, to address deficiencies in nutrition, diet and exercise in juveniles, including reestablishing the Presidential Fitness Test and making it accessible to all students across the state. • Fund specialized therapy sessions (speech, occupational, behavioral) and educational materials. • Train therapists, educators, and parents in evidence-based ASD interventions. • Purchase assessment tools and tracking systems to monitor progress and outcomes. • Provide telehealth or remote consultation support for families in rural areas. • Hire or support care coordinators, nurse navigators, or CHWs to manage high-need patients. • Implement care coordination software or digital case management tools.

Content Category	Description
	• Fund training on chronic disease management, behavioral health integration, and care transitions. • Conduct patient engagement campaigns to increase participation and adherence. • Monitor and evaluate patient outcomes, including hospital readmissions, ER visits, and chronic disease metrics. • Establish a reimbursement mechanism for CHW services within participating provider organizations. • Fund CHW training and certification programs to ensure quality and consistency. • Provide stipends or salary support for CHWs during the pilot period. • Develop supervision, reporting, and evaluation processes for CHW activities. • Monitor program outcomes, such as improved care coordination, patient engagement, and reduced hospitalizations. • Develop evidence-based strategies to provide mental health services to emergency responders coping with on-the-job trauma, including exploring the establishment of crisis response teams, peer support programs, trauma debriefing training, and financial support for uncompensated outpatient mental health therapy. **Other considerations:** • Funding for provider payments is subject to restrictions described in funding policies and limitations. • Funding for capital expenditures and infrastructure is subject to restrictions described in funding policies and limitations. • Limit direct payments to individual providers or facilities without alignment to BRIDGE initiative. • Arrangements/affiliations should not be contingent on or influence ownership and/or independence of participating providers.
Main Strategic Goals	Tech Innovation; Make Rural America Healthy Again
Use of Funds	D. Training and Technical Assistance E. Workforce G. Capital Expenditures and Infrastructure I. Innovative Care K. Fostering Collaboration
Technical Score Factors	B.1 Population health clinical infrastructure C.1 Rural provider strategic partnerships E.1 Medicaid provider payment incentives F.1 Remote Care Services

Content Category	Description
	F.3 Consumer-facing technology
Key Stakeholders	Rural hospitals, FQHCs, telehealth vendors, community health centers, State Office of Rural Health
Possible Outcomes (not exhaustive)	• Increased telehealth visits across rural and underserved communities. • Reduced geographic and transportation barriers for patients. • Expanded access to specialty care through remote consultation models. • More providers offering telehealth services without financial loss. • Successful testing and implementation of new telehealth payment models. • Sustained adoption of virtual care after the incentive period ends. • Increased number of fully equipped telehealth hubs across the State. • Improved broadband connectivity and IT readiness among rural providers. • Reliable, secure, and interoperable telehealth platforms supporting continuity of care. • Higher telehealth utilization among patients due to improved awareness and comfort. • Providers demonstrate improved confidence and competency in telehealth delivery. • Increased patient satisfaction and engagement with virtual care options. • Improved access to follow-up care and preventive services through telehealth. • Better care continuity and adherence to treatment for patients with chronic conditions. • Data-driven monitoring and evaluation of telehealth outcomes to inform future policy.
Impacted Counties	All Rural Counties
Estimated Required Funding	$[redacted]
Process and Criteria for Selecting Subgrantees	The State will establish a transparent process to solicit, review, and award subgrants. Applications will be evaluated based on demonstrated need, service to priority populations, organizational capacity, and commitment to responsible use of funds. Subgrantees will comply with all reporting and accountability requirements under 2 CFR Part 200, and performance will be monitored to ensure alignment with program goals.

Content Category	Description
	If procurement is required, the State will follow all applicable state and federal procurement laws.

IMPLEMENTATION PLAN AND TIMELINE

Statewide Rural Health Assessment

Month	Stage	Key Milestones/Activities
January 2026	Stage 0	• Draft and finalize RFP • Secure approvals and budget allocation • Define project scope, objectives, and evaluation framework
February 2026	Stage 1	• Issue RFP and solicit proposals (3-week response period) • Review submissions and select contractor • Assign internal staff and establish project governance structure • Initial kickoff meeting with contracted firm
March–April 2026	Stage 2	• Contractor begins data collection, document review, and preliminary analysis • Stakeholder mapping and outreach initiated • Refine project plan based on early findings
May–June 2026	Stage 3	• Conduct stakeholder engagement: focus groups, interviews, and listening sessions • Continue data analysis; identify gaps and high-impact opportunities • Adjust project plan as needed
July-August 2026	Stage 4	• Draft report with findings, recommendations, and strategic roadmap • Review and feedback cycles with internal team and key stakeholders • Incorporate revisions and finalize visualizations/dashboards • Present final report and recommendations to State leadership • Confirm alignment with RHT Program goals and proposed use of funds • Prepare any public-facing summaries or presentations
September 2026	Stage 5	• Project complete; deliverables finalized and submitted • State integrates findings into RHT Program investment planning

		• Document lessons learned and establish metrics for measuring outcomes

Coordinated Regional Integrated Systems Initiative (CRIS)

Date	Stage	Key Milestones/Activities
Jan 2026 – Dec 2026	Stage 0	• Finalize CRIS governance and oversight committees • Develop detailed project plans for all programs • Identify participating hospitals, FQHCs, EMS providers, and community organizations • Secure vendor partnerships for IT, dashboards, telehealth, AI • Conduct baseline needs assessment and data collection • Initiate workforce recruitment planning
Jan 2026 – Dec 2026	Stage 1	• Assign project leads, coordinators, and data analysts • Begin procurement of IT infrastructure, vehicles, telehealth platforms, EMS equipment • Initiate protocol development for Regionalized EMS and Treat In Place programs • Engage public safety answering points for PSAP integration planning • Start staff training on data collection, telehealth, and EMS workflows
Jan 2027 – Dec 2027	Stage 2	• Launch Treat In Place EMS and AI decision support pilots in select districts • Begin nurse navigation lines and remote medical assistance platforms • Implement district-level dashboards to monitor EMS/hospital performance metrics • Start EHR integration for clinical coordination and post-discharge care tracking • Initial rollout of closed loop referral systems • Conduct community/provider education on new systems and processes
Jan 2028 – Dec 2028	Stage 3	• Expand Treat In Place and AI-supported EMS pilots to additional districts • Full operational deployment of nurse navigation and telehealth support lines • Refine protocols/workflows based on initial data • Monitor outcomes: hospital readmissions, EMS response times, patient satisfaction

		• Continue workforce training for EMS, nurse navigators, and community health staff • Evaluate interoperability between hospitals, EMS, public health, and social services
Jan 2029 – Dec 2029	Stage 4	• Finalize statewide rollout of AI decision support tools • Complete integration of EHRs, referral tracking, and dashboards • Scale closed loop referrals and wraparound social services statewide • Standardize Treat In Place protocols and nurse guidance procedures • Conduct advanced workforce development and training refreshers • Prepare mid-term evaluation reports on patient outcomes, EMS efficiency, and care coordination
Jan 2030 – Dec 2031	Stage 5	• CRIS fully operational across all rural counties • All EMS, clinical integration, nurse navigation, AI support, and PSAP systems active and interoperable • Performance monitoring dashboards continuously inform quality improvement • Evaluate statewide metrics: EMS coverage, response times, hospital transports avoided, post-discharge follow-up, patient satisfaction • Document lessons learned, best practices, and sustainability plans • Share results with state/community stakeholders • Ongoing monitoring and evaluation of outcomes and operational efficiency • Updates and refinements to AI decision support and telehealth platforms • Continuous workforce training, retention programs, and protocol optimization • Dissemination of CRIS best practices for replication • Annual reporting of measurable outcomes: reduced hospital readmissions, improved EMS efficiency, enhanced care continuity, and strengthened community engagement

Workforce Expansion Initiative (WEI)

Date	Stage	Key Milestones/Activities
Jan 1- Mar 31, 2026	Stage 0	• Conduct statewide workforce gap assessment by profession and region.

		• Establish governance and project management framework. • Develop detailed implementation plan, performance metrics, and data collection protocols. • Define eligibility, compliance requirements, and funding mechanisms. • Draft outreach and communications strategy targeting rural providers and educational institutions. • Final WEI implementation plan and budget approved by Mar 2026.
Apr 1 – Jun 30, 2026	Stage 1	• Assign program staff and finalize MOUs with medical schools, FQHCs, and workforce partners. • Develop application platforms and administrative systems for retention awards, stipends, and Residency Expansion grants. • Launch marketing and recruitment campaigns for retention awards and Residency programs. • Initiate secondary school outreach and Preceptor Expansion program planning. • Begin baseline data collection for workforce supply and retention. • Program infrastructure operational and application systems live by Jun 2026.
Jul 1, 2026 – Dec 31, 2027	Stage 2	• Award initial funding and incentives for retention awards and Residency Expansion. • Launch Earn While You Learn cohort and CHW stipend programs. • Pilot Preceptor Expansion in select rural regions. • Begin secondary school healthcare career outreach programs. • Adjust project plan and tools based on early feedback. • All WEI subprograms active with the enrolled participants by Dec 2027.
Jan 1, 2028 – Dec 31, 2029	Stage 3	• Expand participation in residency, preceptor, and Earn While You Learn programs statewide. • Implement advanced recruitment and retention strategies. • Deliver professional development and leadership training for rural providers. • Enhance data tracking and workforce dashboards for continuous monitoring. • Conduct midpoint evaluation and refine strategies. • Midpoint evaluation completed by Jun 2028; 50% of workforce expansion targets met by Dec 2029.

Jan 1 – Dec 31, 2030	Stage 4	• Validate outcomes against workforce projections and baseline data. • Complete comprehensive evaluation of retention, recruitment, and training effectiveness. • Document best practices, success stories, and lessons learned. • Develop sustainability plan and integrate successful programs into long-term workforce infrastructure. • Final evaluation report submitted by Dec 2030.
Jan 1 – Dec 31, 2031	Stage 5	• Institutionalize successful WEI programs into statewide workforce development structures. • Maintain long-term monitoring of retention, satisfaction, and provider distribution. • Formalize ongoing partnerships with educational and healthcare entities. • Transition pilot incentives to permanent funding streams, where feasible. • Use outcome data to inform future rural workforce policy. • WEI fully implemented and producing measurable statewide workforce improvements by Dec 2031.

Health Technology Advancement and Modernization Initiative (HTAM)

Dates	Stage	Key Milestones/Activities
Jan 1 – Mar 31, 2026	Stage 0	• Conduct statewide assessment of rural provider IT capacity and cybersecurity readiness. • Define grant eligibility criteria and funding mechanisms. • Establish governance and program management structures. • Develop program implementation plan and evaluation framework. • Approved HTAM plan, budget, and stakeholder engagement strategy by Mar 2026.
April 1 – June 30, 2026	Stage 1	• Assign program staff and execute MOUs with hospitals, FQHCs, and technology vendors. • Launch application portals for Rural Provider Technology and EHR Replacement grants. • Begin outreach to eligible providers and initiate vendor selection for cybersecurity modernization. • Program infrastructure operational and first grant applications accepted by Jun 2026.

Dates	Stage	Key Milestones/Activities
Jul 1, 2026 – Dec 31, 2027	Stage 2	• Award initial grants for EHR upgrades, HIE implementation, and cybersecurity projects. • Begin small-scale deployment of technology and HIE pilot programs. • Provide technical assistance and training for early adopter sites. • Collect baseline IT performance and provider-readiness data. • First providers equipped and HIE pilots launched by Dec 2027.
Jan 1, 2028 – Dec 31, 2029	Stage 3	• Expand technology adoption across rural hospitals and FQHCs. • Implement cybersecurity protocols and HIE integration statewide. • Deliver ongoing technical support and provider training. • Monitor performance metrics and refine system deployments. • 50% of target providers fully integrated into modernized IT systems by Dec 2029.
Jan 1 – Dec 31, 2030	Stage 4	• Validate technology adoption and interoperability outcomes. • Conduct comprehensive evaluation of IT performance, HIE connectivity, and cybersecurity readiness. • Document best practices and lessons learned. • Develop sustainability plan for ongoing IT support and upgrades. • Evaluation report completed and shared with stakeholders by Dec 2030.
Jan 1 – Dec 31, 2031	Stage 5	• Institutionalize IT and HIE infrastructure into routine provider operations. • Maintain long-term monitoring of system performance, data quality, and cybersecurity compliance. • Provide continuous technical support and system optimization. • Leverage lessons learned to inform future State IT and rural health initiatives. • HTAM fully implemented with measurable improvements in provider IT capacity and data exchange by Dec 2031.

Telehealth Adoption and Provider Support Initiatives (TAPS)

Date	Stage	Key Milestones/Activities
Jan 1- Mar 31, 2026	Stage 0	• Assess current telehealth adoption and reimbursement gaps among rural providers. • Define eligibility and incentive structures for telehealth adoption grants. • Establish governance, program management, and evaluation framework. • TAPS plan approved and baseline assessment completed by Mar 2026.
Apr 1 – Jun 30, 2026	Stage 1	• Assign staff and finalize MOUs with rural clinics and telehealth vendors. • Launch application portals for telehealth adoption incentives and hub connectivity grants. • Develop provider and patient education strategies. • Program systems operational and applications accepted by Jun 2026.
Jul 1, 2026 – Dec 31, 2027	Stage 2	• Award telehealth adoption incentives and hub connectivity grants. • Begin installation of telehealth equipment and software. • Launch provider and community education programs. • Collect baseline telehealth utilization and access metrics. • First providers fully connected and trained by Dec 2027.
Jan 1, 2028 – Dec 31, 2029	Stage 3	• Expand telehealth adoption to additional providers and regions. • Optimize telehealth workflows and billing processes. • Deliver ongoing technical assistance and patient education programs. • Monitor utilization, satisfaction, and clinical outcomes. • 50% of target rural providers actively using telehealth by Dec 2029.
Jan 1 – Dec 31, 2030	Stage 4	• Evaluate telehealth adoption, provider satisfaction, and patient access improvements. • Conduct cost-effectiveness and utilization analyses. • Document best practices and integrate into statewide telehealth policies. • TAPS outcomes report finalized by Dec 2030.
Jan 1 – Dec 31, 2031	Stage 5	• Integrate telehealth systems into routine rural provider operations.

Date	Stage	Key Milestones/Activities
		• Maintain technical support, training, and patient engagement programs. • Use telehealth data to guide ongoing policy and reimbursement adjustments. • TAPS fully implemented with sustained telehealth adoption and measurable improvements in access by Dec 2031.

Building Rural Infrastructure for Delivery, Growth and Efficiency Initiative (BRIDGE)

Date	Stage	Key Milestones/Activities
Jan 1- Mar 31, 2026	Stage 0	• Conduct statewide assessment of rural infrastructure gaps in PES, capital projects, and pilot program needs. • Establish program management and governance framework. • Define grant criteria, pilot parameters, and evaluation methodology. • BRIDGE implementation plan approved by Mar 2026.
Apr 1 – Jun 30, 2026	Stage 1	• Assign staff and execute MOUs with hospitals, EMS systems, and community providers. • Launch application portals for PES Development, Care Gap Closure, and pilot programs. • Begin stakeholder engagement and community outreach for pilot initiatives. • Operational systems and initial applications accepted by Jun 2026.
Jul 1, 2026 – Dec 31, 2027	Stage 2	• Award initial grants for PES development and capital improvement projects. • Begin pilot programs, including EI interventions, ASD-focused care, and CHW reimbursement models. • Collect baseline data on emergency care, care gaps, and service delivery outcomes. • First infrastructure projects and pilot programs launched by Dec 2027.
Jan 1, 2028 – Dec 31, 2029	Stage 3	• Expand PES systems and capital project implementation statewide. • Optimize pilot program interventions and data collection for impact analysis. • Conduct midterm evaluation and refine program strategies based on early outcomes.

Date	Stage	Key Milestones/Activities
		• 50% of target infrastructure and pilot goals achieved by Dec 2029.
Jan 1 – Dec 31, 2030	Stage 4	• Evaluate PES, capital projects, and pilot program effectiveness. • Document lessons learned and best practices for statewide dissemination. • Prepare sustainability plans for ongoing infrastructure support and pilot program continuation. • Comprehensive evaluation report completed by Dec 2030.
Jan 1 – Dec 31, 2031	Stage 5	• Fully integrate PES, care gap closure projects, and successful pilots into ongoing rural healthcare infrastructure. • Maintain continuous monitoring of performance and community health outcomes. • Use findings to inform future State and federal rural health initiatives. • BRIDGE fully implemented with measurable improvements in rural healthcare delivery and system efficiency by Dec 2031.

STAKEHOLDER ENGAGEMENT

Consulted and Prospective Stakeholders

On July 31, 2025, the Mississippi Division of Medicaid launched a publicly available survey "to solicit public input through a public survey and a stakeholder forum to develop a Rural Health Transformation Plan (Plan) and submit a timely application for the grant funding." The survey asked stakeholders to describe current challenges and solutions for RHT Program focus and use of funds. The State received 145 responses with stakeholders coming from nearly half of the counties in the State. Respondents included State health officials, public health workers, healthcare providers and administrators, health plan representatives, members of the public, and potential vendor partners. The State analyzed the survey results to identify common themes and began developing initiatives to include in this application. A complete list of respondents can be found in the attachment section.

Based on survey results, Mississippi then hosted a full-day listening forum on August 28, 2025. Attendees included representatives from the State Department of Health and Mental Health, Emergency Management, Workforce Development, Institutes of Higher Learning, select providers, and association leaders that represented hospitals, rural providers, community health centers, ambulance services, and nursing homes. Each forum participant brought expert insight into Mississippi's rural health needs and potential solutions, helping the State to solidify the initiatives in this plan.

The leadership team from the Office of the Governor, Department of Health, and Division of Medicaid has also conducted many additional conversations with stakeholders, including rural providers, tribal leaders, and potential vendor partners outside of the official survey and forum settings. Best efforts were made to include as many stakeholder perspectives as possible, enabling the State to develop an application and plan that best serve the needs of Mississippi's rural residents.

Engagement Framework and Project Governance

Mississippi plans to continue having an open process for stakeholder engagement. The State will explore structures such as a stakeholder advisory committee or other regular meetings and forums to ensure that the expectations of the populations intended to benefit from RHT Program funds are being met.

Mississippi plans to maintain the same program governance used during the application development. The Office of the Governor will work in conjunction with the State Department of Health (which houses the State Office of Rural Health) and Division of Medicaid to oversee the RHT Program. The State also plans on partnering with a third-party

organization to assist with deploying funds, tracking milestones, assessing impact and performing regular program monitoring for compliance and efficacy.

Through the evaluation and monitoring process, the State will regularly communicate and establish checkpoints with local communities, providers and health departments to gather feedback and adjust programs accordingly. The Mississippi Department of Health has offices in every county in the State, which will serve as major connection points between local and State leaders. Mississippi will also continue consultation with the Mississippi Band of Choctaw Indians to ensure coordination, mutual understanding, and inclusion in statewide rural health efforts.

METRICS AND EVALUATION PLAN

Metrics

State Rural Health Assessment

Metric	Completion of the statewide assessment	Number of stakeholders engaged	Identification of gaps and opportunities	Delivery of a data-driven roadmap with prioritized recommendations
Numeric Target	100% of planned assessment activities completed by project end	≥150 stakeholders (providers, community leaders, patients)	At least 5 major service, workforce, or infrastructure gaps identified statewide	90% of recommendations aligned with assessment findings delivered in final report
Data Source	Project management documentation, contract deliverables	Attendance logs, focus group/meeting records, survey submissions	Assessment reports, data analysis outputs	Final assessment report, dashboards, strategic recommendations
Reporting Geography	Statewide	County-level breakdown by region	County-level	Statewide

Metric	Completion of the statewide assessment	Number of stakeholders engaged	Identification of gaps and opportunities	Delivery of a data-driven roadmap with prioritized recommendations
Update Frequency	Upon project completion	Quarterly	Upon project completion	Upon project completion
Notes	Includes all data collection, stakeholder engagement, analysis, and reporting milestones. Tracks the timely and full completion of the statewide rural health assessment, ensuring all planned data, engagement, and reporting activities are delivered to inform decision-making.	Includes rural hospitals, FQHCs, EMS, behavioral health, and community representatives. Measures the breadth and inclusivity of stakeholder engagement, ensuring diverse perspectives guide assessment findings and funding decisions.	Includes gaps in clinical services, workforce capacity, technology, and access. Captures the actionable insights produced by the assessment, providing a foundation for targeted ongoing RHT Program investments.	Roadmap includes prioritization by urgency, impact, and feasibility. Ensures the assessment produces a clear, actionable, and prioritized plan for RHT Program fund allocation to maximize sustainability and health outcomes.

Coordinated Regional Integrated Systems Initiative (CRIS)

Metric	Percentage reduction in low-acuity ER visits through nurse navigation and treat-in-place interventions	Percentage of rural hospitals and clinics participating in coordinated care networks	Percentage of high-risk patients with a completed care plan within 7 days of discharge	30-day hospital readmission rate for high-risk patients
Numeric Target	≥10% reduction by Year 5	≥50% by Year 5	≥35% by Year 5	≤20% by Year 5

Data Source	Hospital ED records, EMS logs, nurse navigation program report	State hospital registry, MOUs	State data system and provider scheduling systems	Hospital EMRs, State hospital discharge data
Reporting Geography	County-level and regional rural healthcare district	County-level	County-level	County-level
Update Frequency	Quarterly	Annual	Quarterly	Quarterly
Notes	Captures both EMS treat-in-place cases and redirected patients; verified via provider submissions and State health system data. Evaluates how effectively CRIS programs redirect low-acuity patients from the emergency department to appropriate care through nurse navigation and treat-in-place protocols, improving access and reducing system strain.	Verified through signed MOUs and participation logs. Reflects the extent of provider engagement in CRIS's regional care networks, ensuring patients receive coordinated, timely, and continuous care across hospitals and clinics.	Includes follow-up visits and care coordination documentation. Timely completion of care plans for high-risk patients ensures continuity of care, reduces readmissions, and improves health outcomes in rural communities.	Risk-adjusted per CMS methodology. Tracks the effectiveness of CRIS care coordination and follow-up interventions, aiming to reduce avoidable readmissions and improve patient outcomes.

Workforce Expansion Initiative (WEI)

Metric	Percentage of WEI program participants retained in rural practice 5 years post-completion	Number of healthcare professionals recruited and retained in rural areas	Number of residency or training slots added and filled	Number of preceptors and mentors trained or engaged
Numeric Target	≥20% retention	≥150 new clinicians, allied health professionals, and support staff retained for at least 5 years	≥35 new residency or training positions filled	≥50 preceptors/mentors actively supervising students or residents
Data Source	Employment/HR records, program follow-up surveys	Program enrollment records, HR/employment data	Program records, residency program rosters	Program records, training completion logs
Reporting Geography	County-level	County-level	County-level	County-level
Update Frequency	Annual	Annual	Annual	Annual
Notes	Includes clinicians, allied health professionals, and support staff. Measures the long-term effectiveness of WEI programs in retaining trained healthcare professionals in rural areas, ensuring sustainable workforce improvements.	Includes physicians, nurses, CHWs, therapists, pharmacists, lab techs, IT staff. Measures the initiative's impact on expanding the rural healthcare workforce and addressing provider shortages in underserved areas.	Includes all eligible disciplines supported by WEI. Tracks growth of local training capacity and the development of a pipeline of providers committed to rural practice.	Includes clinical, allied health, and support staff preceptors. Reflects WEI's capacity-building efforts, ensuring high-quality hands-on training and mentorship for future rural healthcare professionals.

Health Technology Advancement and Modernization Initiative (HTAM)

Metric	Percentage of participating rural providers with upgraded or fully interoperable EHR systems	Participation rate in statewide Health Information Exchange (HIE)	Staff technical training completion	Patient engagement with consumer-facing technology
Numeric Target	≥90% of funded providers by Year 5	≥75% of eligible rural providers actively sharing data by Year 5	≥50% of applicable provider staff completing cybersecurity, EHR, or IT training by Year 5	≥40% of patients served by funded providers actively using patient portals, remote monitoring, or telehealth tools by Year 5
Data Source	Program records, vendor reports, State IT registries	HIE enrollment logs, State reporting	Training attendance logs, program records	Patient portal usage logs, telehealth platform analytics, surveys
Reporting Geography	County-level	County-level	County-level	County-level
Update Frequency	Annual	Annual	Annual	Annual
Notes	Includes small rural hospitals, clinics, and FQHCs. Measures the adoption of modern, interoperable EHR systems, ensuring rural providers can securely share patient data and participate in value-based care initiatives.	Verified via HIE system participation metrics. Tracks provider engagement in statewide HIE efforts, enabling real-time data exchange, improved care coordination, and population health management.	Includes clinical, patient-centered administrative, and IT staff. Ensures that staff are prepared to safely and effectively use upgraded systems, strengthening provider capacity and sustaining	Includes portal login, messaging, telehealth participation, and remote monitoring. Measures the degree to which patients are leveraging digital tools to manage their health, supporting self-care, engagement, and

Metric	Percentage of participating rural providers with upgraded or fully interoperable EHR systems	Participation rate in statewide Health Information Exchange (HIE)	Staff technical training completion	Patient engagement with consumer-facing technology
			technological improvements over time.	better health outcomes.

Telehealth Adoption and Provider Support Initiative (TAPS)

Metric	Telehealth utilization among rural providers	Provider participation in telehealth adoption incentive programs	Telehealth hub readiness and connectivity	Provider telehealth competency and training completion
Numeric Target	≥40% increase in telehealth visits among funded providers by Year 5	≥50% of eligible providers enroll and sustain telehealth service delivery for at least two consecutive years	≥85% of funded sites achieve full operational readiness, including secure connectivity and functional telehealth equipment, by Year 5	≥50% of participating applicable provider staff complete telehealth training within the first year of program implementation
Data Source	Provider encounter data, Medicaid claims, program reports	Program enrollment and payment records	Site readiness assessments, vendor installation records	Training logs, attendance records
Reporting Geography	County-level	County-level	County-level	County-level
Update Frequency	Annual	Annual	Annual	Annual
Notes	Captures both video and audio-only visits.	Includes primary care, specialty, and	Includes broadband, device	Covers clinical, administrative, and IT staff.

Metric	Telehealth utilization among rural providers	Provider participation in telehealth adoption incentive programs	Telehealth hub readiness and connectivity	Provider telehealth competency and training completion
	measures the growth of telehealth service delivery statewide, demonstrating increased access to care for rural and underserved populations through expanded virtual care capacity.	behavioral health providers. Tracks provider engagement and sustained participation in telehealth adoption initiatives, ensuring program incentives translate into lasting virtual care capacity.	functionality, and system integration. Measures the successful establishment of telehealth hubs and infrastructure improvements that make virtual care accessible in every participating rural community.	Ensures providers and staff are fully trained to deliver safe, effective, and compliant telehealth services, enhancing confidence and quality of care.

Building Rural Infrastructure for Delivery, Growth and Efficiency Initiative (BRIDGE)

Metric	Number of Psychiatric Emergency Services (PES) units established	Number of rural capital projects completed	Increase in service capacity (e.g. obstetrics, behavioral health)	Increase in primary and specialty care visits for rural populations
Numeric Target	≥3 PES units established by year 5	≥25 projects statewide by year 5	≥15% increase service lines	≥25% increase
Data Source	Program records, State facility licensing data	Program records, project completion reports	Facility reporting, reimbursement requests, payor data, licensing data	Provider-reported data, referral logs
Reporting Geography	County-level	County-level	County-level	County-level
Update Frequency	Annual	Annual	Annual	Annual
Notes	Based on number of PES units that provide services to rural patients. Measures the expansion of behavioral health crisis response capacity in rural areas, reducing ED bottlenecks and improving access to specialized psychiatric care.	Includes facility renovations, retrofitting for service provision, and equipment acquisitions. Monitors progress in addressing rural infrastructure gaps and increasing service capacity for underserved populations.	Calculated per facility and aggregated statewide. Includes the ability of rural providers to provide new services via the augmentation and use of telemedicine. Measures the tangible impact of infrastructure investments on access to care and operational efficiency.	Focused on rural populations. Quantifies improvements in access to care and lowered transportation barriers for patients in remote areas.

Metric	Number of Community Health Workers (CHWs) and clinical staff trained and deployed	Reduction in preventable ER visits among pilot program participants	Proportion of pilot programs showing measurable improvements in outcomes	Rural population reached through BRIDGE-funded programs
Numeric Target	≥100 staff	≥15% decrease	≥50%	≥100,000 residents
Data Source	Training logs, deployment records, and licensing records	Hospital ED data, program monitoring, and State system data	Program evaluation reports, data dashboards, and State system data	Program evaluation reports, data dashboards, and State system data
Reporting Geography	County-level	County-level	Statewide	County-level and statewide aggregate
Update Frequency	Annual	Semiannual	Annual	Annual
Notes	Includes all facets of healthcare providers, behavioral health, obstetrics, school-based medicine, etc. Tracks workforce capacity-building efforts that enhance care coordination and service delivery in rural communities.	Focused on populations impacted in areas where pilot programs are implemented. Demonstrates the effectiveness of pilot programs in reducing avoidable hospital utilization and improving patient outcomes.	Includes all Pilot Program populations. Measures success of innovative programs and informs scalability and sustainability of effective models.	Aggregated across all initiatives. Captures the overall reach and impact of BRIDGE on improving healthcare access and outcomes for rural populations.

Evaluation plan

Mississippi will cooperate with any CMS-led evaluation or monitoring. Mississippi plans to partner with a qualified firm with extensive 2 CFR 200 and rural health experience to perform compliance and monitoring services for the RTH Program. This partnership will include conducting program evaluation activities, ensuring that implementation aligns with program goals and identifying areas for continuous improvement.

Sustainability Plan

Mississippi recognizes that for RHT Program funds to drive true transformation, initiatives must have a sustainable path beyond the RHT Program's five-year window. Our initiatives balance **one-time investments** in infrastructure and technology with **programmatic investments** designed to demonstrate value and transition to **State-level sustainable funding**. The goal is to:

- Strengthen the healthcare workforce **without creating dependency** on RHT Program funds,
- Develop **scalable, replicable clinical models** that improve care quality and efficiency, and
- Create new revenue streams and support provider transition to **value-based payment models** for long-term sustainability.

INITIATIVE SUSTAINABILITY PLANS

RURAL HEALTH STATEWIDE ASSESSMENT

A **one-time investment** to verify care gaps and key factors affecting rural health. The assessment contractor will also review and strengthen sustainability plans for each initiative, providing recommendations to enhance long-term impact.

COORDINATED REGIONAL INTEGRATED SYSTEMS (CRIS) INITIATIVE

Regionalized EMS System – Rural Healthcare Districts: Investments will reorganize and enhance existing EMS systems. Sustainability will come from operational efficiencies, cost savings, and reduced downstream care costs by ensuring patients receive appropriate care in the right setting.

EMS Treat in Place Pilot Program: Aims to reduce unnecessary ER visits and hospitalizations, lowering the cost of care. Sustainability will come through **new reimbursement models** from Medicaid and private insurers.

Clinical Integration & Post-Discharge Care Coordination: RHT Program will provide start-up funding for regional or statewide Clinically Integrated Networks (CINs). These will be governed by participants and sustained through payer contracts, value-based care arrangements, and participant investments.

Remote Medical Assistance & Nurse Navigation Lines: Provides statewide patient guidance to improve care coordination and reduce costs. Once cost savings are demonstrated, the State will commit to continued funding.

AI & Algorithmic EMS Decision Support Pilot: AI tools will improve efficiency within the new regionalized EMS system. Sustainability will be driven by the cost savings generated through these efficiencies.

Closed-Loop Referral & Wraparound Social Services: Connects patients to social services addressing social determinants of health (SDOH). By improving long-term health and reducing reliance on Medicaid and SNAP, State savings will support ongoing program funding.

WORKFORCE EXPANSION INITIATIVE (WEI)

Retention Award Pilot Program: Evaluated at program end; successful pilots will transition to State-level funding.

Residency Program Expansion Grant: Covers two-year start-up costs for new residency slots. Thereafter, programs will receive standard **CMS residency funding**.

Preceptor Expansion Program: Provides incentive payments to nurse preceptors. Upon proven success, the State will maintain funding.

Earn While You Learn: Reduces financial barriers for healthcare trainees. If successful in growing the rural workforce, the State will continue funding.

Secondary Education Medical Career Outreach: Funds educational materials and activities guiding students toward healthcare careers. Continued funding will depend on program success in expanding the rural healthcare pipeline.

HEALTH TECHNOLOGY ADVANCEMENT & MODERNIZATION (HTAM) INITIATIVE

Small Provider Technology Grants: One-time funding for providers to upgrade technology that enhances efficiency and supports care integration. No continuation beyond RHT Program.

Small Provider EHR Replacement Grants: One-time funding for providers to replace low-performing EHR systems with high-performing ones. No continuation beyond RHT Program.

TELEHEALTH ADOPTION & PROVIDER SUPPORT (TAPS) INITIATIVE

Telehealth Adoption Incentives: Supports provider transitions to telehealth operations. Once implemented, facilities will sustain operations through billing revenue. No continuation beyond RHT Program.

Telehealth Hub Connectivity & Equipment: One-time funding for telehealth equipment and connectivity. No continuation beyond RHT Program.

Telehealth Education: Supports development of telehealth curriculum for medical, nursing, and undergraduate programs. If effective in expanding the workforce, the State will maintain funding.

BUILDING RURAL INFRASTRUCTURE FOR DELIVERY, GROWTH & EFFICIENCY (BRIDGE) INITIATIVE

Psychiatric Emergency Services (PES) Development: One-time capital to create Psychiatric Emergency Departments (PEDs), plus staffing and overhead support. These facilities are expected to become **self-sustaining through revenue generation**.

Rural Capital for Care Gap Closures: One-time funds for minor facility renovations to improve access and close care gaps. No continuation beyond RHT Program.

Clinical Pilot Programs: Funds pilot projects targeting key rural care gaps. Successful pilots will transition to ongoing State-level funding.

END NOTES

1. https://www.mspha.org/wp-content/uploads/2024/02/MPHA2024LegislativeAgenda.pdf
2. www.mspha.org/wp-content/uploads/2024/02/MPHA2024LegislativeAgenda.pdf
3. https://chroniccarealliance.org/wp-content/uploads/2023/11/CCPA-Mississippi-State-of-Chronic-Disease-2023.pdf
4. https://www.mhanet.org/Online/Online/Press/2024/Mississippi-Rural-Hospitals-Tackle-Workforce-Shortages-with-Innovative-Solutions-.aspx
5. https://msdh.ms.gov/msdhsite/index.cfm/31,20750,444,pdf/Maternal_Health_Action_Plan_2024.pdf
6. https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
7. https://www.msfoodnet.org/about-us/hunger/
8. https://extension.msstate.edu/publications/mississippi-economic-and-financial-well-being-patterns-and-trends
9. https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html
10. https://www.ncsl.org/health/overview-of-rural-health
11. https://www.hrsa.gov/rural-health/about-us/what-is-rural/data-files
12. https://msdh.ms.gov/msdhsite/_static/44,0,111.html#rural
13. https://censusreporter.org/profiles/04000US28-mississippi/
14. https://extension.msstate.edu/publications/mississippi-economic-and-financial-well-being-patterns-and-trends
15. https://www.census.gov/topics/education/educational-attainment.html
16. https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes
17. https://chroniccarealliance.org/wp-content/uploads/2023/11/CCPA-Mississippi-State-of-Chronic-Disease-2023.pdf
18. https://www.cdc.gov/heart-disease-and-stroke-data/hd-stroke-trends-dashboard/index.html
19. https://assets.aecf.org/m/databook/2025-KCDB-profile-MS.pdf
20. https://childrensfoundationms.org/
21. https://www.cdc.gov/nchs/maternal-mortality/mmr-2018-2022-state-data.pdf
22. https://www.cdc.gov/nchs/maternal-mortality/data.htm
23. https://medicaid.ms.gov/wp-content/uploads/2025/01/MOMS-Initiative-Presentation.pdf
24. https://maternalhealthms.org
25. https://www.childstats.gov/americaschildren/prenatal.asp
26. https://www.marchofdimes.org/peristats/reports/mississippi/maternity-care-deserts
27. https://www.pewresearch.org/short-reads/2018/12/12/how-far-americans-live-from-the-closest-hospital-differs-by-community-type/
28. https://msdh.ms.gov/msdhsite/_static/resources/7357.pdf
29. https://mspublictransitassociation.org/resources
30. https://mdot.ms.gov/connectms/
31. https://www.ruralhealthinfo.org/states/mississippi
32. https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/phys-workforce/Mississippi.pdf

33. https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
34. https://www.clarionledger.com/story/news/2025/07/10/medicaid-cuts-could-lead-to-8-mississippi-hospitals-closing-see-why/84530916007/
35. https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
36. https://www.mhanet.org/common/Uploadedfiles/Advocacy/TransformingRuralHealthinMississippi-SecondUpdate2011.3.25.pdf
37. www.mstelehealth.org/wp-content/uploads/2017/08/Mississippi-Telehealth-Manual.pdf
38. https://www.americashealthrankings.org/explore/measures/ChildPoverty/MS
39. https://www.bls.gov/charts/state-employment-and-unemployment/state-unemployment-rates-map.htm#
40. https://www.mhanet.org/common/Uploadedfiles/Advocacy/TransformingRuralHealthinMississippi-SecondUpdate11.3.25.pdf
41. https://mdek12.org/wp-content/uploads/sites/33/2025/02/Grad-Dropout-Rates-2025-Report.pdf