2025

CONNECTICUT RURAL HEALTH TRANSFORMATION PROGRAM

GRANT APPLICATION

Opportunity Number: CMS-RHT-26-001

November 5, 2025

Submitted by:

Connecticut Department of Social Services

Table of Contents

Acronym Glossary

Acronym	Definition
ADS	Department of Aging and Disability Services
AHEAD	Achieving Health Efficiency through Accountable Design
AHEC	Area Health Education Center
APCD	All-Payer Claims Database
APM	Alternative Payment Model
ASD	Autism Spectrum Disorder
CBO	Community-Based Organization
CCBHC	Certified Community Behavioral Health Clinic
CHWC	Community Health and Wellness Center
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nurse Aide
CON	Certificate of Need
CR-PACP	Connecticut Rural Predictive Analytics and Care-Coordination Platform
DEEP	Department of Energy and Environmental Protection
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DSH	Disproportionate Share Hospital
DSS	Department of Social Services
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Services
FFY	Federal Fiscal Year (*October - September*)
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
ICM	Intensive Care Management
IMLC	Interstate Medical Licensure Compact
MIH	Mobile Integrated Health
MSA	Metropolitan Statistical Areas
NOFO	Notice of Funding Opportunity
OEC	Office of Early Childhood
OHS	Office of Health Strategy
OPM	Office of Policy and Management
PACE	Program of All-Inclusive Care for the Elderly
PCMH	Person-Centered Medical Home
PCMH+	Person-Centered Medical Home Plus
PMPM	Per Member Per Month
PSA	Primary Service Area
RHT	Rural Health Transformation
RPM	Remote Patient Monitoring
SFY	State Fiscal Year (*July - June*)
SNF	Skilled Nursing Facility
TCM	Targeted Case Management
UCHC	University of Connecticut Health Center
VBP	Value-Based Payment

Table 1 – Acronym Glossary

Project Narrative

Connecticut's rural communities encompass some of the state's most charming and bucolic settings. They reflect an enduring character of civic integrity, disciplined governance, care for one's neighbor, and grit in the face of long-standing challenges brought on by deindustrialization and population decline. However, these challenges continue to confront residents of those communities today, as they do for similar regions across the nation. An integrated, technology-driven, accountable healthcare delivery network is a fundamental component of a thriving life. Far too often, our rural residents encounter an ecosystem where information is not shared effectively and efficiently. As a result, residents experience barriers in accessing services, lack access to innovative technology that can connect them to providers, and face unacceptable health outcomes.

Connecticut relishes this opportunity to transform rural healthcare and assure a healthier future for our residents. The Rural Health Transformation (RHT) Program will allow the state to enhance health outcomes by investing in access to primary care and refocusing on the fundamental sources of good health, such as exercise, recreation, and nutritious food, to avoid unnecessary care. By 2031, rural Connecticut residents will enjoy benefits from accessible, integrated care delivered by providers who are rewarded for their performance rather than for service volume. By investing in telehealth and AI-powered virtual monitoring tools, rural patients can more easily overcome barriers created by limited transportation infrastructure and significant travel distances to providers. Through the RHT Program, Connecticut will be able to address chronic workforce gaps affecting care availability in rural areas, promote innovative care delivery models that respond to the needs of patients, and support sustainable improvements in critical healthcare facility access points beyond the RHT grant period. This opportunity's

strategic goals provide a clear roadmap for investment that will improve not only healthcare but also enrich life for the individuals and families who are the backbone of our rural communities.

As the "Land of Steady Habits," Connecticut has historically fostered strength and progress, yet those same traits, if unexamined, risk leaving residents in our rural communities behind. Rural hospitals continue to operate under financial strain: according to Medicare cost reports filed by the state's hospitals, uncompensated care costs totaled more than $271 million in 2024.[1] The state's aging population, transportation barriers, and limited behavioral health capacity compound the crisis.[2] In a small state where 9% of residents live in rural areas[3] and are represented in seven of the state's nine planning regions,[4] adverse impacts can reverberate statewide. Without targeted investment, rural health systems will continue to erode, threatening not only access to services for residents in rural areas but also the economic and social stability of rural communities. The RHT Plan is a critical mechanism for Connecticut to bridge historical divides, build data-driven resilience, and deliver on its commitment to high-quality care and innovation to rural communities. Such improvements will further extend and adapt health advancements, ones that have primarily occurred in urban and suburban communities, to rural communities in ways that reflect and respond to local needs.

I. Rural Health Needs and Target Population

Connecticut (total area: 5,543 square miles)[5] has a substantial rural presence across its geography: (1) Population: The rural population is 323,304, representing 9.0% of the state's total population of 3.6 million,[3] 5.8% of the state lives outside Census-designated Metropolitan Statistical Areas[6] (MSAs), and an additional 3.2% reside in rural census tracts within MSAs;[6] (2) Governance and Regions: Connecticut operates without county governance, using nine geographic planning regions as statistical equivalents.[7] For the purpose of this application, **the**

state has adopted the rural definition determined by the Health Resources and Services Administration (HRSA) under the Federal Office of Rural Health Policy (FORHP) in September 2025. Two of these planning regions, Northeastern Connecticut and Northwest Hills, are entirely designated as rural by the FORHP.[8] Rural residents are distributed across seven of the nine planning regions and constitute the populations primarily targeted by Connecticut's proposed RHT Program initiatives, in addition to the two federally-recognized tribes in the state: the Mohegan Tribe and the Mashantucket Pequot Tribal Nation.[4]

Rural Health Facility Count	
Rural Facility Type	**Number of Facility Types Located in Rural Connecticut**
Critical Access Hospitals (CAH)	0
Sole Community Hospitals (SCH)	1
Medicare Dependent Hospitals (MDH)	1
Low Volume Hospitals (LVH)	3
Rural Emergency Hospitals (REH)	0
Total Number of Facilities	**5**
Rural Health Clinics (RHC)	0
Federally Qualified Health Centers (FQHC) and Section 330 Grantees	17
Community Mental Health Centers (CMHC)	4
Opioid Treatment Facilities	2
Certified Community Behavioral Health Clinics (CCBHC)	1
Total Number of Facilities	**24**

Table 2 - Rural Health Facility Count[9] [10] [11] [12] [13]

These statistics quantify the low number of healthcare facilities in rural areas and capture the complexities of the challenges rural residents encounter in accessing healthcare. Lack of access to transportation, whether public or private, is one of the most significant barriers to obtaining essential healthcare in rural areas. Travel for rural residents from the state's outlying areas via public transit relies on limited local access routes, making it difficult to reach a medical appointment on time. Constrained public transportation in rural Connecticut significantly impedes rural residents' ability to get needed healthcare and other health-promoting services.

A significant challenge to healthcare provision for rural residents is the current strain the healthcare system is under due to financial instability. In federal fiscal year (FFY) 2024,

according to Medicare Cost Reports filed by hospitals in the state, the total cost of uncompensated care in Connecticut was $271,470,982, representing 1.5% of hospitals' operating costs.[1] Further, 8 of 39 hospitals in Connecticut, or 20.5%, receive Medicaid Disproportionate Share Hospital (DSH) payments.[14] This level of financial challenge can affect healthcare providers' ability to expand services, particularly in rural areas with low population density. These challenges also create pressure on rising healthcare insurance premiums in the commercial market for businesses and families, with annual rate increases of 11%.[15]

Household income has a significant impact on rural residents' health, as the cost of traveling long distances for healthcare and the cost of services and insurance can lead people to avoid treatment.[16] Low-income significantly affects health outcomes in Connecticut's rural communities, driving greater need and higher costs. Across all rural tracts, 26% of households earn under $50,000 and 44% of rural employees earn less than $75,000 per year. The most common employment sectors for rural Connecticut residents are *Health Care and Social Assistance* (16%), *Retail Trade* (10%), *Accommodation and Food Services* (9%), and *Manufacturing* (9%).[17] Given the high cost of living in Connecticut, lower income levels worsens the strain experienced by many rural households, as these incomes fall far short of the $116,208 Household Survival Budget for a family of four, as reported by the United Way's 2025 ALICE study.[18] Residents of the rural Northeastern planning region have the lowest attainment of college-level degrees in the state, with only 21% earning a bachelor's degree or higher. By comparison, in the more urban Western Connecticut planning region, 50% of residents attained a degree at or above that level.[19]

Of Connecticut's rural population, 4% do not have any health coverage,[20] contributing to the 10.2% of adults statewide reporting medical debt.[20] Higher costs are also a function of

treating complex chronic conditions rather than root causes of health and prevention. This grant provides an opportunity to address root causes and fill gaps in prevention and wellness that avoid expensive hospitalization and downstream health consequences. By establishing mobile clinics to provide primary and dental care to rural residents with significant access barriers, as well as AI-powered care management and predictive analytics platforms, Connecticut can promote greater population wellness while decreasing reliance on less efficient forms of care. Connecticut also supports reducing government subsidies to unhealthy food and sugary drinks and will submit state legislation for a SNAP waiver intended to direct recipients toward consuming more healthy, wholesome food, and providing investments to expand access to healthy produce through the establishment of accessible, innovative farms in rural areas.

Further, a recent Consumer Affairs report ranked Connecticut as the fifth most unaffordable state for healthcare costs, based on factors including average annual health insurance premiums and deductibles, percent of residents forgoing care due to cost, and percent of children whose families struggle with paying medical bills.[21] The report also ranked Connecticut second in overall costs for single insurance coverage and fourth in annual insurance premiums for single coverage.[21] Despite these high and increasing health insurance costs, rural providers often lack market leverage to negotiate for more resources in rural communities. The RHT grant is a significant opportunity for the state to help rural providers transition and prepare for innovative performance-based payments models, such as global budgets, that provide predictability and can help improve quality, long-term sustainability and cost-effective care.

Health Outcomes and Chronic Disease Prevalence

Rural Connecticut residents bear an increased and often compounded burden of certain chronic and infectious conditions, frequently due to limited access to preventive and specialized

care.[22] Below are chronic conditions with an outsized impact in Connecticut's rural communities.

Chronic Illness	Status of Chronic Illness in Connecticut Rural Areas
Cancer	Mortality rates for cancer are statistically higher in rural regions of Connecticut, reinforcing the need for enhanced rural screening and early detection access. In 2019, the cancer death rate in rural areas was 15% higher (164.1 per 100,000) than in urban areas (142.8 per 100,000).[23]
Cardiovascular Heart Disease	Mortality from heart disease is higher across all rural regions of the state when compared to the statewide average, reflecting broader national trends where heart disease death rates are greater in rural areas. In 2019, certain less-dense counties in Connecticut, such as New London, Tolland, and Windham, had heart disease death rates categorized as stable and above the U.S. rate.[24]
Asthma	While asthma is a significant issue in Connecticut's largest cities, its prevalence among school-aged children is also significant in many rural towns, particularly in eastern Connecticut.[25]
Multiple Chronic Conditions	Multiple Chronic Conditions (MCCs) are highly prevalent, affecting 52% of Medicare beneficiaries aged 65–74 in Connecticut.[26] The state ranks among the oldest in the U.S., driving increased demand for home and community-based chronic care services in isolated rural areas.
Behavioral Health	Rural areas face significant challenges, including a high prevalence of binge drinking and tobacco use across all counties, compared to national rates. Furthermore, the eastern region of the state, including a significant portion of the state's rural areas, reports a high volume of cases of people receiving mental health and/or substance use treatment, often necessitating long-distance travel for specialty care.
Chronic Kidney Disease (CKD)	CKD prevalence is directly associated with aging populations, hypertension, and diabetes. As 10.8% of Connecticut adults, 312,000 adults, have been diagnosed with diabetes[27] (a leading cause of kidney failure) and given the higher overall chronic disease burden in rural Connecticut, the incidence and progression of CKD are critical concerns that require improved rural screening and management.
Diabetes	Approximately 10.8% of adults in Connecticut have been diagnosed with diabetes.[27] Nationally, the prevalence of diabetes is consistently reported to be 9% to 17% higher in rural areas than in urban areas, suggesting that rural Connecticut residents face an elevated risk.[28]
Other Challenges	**Status of Challenges Related to Rural Health**
Maternity Care Access	Access to consistent, high-quality prenatal and perinatal care is critically low in rural Connecticut due to a severe shortage of specialty providers. Compounded by previous rural hospital closures and other rural hospitals that have proposed or completed closure of labor and delivery units, expectant mothers are often forced to undertake extended travel, leading to inconsistent care compliance and elevated risks for adverse maternal and infant outcomes.
Early Childhood Risk	Children residing in lower-income rural areas face an elevated risk profile concerning critical developmental and health indicators.[29] This includes a higher likelihood of elevated blood-lead levels, alongside significant challenges related to physical inactivity and the prevalence of being overweight/obese.[30]
Disengaged Youth Risk	Youth disconnection is a critical, yet overlooked, non-clinical factor related to health in rural Connecticut. Isolation resulting from this disconnection directly predicts adverse health outcomes—such as substance use, homelessness, and justice system involvement—which ultimately lead to increased reliance on costly, reactive emergency care.
Aging Population and Complex Chronic Care Demand	The 2025 Connecticut Healthy Aging Data Report revealed that older adults in Connecticut face elevated rates of chronic conditions compared to other New England states, including hip fracture, Alzheimer's disease, and congestive heart failure.[31]
Frail Elderly (Falls)	Unintentional falls are the leading cause of death among Connecticut residents aged 75 and older.[32] In 2022 alone, Connecticut hospitals billed $4.6 billion for fall-related care. This risk is

	disproportionately rural: six towns with a significant rural component were among the top ten statewide for fatal falls between 2019 and 2023.[33]

Table 3 - Chronic Conditions

Primary Care Availability

In Connecticut between 2015 and 2024, rural adults aged 65 and older faced significant access gaps, and 16% delayed medical care, 8% skipped care entirely, and 6% lacked a designated primary care provider.[22] These gaps worsen chronic conditions and lead to treatment interruptions. The RHT Plan will focus on leveraging initiatives such as the Program of All-Inclusive Care for the Elderly (PACE) and mobile integrated health initiatives in rural areas to improve the management of chronic conditions, helping to ensure that older adults remain independent to the greatest extent possible and reducing the need for institutional care.

In addition, through the RHT Program, Connecticut will pursue investments in child and maternal health, including expansions in universal home visits to support new families, as well as additional school-based health services to reduce out-of-district placements and keep children close to families and local support systems. Further, the state will invest in a more robust high school workforce pipeline to springboard rural youth into healthcare careers in their own communities, providing economic opportunities for students in a high-demand field and expanding health access to rural residents over the long term.

Connecticut faces significant documented gaps in access to essential healthcare services, particularly in its rural regions, which contribute to elevated healthcare costs and poor outcomes. Access to primary care, behavioral health, and specialized hospital services (e.g., labor and delivery, and inpatient psychiatric care) are highly variable across the state. Connecticut rural residents face demonstrable access challenges including (1) emergency service lag, including extended drive times for critical, time-sensitive medical events, which are at least 1.5 times longer, on average, than non-rural residents, and (2) low utilization of electronic data

documentation. The Office of Health Strategy (OHS) formally recognizes these challenges through publications such as the *Statewide Health Care Facilities and Services Plan* and its annual inventory, which guide state policy and regulatory efforts. Notably, rural areas face severe shortages in primary care workforce when compared to more urban regions:

County (Area Type)[34]	Primary Care Physicians per 100,000 Residents[34]	Contrast[34]
Fairfield (SW Metro)	97	Highest Ratio
Litchfield (NW Rural)	56	Relatively Low
Windham (NE Rural)	45	Lowest Ratio (Less than half of Fairfield)

Table 4 - Primary Care Workforce Shortage

Connecticut faces a critical primary care shortage, with 22.6% of the state's physicians, nurse practitioners, and physician assistants practicing in primary care, compared to 27.2% nationally and higher rates in nearby states such as Massachusetts (24.6%) and Rhode Island (>30%).[35]

In response to these workforce challenges, Connecticut enacted numerous policies in recent years that aim to promote telehealth availability and access. From 2020 to 2022, the state established multiple provisions in state law to promote the delivery of telehealth services and insurance coverage of such services to ensure that care remained accessible to residents. In 2024, Connecticut made many of these provisions permanent, including: (1) allowing authorized telehealth providers to use audio-only telephone to provide services; (2) allowing authorized providers to provide telehealth services from any location to patients in any location, subject to applicable state and federal requirements; and (3) prohibiting health carriers from reducing the reimbursement they pay to telehealth providers for covered services appropriately provided through telehealth instead of in person.[36,37] With Connecticut joining neighboring states to enact interstate healthcare licensure compacts, the state will have a stronger foundation with which to further enhance telehealth capacity, expand remote patient monitoring across state lines, and add workforce capacity for our rural border communities.

Limited access drives costly, preventable utilization: the Commonwealth Fund's 2025 Scorecard ranks Connecticut 48th nationally[38] for avoidable hospital use and costs, an eight-place drop[38] since 2023. In 2023, 27% of emergency department (ED) visits were deemed avoidable, and in 2021, 19% of ED users were frequent visitors (four or more visits), with another 32% visiting two or three times.[39] These patterns highlight the urgent need for upstream investment—particularly in community-based crisis stabilization for adults.[39] RHT grant funding will be used to initiate up to four 23-hour crisis stabilization centers integrated with the state's rural hospital system to divert unnecessary behavioral health visits away from EDs, enabling specialists to focus on patients with the most complex care needs. This mission will be furthered by providing more stabilization and home-based treatment to those with less acute mental health needs in community settings closer to people's homes.

Extensive research confirms that limited access to healthcare and care discontinuity lead to substantial financial challenges for healthcare systems. Patients who delay or forgo essential medical services due to financial constraints, transportation issues, or provider shortages tend to incur higher overall healthcare costs. This is particularly evident among rural patients with chronic conditions such as heart failure, where delayed or missed care correlates with increased annual healthcare expenditures compared to those who receive continuous care.[48]

Other Rural Healthcare Access Factors: Behavioral Health

Lack of access to behavioral health services in Connecticut threatens the stability of the mental health safety net and contributes to ED overcrowding. Despite Connecticut ranking third among the six New England states[40] in the total number of behavioral health providers per capita, there remains a critical shortage of highly trained specialists capable of managing complex cases. The state ranks fourth in per capita numbers of psychologists and licensed

clinical social workers,[41] highlighting a fundamental gap in specialized expertise needed for comprehensive behavioral healthcare in rural Connecticut. This workforce deficit is particularly challenging in rural communities. For example, of the 1,178 licensed psychiatrists in Connecticut, only six practices are in the rural Northeastern Connecticut planning region, and only thirteen are in the rural Northwest Hills planning region.[42] Market dynamics, including insurers' reliance on narrow networks and low reimbursement rates for behavioral health services, further restrict access, especially in low-density rural areas.

The consequences of these access gaps are evident in the strain on ED services. The lack of outpatient behavioral health options has led to EDs operating at or beyond capacity, with wait times for behavioral healthcare exceeding national averages.[43] These issues require targeted strategies to improve workforce distribution, increase specialist availability, and expand outpatient services to ensure access across Connecticut. This crisis reached a critical threshold, specifically impacting children and youth, which prompted the state to establish four Urgent Crisis Centers in 2023 to divert ED visits.[43] Unfortunately, there remains insufficient state-level diversion capacity focused on adults, particularly in rural areas, leaving a substantial unmet need for crisis-level behavioral healthcare for this population.

Gaps in outpatient mental health infrastructure are documented across rural regions of Connecticut. For example, according to the most recent data analyzed by OHS, Northeast Connecticut planning region has the lowest percentage of mental health outpatient clinics per 100,000 residents.[44] Windham Hospital, a key acute care facility in the region, provides no inpatient mental healthcare[45] and Day Kimball Hospital, the region's only other acute care facility, provides a small 15-bed inpatient psychiatric unit and outpatient care, but offers no treatment for substance use disorders.[46] Furthermore, sections of the state, including the rural

Northwestern Hills planning region, suffer from a complete lack of non-hospital residential mental health treatment beds.[47] This scarcity highlights a significant gap in community-based mental health support, which is essential for early intervention and ongoing care.[48]

Rural Facility Financial Health and Health Barriers

a. Rural Hospital Sustainability

Rural hospitals in Connecticut face growing financial strain, driven by low patient volumes, a disproportionately high public payer mix, outdated infrastructure, and limited resources to adapt to healthcare advancements. Although many of these facilities serve as the only source of emergency and acute care in their communities, these challenges increasingly threaten their long-term viability. With this grant, there is a new opportunity for health facilities to shift their business models toward prevention, screening, and root causes of health to promote wellness and align payments with performance outcomes, reducing unnecessary treatments.

Rural hospitals, which have high public payer percentages, often face significant financial challenges. In total, Connecticut rural hospitals discharged 13,555 patients in state fiscal year (SFY) 2024, representing 3.7% of the 367,142 total hospital discharges recorded statewide.[49] On average, public payers made up 10 percentage points more of Connecticut's rural hospitals' net revenues than the statewide average, as shown in the table below.

Hospital	% Medicaid Revenue	% Medicare Revenue	Combined Medicaid + Medicare Revenue
Charlotte-Hungerford	21.8%	47.2%	68.9%
Day Kimball	19.5%	40.8%	60.3%
Sharon	9.4%	54.1%	63.6%
Windham	17.0%	40.5%	57.5%
Statewide Total	17.0%	35.6%	52.6%

Table 5 - SFY 24 Payer Mix (As a Percentage of Net Revenue) by Rural Connecticut Hospital[50]

The nationwide total operating margin for hospitals in SFY 2023 was 2.6%,[51] while Connecticut hospitals posted an average margin of -0.5%.[52] By contrast, rural hospitals in

Connecticut experienced an average operating margin of -14.6%.[52] See the table below for a breakdown of statewide economic outcomes and payer mixes reported during SFY 2023.

Hospital	Operating Margin	Income/(Loss) from Operations	Medicaid Payment-to-Cost Ratio	Medicare Payment-to-Cost Ratio
Charlotte-Hungerford	-5.52%	(4,471,900)	1.02	0.86
Day Kimball	-2.31%	($16,041,149)	0.91	0.76
Sharon*	-48.48%	($24,084,000)	0.85	0.63
Windham	-2.14%	($525,738)	0.72	0.86
Statewide Total	-0.45%	$282,351,565	0.87	0.73
** Sharon Hospital's occupancy rate has been about 40% in the last three years; its patient mix is 60% Medicare and Medicaid, and its operating expenses are nearly 1.5 times its patient revenue.*				

Table 6 - SFY 2023 Financial Outcomes by Rural Connecticut Hospital[53]

Rural hospitals, operating with lower patient volumes and limited market power, face reduced negotiating leverage with commercial insurers, particularly independent hospitals lacking the support of larger systems. Consequently, these facilities often receive lower reimbursement rates, constraining their ability to sustain or expand services. Reflecting this strain, rural and rural-serving hospitals are disproportionately represented in terms of population impact in Connecticut's Certificate of Need (CON) requests for service line closures, further exacerbating access issues. Between 2018 and October 2025, all requests involving rural or rural-serving hospitals were approved except the proposed closure of Sharon Hospital's labor and delivery unit. Accompanying the funding initiatives proposed for Connecticut's RHT Program, the state is committed to simplifying and refreshing the purpose of our CON laws to promote market competition and remove barriers to entry.

b. Rural Federally Qualified Health Centers

In rural Connecticut, FQHCs are integral, often serving as the primary, or only, source of comprehensive healthcare in their communities. These centers, including sites operated by Generations Family Health Center, Inc. in Northeastern Connecticut and Community Health and Wellness Center (CHWC) in the Northwest Hills region, fill essential gaps in access to

healthcare for residents who might otherwise need to travel long distances for preventive and primary care services. Additionally, FQHCs operate school-based health centers throughout Connecticut's rural communities. Collectively, FQHCs play a central role in maintaining a healthcare presence in Connecticut's most underserved rural communities, particularly as insufficient public transportation access makes it difficult for patients to travel the distances required to reach providers elsewhere. Notably, DSS recently approved a change in scope for an FQHC in Torrington to open a clinic location in rural Canaan, Connecticut. This location is anticipated to serve approximately 15,000 residents located in Canaan, as well as seven surrounding towns located in the Northwest Hills planning region. In 2024, CHWC locations served 6,700 patients in the Northwest Hills, an increase of 14% since 2023, across 34,000 total visits. 4,000 (67%) of patients served had household incomes at or below 100% of the federal poverty level, and Medicaid covered 3,000 patients.[56]

However, FQHCs in Connecticut face many of the same staffing and reimbursement challenges as hospitals and other facilities. In February 2025, CHWC stopped dental services at both its Torrington and Winsted locations due to an inability to compete with increasing market wages, workforce shortages, and increasing prices for costly dental procedures. By ceasing dental services, only 10 dental practices remain in the area, only two of which accept Medicaid patients, leaving approximately 1,400 CHWC patients without access to dental care. Additionally, because public transportation is limited in rural Litchfield County, the closest dental care for Medicaid members is the University of Connecticut Health Center (UCHC), located up to 40 minutes away for those with access to a personal vehicle.[54]

c. Workforce Shortage

Connecticut faces a persistent shortage of healthcare workers, most notably in primary care and behavioral health. Limited access to providers, particularly in rural areas, has created significant geographic disparities in care. These shortages are projected to worsen as the workforce ages and recruitment barriers continue, with rural regions most affected due to smaller populations, limited resources, and geographic isolation. Two federally designated geographic Primary Care Health Professional Shortage Areas (HPSAs) cover the state's rural Northwest Hills and Northeastern regions, where 20 facilities operate, including the two rural FQHCs referenced above.[55] Connecticut also has 20 low-income population groups designated as primary care HPSAs and, as of September 2025, the state is designated as a Mental Health HPSA. Thirty-three mental health facilities operate within these areas, impacting eleven low-income populations, including four in partially rural settings.[56]

An aging workforce continues to strain capacity. As of 2020, 36% of Connecticut physicians were aged 60 or older, a 25% increase since 2012.[57] Shortages are particularly acute in pulmonology, psychiatry, family medicine, and infectious diseases, with projections showing that only 44% of family medicine needs will be met by 2030.[58] Demand for healthcare professionals will continue to outpace supply through the end of the current decade.[57] Part of the state's vision is to ameliorate these shortages by focusing on root cause factors—nutritious food and eating, exercise, prevention, and early screenings—to free up time and resources that consume clinicians' time downstream.

The National Rural Health Association cites economic and lifestyle factors, including lower salaries, relocation costs, housing limitations, and spousal employment barriers as key contributors to rural workforce shortages.[59] Although Connecticut has advanced solutions

through participation in federal programs and adoption of multiple interstate licensure compacts, workforce barriers remain significant in rural regions.

d. Healthcare Coordination

In recent years, Connecticut has made significant progress and is invested in improving care coordination for patients, including the following under the state Medicaid program: Person-Centered Medical Home (PCMH) program, Person-Centered Medical Home Plus (PCMH+) program, Intensive Care Management (ICM), and Targeted Case Management (TCM) programs. In addition, the state will further promote improved care coordination through the upcoming implementation of the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. In 2021, OHS also operationalized Connie, the state's Health Information Exchange (HIE), which is responsible for connecting healthcare providers to enable the sharing of clinical information electronically, assisting in care coordination among providers, reducing preventable costs, supporting public health reporting, research, and population analytics, promoting standards and interoperability, and granting patients access to their medical information.

The shortage of primary care providers in Connecticut's rural towns, along with longer travel times and limited public transportation, creates significant barriers to care. National-level studies have shown that low-income rural adults, in particular, often lack reliable access to a regular primary care doctor and are more likely to skip necessary care,[60] putting these residents at greater risk of avoidable ED use.[61] Compared with non-rural Connecticut residents, rural patients face disproportionately long travel times to critical care facilities, including trauma centers,

Median Drive Time (minutes)	
Facility Type	**Rural**
Trauma Centers	32
Stroke Centers	26
Maternity Wards	24
Acute Care Hospitals	20
FQHCs (and Look-alike Sites)	14
Substance Use Centers	14
Nursing Facilities	10
Pharmacies	9

Table 7 - Median Drive Time by Facility Type [62]

stroke centers, labor and delivery units, and acute care hospitals. See the table below for a breakdown of travel times (in minutes) by facility type for rural Connecticut residents.[62]

For rural Connecticut patients managing chronic conditions, traveling to and between multiple outpatient healthcare facilities can be especially difficult to coordinate. As a result, rural adults commonly experience interruptions in treatment, poorer health outcomes, and higher overall healthcare costs due to an inability to reliably access care.[63] For example, a 2022 analysis of rural health conditions in Connecticut found that residents of predominantly lower-income rural areas were more likely to delay or forgo necessary medical care compared to residents of non-rural areas. The report's findings showed that 28.5% of Connecticut's rural residents reportedly delayed needed care in the past year compared to 26.6% of non-rural residents.[63] Residents of lower-income rural areas faced even more significant barriers to medical care, with 29.6% reporting having delayed care in the past year and 12.1% reported skipping needed care.[64]

Similarly, access to behavioral health services in Connecticut reflects a growing imbalance between demand and supply, particularly in rural regions. Litchfield and Windham counties, two of Connecticut's most rural and geographically dispersed regions, have among the lowest Medicaid behavioral health provider densities in Connecticut.[65] Rural communities are more likely than urban ones to lack behavioral health specialists, leaving primary care clinicians as the de facto providers of mental health and substance use care for many residents. Within Connecticut's Medicaid population, the rates of any mental health or substance use disorder are 15% and 14% higher, respectively, among those living in rural versus urban or suburban areas.[65] These facts exacerbate geographic, financial, and coordination barriers, resulting in many residents going without timely care or turning to EDs in crisis. Northeast and northwest Connecticut lacks crisis stabilization options outside of hospital EDs, forcing individuals in

behavioral health crises to seek care in settings ill-suited for recovery or continuity. According to DPH data (2016–2020), roughly 10% of all ED visits statewide were primarily due to behavioral health or substance use issues.[66] Among adults, 34% presented with psychoactive substance use disorders and 50% with mood or anxiety disorders, with 82% discharged within 24 hours, often without coordinated follow-up care or linkage to community-based supports.[67]

At the same time, the behavioral health workforce is under significant strain. A recent survey of nonprofit providers found that over 20% of positions were unfilled and that annual staff turnover reached 39%.[68] The combination of rising mental health needs, persistent workforce shortages, and inadequate rural infrastructure has deepened access challenges for residents, resulting in long wait times, limited-service availability, and heightened dependence on ED care. Collectively, these conditions underscore the urgent need for targeted strategies to expand rural behavioral health capacity and strengthen local care networks.

e. Technology and System Needs

As part of Connecticut's Statewide Health Information Technology Plan, which spans calendar years 2022–2026, the state is pursuing various activities to: (1) improve the availability of data to support better care, coordinated services, and accurate measurement of healthcare costs; (2) advance the adoption and use of health IT and HIE services; and (3) bolster the readiness of individuals and organizations to use information technology to make better decisions when providing or receiving care. The state made considerable strides in these areas, including connecting more than five million distinct patients and more than 3,000 provider organization sites to Connecticut's statewide HIE (Connie). Connie now processes about 1.7 million clinical summary documents, and 14 million lab results monthly.[69] Because many residents in Connecticut's rural areas lack reliable access to digital technologies, they face

significant barriers to telehealth and remote communications with their providers, many of whom are not in rural areas. These challenges are compounded when rural providers also lack adequate telemedicine systems or platforms, further limiting access to care.[70] Due to these combined challenges, rural patients often face reduced access to services, treatment delays, and ultimately poorer health outcomes compared to patients in communities with greater telemedicine access.[70]

The 2025 Health IT Annual Report identified numerous persistent challenges and outlined key next steps needed to advance the full implementation of the Health IT Plan. While OHS continues to engage a broad range of stakeholders to support providers' adoption of electronic health record (EHR) and HIE services, there remains a need for greater participation among behavioral health and other specialty providers across the state.[71] While all hospitals and clinical laboratories in Connecticut are required to maintain an EHR that is connected to Connie,[72] those in rural and other underserved areas have yet to comply with this mandate due to persistent technological and financial barriers.

According to OHS data, roughly 20% of Connecticut providers use EHR systems that present major interoperability challenges.[73] When applied to the 1,315 healthcare organizations in Connecticut's rural towns expected to connect with the statewide HIE, about 263 are likely to face similar barriers.[73] Many operate multiple locations, which further increases integration costs. Among priority providers, 12 of 17 FQHCs and roughly 150 nursing homes have not yet begun transmitting data, primarily due to financial and technical obstacles. Improved data exchange across these organizations would strengthen care coordination and patient outcomes.

Financial constraints extend beyond EHR system costs. Smaller rural providers also report limited staff capacity and added administrative expenses (e.g., obtaining legal counsel) as barriers to connectivity. Targeted technical assistance funds could help offset these costs,

ensuring that providers of all sizes can participate in the statewide HIE. Through RHT Program investments in Connie's infrastructure and accessibility, Connecticut will improve provider access to interconnected systems that promote data sharing and avoid unnecessary or duplicative testing, which is costly and a personal strain for rural residents facing transportation barriers. Reliable broadband access is also critical to full participation. While the Governor's 2023 Broadband Action Plan has significantly expanded coverage, reducing the number of homes without high-speed internet from 17,970 in 2022 to 4,472 in 2024,[74] gaps still remain, especially in low-income and rural communities. Technical assistance funding can help bridge these infrastructure and capacity divides, supporting access to the statewide HIE and advancing rural health transformation.[75] This is an essential building block to an accountable healthcare system that is rewarded on performance and outcomes rather than volume.

II. Rural Health Transformation Plan: Goals and Strategies

Connecticut's RHT Plan aims to strengthen the delivery of healthcare in rural communities by implementing sustainable models that improve access and quality. The state's 31 proposed projects collectively seek to expand the rural healthcare workforce, including provider availability and capacity, as well as modernize facilities' technological and physical infrastructure, align services with the needs of rural residents, expand the capabilities of and participation in the state's HIE, and promote virtual healthcare utilization among rural patients and providers. Through coordination among state agencies, hospitals, and community partners, Connecticut will invest approximately $938.4 million to build a more resilient system that emphasizes prevention, supports providers, and ensures high-quality care close to home.

The scale of Connecticut's RHT Plan reflects both the urgency and opportunity within the state's rural health system and builds upon existing Connecticut health infrastructure and

partnerships to incorporate and deliver evidence-based interventions across four critical initiatives: (1) *population health outcomes*, (2) *workforce*, (3) *data and technology*, and (4) *care transformation and stability*. These initiatives collectively establish the foundation for implementing statewide strategies, each as a distinct pathway for achieving the RHT Plan goals.

Connecticut will advance *Population Health Outcomes* through a $132.4 million investment focused on expanding access to preventive and primary care and addressing the social, behavioral, and non-clinical factors that influence health. Efforts to improve access and outcomes will enhance community-based care, expand coordination across rural service areas, and reduce barriers created by distance and provider shortages. By emphasizing prevention and early intervention, the state will improve chronic disease management, reduce avoidable hospitalizations, and strengthen the long-term health of rural residents.

The *Workforce* initiative, supported by a $58.1 million investment, focuses on building a stable, well-trained rural healthcare workforce through coordinated education, licensure, and retention strategies. Connecticut will strengthen partnerships among academic institutions, healthcare providers, and professional organizations to address shortages in critical areas and improve workforce distribution across HPSAs. This investment will create sustainable career pathways and modernize workforce infrastructure to support rural recruitment and retention.

With $74.3 million dedicated to *Data and Technology*, Connecticut will enhance technology use and expand data-driven solutions that enable providers to deliver better, more coordinated care. This investment will expand interoperability, telehealth capacity, and real-time data exchange across the continuum of care. Additionally, by investing in novel AI-powered technologies, including consumer-focused care management tools, enhanced care coordination and remote patient monitoring platforms, and an advanced population-level predictive modeling

mechanism to identify gaps in care, the state seeks to strengthen clinical decision-making, improve communication between providers, and promote access to remote monitoring technologies for rural residents.

Strong partnerships are essential to the RHT Plan's success. The state will fortify collaboration among hospitals, tribal organizations, FQHCs, emergency medical services (EMS) agencies, local and regional government agencies, and community-based organizations to promote shared accountability, financial stability, and coordinated service delivery. Specifically, as described in Section III below, the state's RHT Program includes a project to facilitate regional collaboratives to promote increased cooperation among a variety of healthcare, municipal and regional government, social service, and other stakeholders in each of the state's two largest rural areas. As funding becomes available for projects, entities, or vendors, Connecticut will ensure all procurements comply with 2 CFR 200.317–327 and state laws, maintaining transparent, competitive, and audit-ready processes that uphold fiscal integrity and maximize community benefit.

An investment of $673.6 million in *Care Transformation and Stability* will promote long-term sustainability for rural providers through innovative financial solvency strategies. Connecticut will expand opportunities to participate in value-based and alternative payment models, such as AHEAD, that reward quality, efficiency, and outcomes, ensuring predictable reimbursement and alignment across payers. Enhancing providers' ability to adopt performance-based compensation models will shift incentives toward improved individual health outcomes as opposed to high service volumes alone.

The state developed its curated list of 31 projects following a thorough cause identification process, through which various rural stakeholders were engaged and invited to

identify the barriers they see to accessing high quality healthcare in their communities, as well as opportunities for addressing those challenges. During this process and as described in Section I above, the state recognized that among the unique pressures faced by rural providers—including the state's one currently remaining standalone rural hospital—are consistently low patient volumes, a disproportionately high public payer mix, limited ability to attract and retain a strong workforce, limited transportation options, and long travel distances. The RHT Plan addresses these factors by supporting facility modernization and right-sizing (including evaluating potential adjustments in service lines and other business changes), optimizing service capacity, and strengthening the financial resilience of rural healthcare systems.

The table below summarizes the key risks driving rural healthcare instability that were identified and the strategies Connecticut will employ to address them through the RHT Plan.

Root Cause	Description	Mitigation Strategy	Aligned Initiative
Limited access to preventive and behavioral health services	Distance, transportation barriers, and lack of integrated behavioral health restrict early intervention.	Strengthen community-based service delivery and enhance behavioral health and primary care coordination.	Population Health Outcomes
Workforce shortages and uneven provider distribution	Persistent vacancies and limited training opportunities hinder access to care in rural areas.	Align education, recruitment, and licensure programs with HPSA needs to build a long-term workforce pipeline.	Workforce
Regulatory barriers to workforce mobility and innovation	Inconsistent licensure and restrictive regulatory frameworks limit system responsiveness.	Advance state legislative reforms that promote interstate practice, streamline licensure, and support innovative care models.	Workforce
Fragmented health data and limited interoperability	Rural providers lack access to shared data, leading to inefficiencies and gaps in coordination.	Extend HIE participation to rural providers, modernize health IT, and support telehealth adoption statewide.	Data and Technology
Low patient volume and payer mix imbalance	Rural hospitals experience limited patient flow and high reliance on public payers, reducing financial flexibility.	Expand participation in value-based payment models and support facility optimization to ensure sustainability.	Care Transformation and Stability
Operational inefficiencies and outdated facility infrastructure	Aging rural facilities and inefficient systems hinder modernization and care delivery.	Support facility right-sizing, shared service models, and infrastructure modernization to improve sustainability.	Care Transformation and Stability

Table 8 - Cause Identification

Connecticut will also pursue strategic **legislative and regulatory actions** to advance and sustain rural health transformation. These efforts include extending and enhancing participation in interstate licensure compacts, modernizing workforce regulations, reforming CON processes, and improving population health through increased access to nutritious foods and preventive care. Each policy change supports the Centers for Medicare & Medicaid Services' (CMS) vision for a flexible, responsive, and sustainable rural healthcare system that meets community needs over the long term. The table below summarizes Connecticut's status related to each of the Policy Actions (by technical score factor) identified in the Notice of Funding Opportunity (NOFO) and highlights targeted legislative and regulatory actions that the state will advance in the Spring 2026 legislative session where applicable.

Policy and Legislation	Connecticut Legislative and Policy Actions (Spring 2026 Legislative Session)	Technical Score
B. 2. Health and Lifestyle Prevention	Connecticut will pursue the implementation of the Presidential Fitness Test based on Executive Order 14327	TBD*
B. 3. SNAP waivers	Connecticut will pursue this policy action.	0
B. 4. Nutrition Continuing Medical Education	Connecticut will pursue this policy action.	25
C. 3. Certificate of Need (CON)	Connecticut will propose substantial reforms of CON requirements.	25
Note: Connecticut will propose substantial reform by the dates listed in the NOFO for B. 2., B. 3., B. 4., and C. 3.		

Table 9 - Policy Actions

Policy and Legislation		Status	Technical Score
D. 2. Licensure compacts	**Interstate Licensure Compacts**		
	Interstate Medical Licensure Compact (IMLC) (Physician Score)	Member state issuing non-SPL licenses[76]	50
	Nurse Licensure Compact (NLC)	NLC state[77]	100
	EMS Compact	Not a Member State[78]	0
	Psychology Interjurisdictional Compact (PSYPACT) (Psychology Score)	PSYPACT Participating State[79]	100
	Physician Assistants (PA) Compact (Physician Assistant Score)	Legislation enacted to become a PA Compact member – State is a Compact member[80]	100
D. 3. Scope of practice	**Healthcare Role**		
	Physician Assistants (PA Score)	Moderate Scope of Practice[81]	50
	Nurse Practitioners (NP Score)	Full Scope of Practice[82]	100
	Pharmacists (Pharmacist Score)	Restricted Authority[83]	0
	Dental Hygienists (Dental Hygienists Score)	Semi-Restricted Scope of Practice (5 tasks)[84]	50

Policy and Legislation		Status	Technical Score
E. 3. Short-term, limited-duration insurance (STLDI)		Connecticut will not be pursuing this policy action.	0
F. 1. Remote care services		Connecticut will pursue expanding remote care services.	TBD*
F. 1. Remote care services	**Remote Care Services[85]**		
	Medicaid payment for at least one form of live video	Live Video: Yes	100
	Medicaid payment for Store and Forward	Store-and-Forward: Yes (e-consult codes)	100
	Medicaid payment for Remote Patient Monitoring (RPM)	Remote Patient monitoring: No	0
	In-State licensing requirement exception	Yes	100
	Telehealth License/Registration Process (including special licenses)	Yes	100
Note: Technical score factors that include both Policy Action and Initiative-Based Factors are flagged as "TBD*"			

Table 10 - Legislative Status

The following **program key performance objectives** demonstrate Connecticut's commitment to measurable progress under each initiative by the end of FFY 2031:

RHT Goal	Connecticut Initiative	Key Objective	Baseline Data	Target (FFY 2031)
Make Rural America Healthy Again	Population Health Outcomes	• Expand rural residents' access to preventive, maternal, and community-based care. • Increase integration of behavioral health into rural and school-based settings. • Reduce avoidable ED utilization.	Will be set in Year 1	• By 2031, there will be an increase in rural resident access of 5% • 10% increase in behavioral health services, including referrals by 2031 • 5% year-over-year reduction by 2031
Workforce Development	Workforce	• Increase rural healthcare workforce by expanding training and medical professional access. • Improve recruitment and retention in rural areas through targeted incentives. • Increase access to skilled providers through expedited licensing in rural areas.	Will be set in Year 1	• 10% by 2031 • 5% by 2031 • 5% year-over-year by 2031
Tech Innovation	Data and Technology	• Increase care coordination, information sharing, and rural provider participation in statewide data systems. • Increase use of telehealth and remote monitoring. • Increase the capacity to evaluate population health outcomes across rural regions.	Will be set in Year 1	• 35% increase in HIE connected entities by 2031 • 30% increase in utilization by 2031 • 35% utilization by 2031

RHT Goal	Connecticut Initiative	Key Objective	Baseline Data	Target (FFY 2031)
Sustainable Access & Innovative Care	Care Transformation and Stability	• Increase financial and operational sustainability of rural healthcare facilities through data system efficiencies and Alternative Payment Model (APM) care adoption. • Increase the implementation of APM models, right-sizing strategies, and infrastructure investments. • Increase care coordination and efficiency across the rural healthcare system through integrated networks and shared resources.	Will be set in Year 1	• 3 healthcare facilities will achieve financial stability and data system efficiency by 2031 • Implement one new APM model, and one investment strategy by 2031 • Year-over-year increase of 10% in care coordination network participation by 2031
Note: This table summarizes the project-specific metrics detailed in Section VI. Metrics and Evaluation Plan, which includes a comprehensive set of performance measures and outcomes that exceed NOFO-mandated quantities.				

Table 11 - Legislative Status

For initiatives where baseline data are not initially available, participants will be required to submit standardized data by the end of Year 1, which will establish baseline measurements and inform assessment of progress toward milestones in subsequent years. By aligning strategies across *Population Health Outcomes*, *Workforce*, *Data and Technology*, and *Care Transformation and Stability* initiatives, Connecticut's RHT Plan delivers a coordinated, measurable, and sustainable approach to rural health transformation. The Plan will help to ensure that every resident in rural Connecticut has access to high-quality, person-centered care supported by a strong workforce, modern data systems, and financially stable providers.

Other Required Information – Factor A. 2: As of September 1, 2025, using the current HRSA definition of rurality, Connecticut has no state-certified or Demonstration CCBHC entities within the state, but has twelve active Substance Abuse and Mental Health Services Administration CCBHC sites, one of which meets HRSA's definition of rurality. **Factor A. 7:** Of the 39 Connecticut hospitals recognized in the October 30, 2024 CMS Hospital Provider Cost Report, 8, or 20.5%, receive Medicaid DSH payments.[14]

III. Proposed Initiatives and Use of Funds

Initiative #1: Population Health Outcomes

Description: The state will promote positive health outcomes for rural residents through the following activities: (1) facilitate access to prevention, primary care, dental, and behavioral health for residents of rural and partially rural Connecticut, with an emphasis on general wellness, healthy aging, and reliable mental health support; (2) build simple entry points to care in community settings by strengthening the capacity of primary care clinics, community health centers, rural health clinics, behavioral health providers and telebehavioral services, EMS and community teams, as well as schools, senior centers, parks, and other local organizations; (3) support mobile health delivery—operationalizing new primary care and dental vans will provide access to these services to residents of rural and Tribal communities, ensuring that care reaches people where they live and work; (4) establish a local facilitator or hub to convene partners and implement strategies that promote access to school-based mental health resources and referral, improve access to services for individuals with Autism Spectrum Disorder (ASD), expand preventive services for older adults, promote active living through community assets, and strengthen behavioral health support; and (5) improve access to mental health supports and ED diversion for adults; and (6) extend the *Family Bridge* nurse home visiting program for newborns and postpartum women to advance maternal and family health in the Northeastern and Northwestern planning regions.

Key stakeholders are identified in the Initiative #1: Population Health Outcomes Project Details table below. Agencies primarily responsible for implementing components of this initiative include the Department of Public Health (DPH), the Department of Aging and Disability Services (ADS), the Department of Energy and Environmental Protection (DEEP), the

Department of Mental Health and Addition Services (DMHAS), the Department of Social Services (DSS), and the Office of Early Childhood (OEC). Funds will support:

- Community delivery of healthy aging and falls prevention activities for older adults in senior and community sites, including evidence-based exercise classes, basic risk screening, home and environmental safety supports, transportation assistance, and promotion of active living using local park and trail assets.
- Behavioral health integration in primary care and community settings, including: rapid psychiatric consultation for adults adapted from ACCESS Mental Health; specialized ASD consultation for EDs, mobile crisis, and community providers; and enhanced, high acuity school-based mental health, mental health guidance and referral, collaborative care workflows, warm handoffs, and telebehavioral health capacity for rural residents.
- Expansion of universal nurse home visiting in rural regions, including the Family Bridge model, with perinatal behavioral health screening, lactation and nutrition support, safe sleep education, linkage to social resources, and a plan to reach approximately 3,600 births annually across the Northeastern and Northwestern Connecticut rural regions.
- Team-based chronic condition support within primary care for hypertension, diabetes, and chronic kidney disease, including pharmacist and nurse collaboration, practical remote monitoring where appropriate, care planning and medication management, community health worker navigation, and closed-loop referrals for transportation, nutrition, and other routine supports.
- Practical referral and data improvements that streamline navigation, confirm completion of services, and support basic population health tracking for access, control of chronic conditions, behavioral health follow-up, and preventive service use.

- Deployment of eight mobile health vans—anticipated to be four for primary care and four for dental care—to expand access to preventive, chronic, and oral health services in rural and underserved areas. At least one of each will serve federally recognized Tribal Nations. DPH will fund purchasing, outfitting, and launching of the program, with awardees coordinating routes and reporting on utilization and outcomes.

The projects below put this approach into practice across rural and partially rural communities.

Project Details			
Project	**Use of Funds**	**Description**	**Key Stakeholders**
Promoting Healthy Aging in Rural Connecticut Through Engaging Exercise	A	Bring an evidence-based, structured exercise program to senior centers in up to 30 municipalities in rural Connecticut.	ADS, Area Agencies on Aging
Outdoor Recreation Program	A	Increase rural residents' access to and participation in free, self-directed, outdoor recreation activities that support physical exercise, behavioral health, and chronic disease prevention through minor alterations of an existing, 50-mile, multi-model state park trail traversing the state's rural northeastern region and local partnerships in nine rural towns that increase public points of access and promote trail use.	DEEP
Expand ACCESS Mental Health Model to Adults	H, I, K	ACCESS Mental Health Connecticut offers real-time psychiatric consultation to medical providers when patients present with mental health and substance use concerns. This initiative expands on the ACCESS Mental Health model (which is available for youth and prenatal care) and coordinates behavioral health support across Connecticut to adult populations. This will equip primary care providers in rural areas with accessible and timely behavioral health expert support.	DMHAS, DSS, FQHCs, Primary care practices, CCBHCs, Mobile Crisis Teams, EDs, Tribal partners, Rural health providers
ACCESS Mental Health ASD Service Access	H, I, K	Provide specialized ASD services with the target being EDs, mobile crisis, and community mental health providers.	DSS, DCF, EDs, Mobile Crisis Teams, Rural health providers
ACCESS Mental Health Enhanced School-Based Mental Healthcare	H, I, K	Enhance school-based care, including high-acuity care, by providing clinical guidance/support and resource referrals for cases beyond in-school capabilities.	DSS, DCF, DMHAS, State Department of Education (SDE), School system partners, Clinical partners
Universal Nurse Home Visiting Expansion	A, G, K	Expand Family Bridge universal nurse home visiting services into the two largest HRSA-designated regions of the state —Northeastern and	OEC, DPH, Local health and early childhood providers,

Project Details			
Project	**Use of Funds**	**Description**	**Key Stakeholders**
		Northwestern, Connecticut—serving an estimated 3,600 births annually in these regions.	hospitals, FQHCs, Tribal partners
Mobile Clinic Pilot	A, G, I, K	Support four health vans for primary care and four for dental care with at least one of each designated to serve our two federally-recognized Tribal Nations.	DPH, FQHCs, Tribal partners
Main strategic goal: Make Rural America Healthy Again **Technical score factors:** B. 1., B. 2., C. 1., D. 3., F. 1.			

Table 12 - Initiative #1: Population Health Outcomes Project Details

Outcomes (non-exhaustive)				
Increase the number of rural families utilizing coordinated maternal health services	Increase the number of rural primary care providers participating in ACCESS Mental Health models	Programs consistently achieve full enrollment and retention	Reduce ED and mobile crisis utilization among individuals with ASD	Reduce ED utilization related to chronic disease
Note: This table summarizes the initiative-specific metrics detailed in Section VI. Metrics and Evaluation Plan, which includes a comprehensive set of performance metrics, including baseline data and target plans, which exceed NOFO-mandated quantities.				

Table 13 - Outcomes

Impacted counties: Litchfield, Windham, New London, New Haven, Tolland, Middlesex, Hartford, Fairfield. **Impacted planning regions:** Northwest Hills, Northeastern Connecticut, Capitol Region, Connecticut Metro, Lower Connecticut River Valley, Naugatuck Valley, South Central Regional, Southeastern Connecticut, Western Connecticut.

Estimated required funding for Initiative #1 Population Health Outcomes: $132,445,000

Initiative #2: Workforce

Description: Connecticut's RHT Workforce Initiative strengthens and sustains the people who form the foundation of rural healthcare. Workforce shortages across the state's hospitals, community health centers, behavioral health agencies, and long-term care providers continue to limit access and increase strain on already stretched systems. This initiative addresses those challenges by expanding education and training opportunities, aligning licensure and certification standards, and improving recruitment and retention across all levels of care. The

goal is to build a coordinated, durable system that connects education, employment, and advancement so that every community has consistent access to high-quality care.

Through collaborations with DPH, higher education institutions, workforce boards, professional associations, and healthcare providers, this initiative builds an integrated network that supports workforce readiness at every level. Training programs will become more accessible, certifications will transfer easily between care settings, and opportunities for advancement will be clear and attainable. By expanding clinical placements, modernizing training curricula, and removing barriers to employment in rural areas, Connecticut will develop a stronger healthcare workforce, improving access to services for rural residents.

To achieve these goals, Connecticut will invest in coordinated strategies that strengthen training pipelines, remove practice barriers to education, and enhance career development opportunities across rural and partially rural regions. Funds will support:

- Increasing the number of physician residency programs in rural primary care and behavioral health shortage areas and supporting program design, resident recruitment, and alignment with national accreditation and match processes to strengthen the rural workforce.
- Providing partial salary support for facilities in rural and underserved areas to hire non-licensed professionals at competitive wages, helping build staffing capacity and attract workers to high-need communities.
- Implementing the Strengthening Talent Infrastructure for Training, Care, and Health (STITCH) 4 CT initiative, a five-year Connecticut Area Health Education Center (AHEC)-led program to develop a workforce pipeline that supports recruitment, retention, and advancement from high school to licensed practice.

- Expanding Certified Nurse Aide (CNA) training so that certification applies across all healthcare settings, not only nursing homes, ensuring consistent, high-quality preparation for professionals who deliver direct care. Practicum opportunities will include hospitals, clinics, and home health agencies located in rural areas, providing broader experience and more employment options statewide.
- Establishing a centralized Certified Medication Administration training program within Connecticut's community college system to standardize education and increase access across care settings, allowing CNAs to practice to the full extent of their training and experience across a larger array of healthcare settings. This model consolidates multiple agency-based programs into one streamlined, consistent approach. Graduates will enter the workforce fully trained to their scope and prepared for certification recognized across healthcare environments, including home health, hospice, and rural facilities.
- Supporting DPH's implementation of various interstate licensure compacts, including the Interstate Medical Licensure Compact (IMLC), which expedites licensure across state lines and expands access to qualified clinicians in rural communities. Funds will support additional staff to provide outreach to increase rural participation and to review background checks, verify credentials, and issue qualification letters, ensuring timely processing and compliance with compact requirements.
- Providing technical assistance and training in areas such as care coordination, billing, and supervision to promote sustainability and support retention in rural facilities.
- Offering financial incentives to help offset barriers to practicing in rural areas, such as childcare and housing, allowing providers to remain in and serve rural communities.
- Partnering with healthcare facilities, academic institutions, and professional associations

to expand clinical training sites, rural mentorship programs, preceptorships, and continuing education opportunities in rural regions.

The projects below put this approach into practice across rural and partially rural communities.

Project Details			
Project	**Use of Funds**	**Description**	**Key Stakeholders**
Formalize CNA Training	E, G, K	Formalize the CNA training to make it applicable to all healthcare settings.	DPH, Education partners, Employer partners
Formalize Medication Administration Training	E, G, K	Centralize medication administration training at the state's community colleges.	DPH, Education partners, Employer partners
Interstate Licensure Compact Support	E, G, K	Support the process of fully implementing various interstate licensure compacts to expedite licensure across state lines and increase participation in rural areas.	DPH, Medical Society, Licensing boards, Rural hospitals, FQHCs
Rural Provider Incentives	E	Incentives are distributed annually and may be used flexibly to help providers remain in rural practice.	DPH, Rural hospitals, Health centers
Rural Residency Development Grant	E	Add physician residency programs in primary care and/or behavioral health, strengthening the rural workforce through program design, resident recruitment, and alignment with national accreditation and the match program.	UCHC, DPH, ACGME, NRMP, Rural hospitals, Health centers, Education partners
Salary Supplements for Non-Licensed Healthcare Workers	E	Provide partial salary incentive support for facilities in rural and underserved areas to hire non-licensed professionals above market rate, helping strengthen staffing and attract workers to high-need communities.	DPH, Hospitals, FQHCs, Health providers, Education partners,
Area Health Education Center (AHEC) Expansion	E	Build a quality-driven rural health workforce pipeline, addressing staffing retention, financial sustainability, and access barriers through coordinated programs from high school to licensed practice.	AHEC, UCHC, Education partners, FQHCs, Rural hospitals, Health centers
Main strategic goal: Workforce **Technical Score factors:** C.1., D.1., D.2., D.3., F.1.			

Table 14 - Initiative #2: Workforce Project Details

Outcomes (non-exhaustive)			
Increase the number of full-time equivalent healthcare providers	Rural providers experience faster credentialing and onboarding	Healthcare providers experience a 5% increase in interstate licensure compact enrollment year-over-year	Rural non-licensed providers demonstrate higher retention rates
Increase the hiring of Certified Nurse Aides in non–nursing home settings		Maximize 5-year retention rate among primary care and behavioral health providers who received RHT-funded recruitment and retention incentives in rural HPSAs.	
Note: This table summarizes the initiative-specific metrics detailed in Section VI. Metrics and Evaluation Plan, which includes a comprehensive set of performance metrics, including baseline data and target plans, which exceed NOFO-mandated quantities.			

Table 15 - Outcomes

Impacted counties: Litchfield, Windham, New London, New Haven, Tolland, Middlesex, Hartford, Fairfield. **Impacted planning regions:** Northwest Hills, Northeastern Connecticut, Capitol Region, Connecticut Metro, Lower Connecticut River Valley, Naugatuck Valley, South Central Regional, Southeastern Connecticut, Western Connecticut.

Estimated required funding for Initiative #2 Workforce: $58,150,000

Initiative #3: Data and Technology

Description: Connecticut's Rural Health Transformation Data and Technology Initiative seeks to strengthen the digital foundation of care delivery across rural and partially rural communities. Rural providers often face barriers that limit access to timely, coordinated, and efficient care, including limited interoperability, inconsistent data systems, and insufficient capacity to use real-time information to guide decision-making. This initiative addresses those challenges by expanding statewide HIE participation, building shared technology infrastructure, and supporting innovative data tools that connect providers, improve care coordination, and ensure access to modern health systems for rural residents. Through collaboration with OHS, DPH, DSS, and Connecticut's statewide HIE, Connie, the initiative creates a fully integrated data ecosystem that enables providers to share information, track outcomes, and respond quickly to patient needs. Hospitals, FQHCs, long-term care providers, behavioral health providers, and EMS will be better connected through shared tools for population health management, event notification, and predictive analytics. These systems will improve care coordination, reduce unnecessary ED use, and support proactive outreach and chronic disease management in rural settings.

By advancing digital infrastructure and data-sharing capabilities, Connecticut will ensure that rural residents receive coordinated, data-driven care, while supporting local providers to remain independent and financially sustainable. Funds will support:

- Expanding consumer-facing digital tools that help residents manage their health, access information, and securely connect with local care teams through easy-to-use technology.
- Developing integrated care networks that link rural hospitals, community health centers, long-term care providers, EMS agencies, and community-based organizations through shared staffing, telehealth connectivity, and coordinated referral systems.
- Expanding participation in Connecticut's HIE (Connie) by subsidizing onboarding costs and providing technical assistance for FQHCs, behavioral health providers, rural nursing homes, and EMS agencies to improve care transitions and follow-up.
- Establishing a predictive analytics and care coordination platform that uses existing data assets, such as Connie and the state's all-payer claims database, to identify high-risk patients, flag preventable hospitalizations, and support community-based interventions.
- Building shared IT infrastructure and telehealth capacity for rural hospitals and providers to ensure full interoperability, secure data exchange, and remote access to care.
- Implementing a statewide bed capacity tracking system to provide real-time visibility into hospital capacity, improve transfers, and reduce overcrowding.
- Supporting the adoption of AI-enabled remote patient monitoring, virtual care platforms, and connected devices to strengthen chronic disease management, behavioral health engagement, and maternal care access in rural and tribal communities.
- Expanding consumer-facing digital tools that help residents manage their health, understand treatment options, and securely connect with local care teams through patient-friendly technology. The projects below put this approach into practice across rural and partially rural communities.

Project Details			
Project	**Use of Funds**	**Description**	**Key Stakeholders**
Bridging the Digital Divide	A, C, D	Expand digital access and literacy for older adults and individuals with disabilities in rural Connecticut by providing technology, training, and support to strengthen social connection, telehealth access, and participation in virtual programs through coordinated community partnerships and local digital inclusion efforts.	ADS, UCHC, Senior centers, Education partners, Tribal partners
Integrated Care Network	D, F, G, I, J, K	Unite rural hospitals, FQHCs, long-term care providers, EMS agencies, and community organizations through shared staffing, telehealth integration, population health analytics, and coordinated referral pathways, creating a unified system of care that strengthens prevention, chronic disease management, and access to essential services for residents in underserved areas.	DSS, Rural hospitals, FQHCs, Health providers, EMS, Community organizations, Tribal partners
HIE Expansion for Rural Providers, EMS, and Nursing Homes	D, F, G, H, K	Expand participation in Connecticut's HIE, Connie, by supporting rural and community providers with onboarding and technical assistance, implementing real-time event notifications to improve care coordination, integrating EMS data to strengthen response and follow-up, and introducing a consent management system that gives residents meaningful control over their health information.	OHS, DPH, FQHCs, Health clinics, Rural hospitals, Skilled nursing facilities (SNFs), EMS, Tribal partners
Connecticut Rural Predictive Analytics and Care – Coordination Platform (CR-PACP)	A, D, E, F, G, H, I, K	Leverage existing data systems to identify patients and communities at high risk for emergency visits and avoidable hospitalizations, providing actionable insights, coordinated care tools, and a clinician-led governance model to guide ethical use, improve prevention and chronic care, and strengthen outcomes in rural communities.	OHS, Rural hospitals, FQHCs, Health providers, Health clinics, SNFs, Tribal partners
Rural Health Transformation through Shared Infrastructure and Telehealth Innovation	A, D, E, F, G, H, I, J, K	Expand telehealth services and building shared IT infrastructure that enables rural providers to deliver connected, high-quality care, reduce preventable hospital use, and strengthen the long-term sustainability of rural health systems.	OHS, Rural hospitals, FQHCs, Health providers, Health clinics, SNFs, Tribal partners
Connecticut Healthcare Bed Capacity Tracking System	F, G, H, K	Create a statewide, real-time platform for monitoring hospital capacity through shared data, improving coordination among hospitals, reducing overcrowding and transfer delays, and ensuring patients receive the right level of care faster while promoting access, efficiency, and sustainability across all Connecticut hospitals.	OHS, Rural hospitals, FQHCs, EMS, Health providers, Health clinics, SNFs, Tribal partners
Consumer AI-Powered Care Management Tools	C, D, F	Modernize rural healthcare through AI-enabled remote monitoring and virtual care, help providers manage patients in home and community settings, reduce avoidable hospitalizations, and improve outcomes while addressing workforce shortages and ensuring accessibility, safety and sustainability. The program supports the adoption of advanced remote monitoring technologies supported by provider training, patient engagement, and input from a statewide patient and family advisory board.	OHS, DSS, Rural hospitals, FQHCs, EMS, Health providers, Health clinics, SNFs, Tribal partners

Project Details			
Project	**Use of Funds**	**Description**	**Key Stakeholders**
Main strategic goal: Tech Innovation **Technical score factors:** B.1., C.1., C.2., D.1., D.3., E.2., F.1., F.2., F.3.			

Table 16 - Initiative #3: Data and Technology Project Details

Outcomes (non-exhaustive):						
Increased participation by rural providers, EMS agencies, and SNFs in the state HIE	Improved consumer access to telehealth-enabling technology	Rural hospitals, clinics, and community partners adopt a shared predictive-analytics platform	Increase utilization of specialty e-Consults and RPM services	Establish integrated data and reporting frameworks	Rural providers expand remote care and remote monitoring interventions	Establish a statewide automated bed capacity tracking system
Note: This table summarizes the initiative-specific metrics detailed in Section VI. Metrics and Evaluation Plan, which includes a comprehensive set of performance metrics, including baseline data and target plans, which exceed NOFO-mandated quantities.						

Table 17 - Outcomes

Impacted counties: Litchfield, Windham, New London, New Haven, Tolland, Middlesex, Hartford, Fairfield. **Impacted planning regions:** Northwest Hills, Northeastern Connecticut, Capitol Region, Connecticut Metro, Lower Connecticut River Valley, Naugatuck Valley, South Central Regional, Southeastern Connecticut, Western Connecticut.

Estimated required funding for Initiative #3 Data and Technology: $74,250,000

Initiative #4: Care Transformation and Stability

Description: Connecticut's Care Transformation and Stability initiative strengthens the foundation of rural healthcare by supporting infrastructure and right-sizing support, improving care coordination, as well as supporting value-based models and sustainable financing strategies that enable providers to deliver consistent, high-quality care in their communities. Rural regions continue to face persistent challenges such as workforce shortages, limited behavioral health access, and narrow operating margins. This initiative supports integrated systems of care that expand access to community-based services, reduce reliance on hospital-based interventions, and improve financial resilience for local providers. The initiative also supports the development of

23-hour adult crisis stabilization units that provide short-term, non-hospital crisis care in safe, home-like environments. These units serve as essential diversion sites from EDs, offering immediate stabilization, observation, and follow-up care for individuals experiencing behavioral health crises. By expanding these services to rural areas, Connecticut will reduce unnecessary hospitalizations, improve outcomes, and close longstanding service gaps.

In addition to behavioral health services, this initiative invests in the long-term stability of rural hospitals, community health centers, and behavioral health providers. Through collaboration with DSS, DMHAS, and OHS, the initiative will provide technical assistance, promote coordinated service delivery, and strengthen VBP participation. The goal is to build a sustainable healthcare system that supports providers and patients. Funds will support:

- A state-coordinated infrastructure and right-sizing program to help providers transform rural facilities and services to better meet the needs of their communities and facilitate long term solvency.
- Establishing 23-hour adult crisis stabilization units in rural areas to deliver immediate behavioral healthcare and reduce ED utilization.
- Developing integrated behavioral and primary care models that strengthen coordination and access across rural and underserved regions.
- Providing technical and financial assistance to rural hospitals and community-based providers preparing for value-based care and population health models.
- Supporting embedded care coordination in primary care practices serving rural Medicaid members.
- Implementing a PACE initiative that serves dually eligible older adults in the rural Northwest Hills planning region.

- Advancing reimbursement models and incentive structures that reward improved outcomes and operational efficiency.
- Facilitating regional collaboratives to promote shared learning, resource optimization, and sustainable financial performance across rural health networks.

The projects below put this approach into practice across rural and partially rural communities.

Project Details			
Project	**Use of Funds**	**Description**	**Key Stakeholders**
Adult 23-Hour Crisis Stabilization Units	G, H, K	Expand existing crisis stabilization model to rural areas, offering short-term, home-like alternatives to EDs for individuals experiencing behavioral health crises. These centers provide 23-hour observation and stabilization services, reducing unnecessary hospital visits and supporting the state's 988 Crisis Lifeline network expansion through faster, community-based intervention and care coordination.	DMHAS, EDs, Rural hospitals, Crisis units, EMS, Community-based organizations (CBOs), Tribal partners
Mobile Integrated Health Pilot	A, G, I, K	Pilot program to bring preventive, chronic, and post-acute care directly into homes and communities through partnerships with EMS, hospitals, and local health and social service agencies. The program will focus on follow-up care, chronic disease management, behavioral health support, and coordination with community resources to reduce hospitalizations and improve wellness. This pilot will collect data on outcomes to support the design of future reimbursement models and potential expansions of Mobile Integrated Health (MIH) services.	DPH, EMS, Hospitals, primary care, Health providers, CBOs, Tribal partners
Connecticut Rural Hospital Transformation and Rural Health Facility Right-Sizing and Infrastructure Program	D, G, I, J, K	Help rural and rural-serving hospitals and other eligible provider facility types strengthen financial stability, right-size service array to match local need, improve operations, prepare for value-based care, and complete minor alterations and renovations projects. Through individualized technical assistance and peer learning, facilities will build the capacity to modernize systems, enhance care coordination, and sustain high-quality, community-based services. This is intended to support rural facilities' financial sustainability, including rural hospitals; rural-serving chronic disease hospitals; and tribe-operated health centers, and their ability to continue providing needed care to their communities. It is anticipated that grants will be prioritized in the following order: (i) independent or university-affiliated hospitals located in rural areas, (ii) health system-affiliated rural hospitals, (iii) rural-serving hospitals and rural-serving chronic disease hospitals, and (iv) all other eligible provider facility types, and will be awarded through a rigorous application process. The program may be scaled to include or exclude rural or rural-	DSS, OHS, OPM, Rural hospitals, UCHC, Health providers, Health clinics, EMS, CBOs, Tribal partners

Project Details			
Project	**Use of Funds**	**Description**	**Key Stakeholders**
		serving provider types to the extent necessary based on available funding. As part of this process, each facility must submit and implement a state-approved plan, to improve financial sustainability, quality of care, cost containment, appropriate access to services needed by their rural patient communities, and other criteria to be determined by the state as part of a formal application process.	
Improving Primary, Maternal, Behavioral, and Dental Health through Direct Investment and Value-Based Payment (VBP)	A, B, D, G, I, K	Support rural primary care providers in achieving NCQA PCMH certification, as well as assisting rural primary care, maternal, behavioral health, and dental health providers in improving care delivery, such as adopting EHRs and integrating emerging technologies (e.g., remote monitoring and virtual care), and completing Minor Alterations and Renovations projects. Continue development of payment models that sustain rural providers through value-based arrangements.	DSS, Health providers, FQHCs, Rural hospitals, Health clinics, CBOs, Tribal partners
Program for All-Inclusive Care for the Elderly (PACE)	A, G, H, I, J, K	Establish a hub to extend comprehensive, coordinated care to older adults dually eligible for Medicare and Medicaid in surrounding rural communities. The regional hub will integrate primary, behavioral, and long-term care, reduce avoidable hospitalizations, support aging in place, promote independence, and avoid/delay premature institutional nursing home care through a sustainable, community-based model that leverages the urban-rural connections between towns.	DSS, OPM, PACE organizations, CBOs, Health providers, EMS, Rural hospitals, Tribal partners
Regional Collaboratives	K	Create regional coordination anchors to align RHT Plan initiatives, strengthen collaboration among agencies and local partners, and reduce duplication. These anchors will coordinate services, integrate efforts with existing infrastructure, and support sustainability through shared planning, community engagement, and pursuit of additional funding for sustainability.	DSS, Local governments, FQHCs, Health providers, CBOs, Health clinics, Rural hospitals, Tribal partners
Community Health Navigator Program	A, C, G, I	Pilot a regional community health navigator program to connect rural residents with essential health and preventive services and facilitate patients' use of consumer-facing health technologies. Community health navigators will contribute to the success of the broader RHT Program and will build awareness of programs created, as well as promote rural residents' participation in preventive health programs and services, including mental health and fitness projects.	DSS, ORH, Local governments, FQHCs, Health providers
High Acuity School-Based Behavioral Health Programming	A, B, C, D, E, F, G, H, I, K	Develop a model to strengthen mental and behavioral health systems across identified rural school districts. The assessment of existing programs, staffing, and resources to identify gaps and guide the design of systems of integrated, evidence-based supports for students and staff. Through data-driven evaluation, training, partnerships, and improved referral systems, the model will build a coordinated framework and systems of support that promote student well-being and	SDE, CCBHCs, FQHCs, Health providers, Health clinics, Crisis system

Project Details			
Project	**Use of Funds**	**Description**	**Key Stakeholders**
		academic success through a "push-in" approach for high acuity cases and promotion of telehealth.	
Main strategic goal: Sustainable Access, Innovative Care **Technical score factors:** B.1., C.1., D.1., D.2., D.3., E.1., E.2., F.1., F.2., F.3.			

Table 18 - Initiative #4: Care Transformation and Stability Project Details

Outcomes (non-exhaustive)			
Complete right-sizing and transformation efforts for rural or rural-serving facilities, achieving measurable improvements in financial stability, service alignment, and care quality.	Expand access to and network adequacy of primary, maternal, behavioral, and dental health services in rural areas	Demonstrate measurable improvement in care coordination performance, including increased participation in shared care plans, timely follow-up after hospital discharge, and enhanced integration with behavioral health and community services	Demonstrate a reduction in avoidable ED visits and hospital readmissions, including for behavioral health
Establish and pilot MIH programs	Expand adoption of VBP arrangements	Establish and operate 23-hour crisis stabilization units in rural and underserved areas	
Note: This table summarizes the initiative-specific metrics detailed in Section VI. Metrics and Evaluation Plan, which includes a comprehensive set of performance metrics, including baseline data and target plans, which exceed NOFO-mandated quantities.			

Table 19 - Outcomes

Impacted counties: Litchfield, Windham, New London, New Haven, Tolland, Middlesex, Hartford, Fairfield. **Impacted planning regions:** Northwest Hills, Northeastern Connecticut, Capitol Region, Connecticut Metro, Lower Connecticut River Valley, Naugatuck Valley, South Central Regional, Southeastern Connecticut, Western Connecticut.

Estimated required funding for Initiative #4 Care Transformation and Stability:

$673,555,121

IV. Implementation Plan and Timeline

Connecticut has developed a focused and achievable plan to guide the RHT Program from FFY 2026 through FFY 2031. The Implementation Plan and Timeline organize work across four connected initiatives—Population Health Outcomes, Workforce, Data and Technology, and

Care Transformation and Stability—that will improve access, quality, and sustainability in rural and underserved communities.

Each initiative follows the federally defined Stages 0–5 framework, progressing from planning through implementation and evaluation to full integration within existing state systems, with demonstrated goal attainment and measurable, reportable outcomes. This structured approach ensures that activities are built upon one another and that progress can be measured and reported consistently over the life of the cooperative agreement.

Implementation Phases

The table below represents the implementation plan and timeline, with various stages of implementation in compliance with the NOFO. Progress will be tracked through quarterly status reports, semi-annual fiscal reviews, and annual outcome evaluations.

Phase	Timeframe	Milestone	Key Activities
Initiative 1: Population Health Outcomes			
Stage 0	FFY 2026 Q1–Q3	Program Design & Procurement	Utilize framework for population health improvement; establish goals, partners, and performance indicators.
Stage 1	FFY 2026 Q4–FFY 2027 Q3	Initial Implementation	Launch targeted initiatives addressing chronic disease, behavioral health, and maternal outcomes in rural areas.
Stage 2	FFY 2027 Q4–FFY 2028 Q4	Expansion & Monitoring	Expand participation across additional providers and regions; monitor key health outcome metrics.
Stage 3	FFY 2029	Evaluation & Refinement	Assess program outcomes, population-level improvements, and cost savings; refine strategies as needed.
Stage 4	FFY 2030–FFY 2031 Q2	Goal Completion & Transition	Integrate successful models into state programs and value-based care frameworks; document lessons learned.
Stage 5	FFY 2031 Q3–Q4	Fully implemented	Achieve rural health improvement benchmarks and sustain long-term outcomes.
Initiative 2: Workforce			
Stage 0	FFY 2026 Q1–Q3	Program Design & Procurement	Develop rural workforce strategy; establish eligibility criteria and funding mechanisms.
Stage 1	FFY 2026 Q4–FFY 2027 Q3	Initial Implementation	Begin coordinated recruitment and training programs across multiple health disciplines.
Stage 2	FFY 2027 Q3–FFY 2028 Q4	Expansion & Monitoring	Expand training programs and implement workforce retention initiatives in rural and high-need areas.
Stage 3	FFY 2029	Evaluation & Refinement	Review progress; adjust training capacity and incentives based on performance data.
Stage 4	FFY 2030–FFY 2031 Q2	Goal Completion & Transition	Incorporate successful workforce strategies into ongoing state operations and policy frameworks.
Stage 5	FFY 2031 Q3–Q4	Fully implemented	Workforce initiatives fully operational; sustained improvement in recruitment, retention, and provider distribution.

Phase	Timeframe	Milestone	Key Activities
Initiative 3: Data and Technology			
Stage 0	FFY 2026 Q1–Q3	Program Design & Procurement	Define strategy for data integration, telehealth, and digital access; establish governance and funding guidelines.
Stage 1	FFY 2026 Q4–FFY 2027 Q3	Initial Implementation	Initiate technology grants supporting HIE participation, telehealth expansion, and data modernization.
Stage 2	FFY 2027 Q3–FFY 2028 Q4	Expansion & Monitoring	Expand data sharing and interoperability across rural and community health systems.
Stage 3	FFY 2029	Evaluation & Refinement	Evaluate and refine strategy regarding data utilization, interoperability, and impact on care coordination and efficiency.
Stage 4	FFY 2030–FFY 2031 Q2	Goal Completion & Transition	Transition successful systems into state and Medicaid infrastructure; formalize sustainability plans.
Stage 5	FFY 2031 Q3–Q4	Fully implemented	Digital infrastructure fully integrated; sustained improvements in data-driven decision-making.
Initiative 4: Care Transformation and Stability			
Stage 0	FFY 2026 Q1–Q3	Program Design & Procurement	Establish framework for rural hospital transformation and value-based payment integration.
Stage 1	FFY 2026 Q4–FFY 2027 Q3	Initial Implementation	Begin technical assistance and initial transformation projects to strengthen operational efficiency.
Stage 2	FFY 2027 Q3–FFY 2028 Q4	Expansion & Monitoring	Extend participation in transformation and financial stability initiatives; align with regional collaboratives.
Stage 3	FFY 2029	Evaluation & Refinement	Assess financial performance, service delivery improvements, and sustainability indicators.
Stage 4	FFY 2030–FFY 2031 Q2	Goal Completion & Transition	Incorporate successful care transformation models into Medicaid and the overarching healthcare system.
Stage 5	FFY 2031 Q3–Q4	Fully implemented	Improved stability and strengthened hospitals and health systems; care transformation models embedded.

Table 20 - Implementation Plan and Timeline

Legislative Policy and Regulatory Actions

To support implementation, Connecticut will complete required policy and regulatory actions by December 31, 2027, with remaining technical updates finalized by December 31, 2028, in accordance with federal guidance. Activities with pending state legislation include:

Initiative	Legislation
Population Health Outcomes	Submit a request for a SNAP waiver to promote the purchase of healthy food options (e.g., prohibiting use of SNAP benefits for energy drinks and/or candy); and explore opportunities for including nutrition as a requirement for CME to emphasize chronic-disease prevention and food-security screening.
Workforce	Standardize CNA and medication-administration training across care settings; make permanent the Nurse Licensure Compact; and support full implementation of the Interstate Medical Licensure Compact to streamline physician licensing, including any conforming changes that will allow Connecticut to issue interstate licenses to Connecticut physicians.
Data and Technology	Expand the state HIE to include EMS, long-term care, and behavioral-health providers; modernize privacy and consent regulations to support interoperability; and establish a consistent consent-management framework.
Care Transformation and Stability	Align Medicaid's value-based payment models with hospital transformation goals, update cost-reporting and licensure standards, and formalize sustainability metrics for rural facilities; enact legislation to reform CON to streamline market activities.

Table 21 - Activities Pending Legislation

Program Governance, Management Structure, and Coordination

Program management will be led by DSS, in collaboration with OHS, DPH, OPM, ORH, and other implementing agencies. These agencies will coordinate strategy, fiscal oversight, and evaluation through a joint implementation team. A Project Director and an Assistant Project Director within DSS will oversee the Division of Rural Health Transformation, responsible for day-to-day coordination and reporting. Two Lead Planning Analysts will coordinate activities for distinct geographic areas, supporting the Regional Collaboratives and on-the-ground coordination among RHT Program-funded organizations and activities. Two Grants and Contracts Specialists, a Staff Attorney, and five Accountants will monitor budgets and procurement, support performance measure tracking, and prepare reports. Also, especially for budget period 1 while state staff are being hired and trained and to a lesser extent in budget period 2, DSS will contract with an outside grants management vendor to provide overall support to DSS in managing the RHT Program. DSS will also contract with an outside evaluation entity for independent evaluation. DSS will directly coordinate with program leads from all implementing state agencies. In addition, a Rural Health Transformation Advisory Council composed of representatives from implementing agencies and relevant stakeholders will convene quarterly to review progress and resolve issues.

V. Stakeholder Engagement

Stakeholder Engagement Strategy

Connecticut has prioritized inclusive and meaningful stakeholder engagement in the development of its RHT Program application. Our approach has been guided by the principle that rural health transformation must be community-informed and locally responsive.

Planning Phase Engagement of Rural Stakeholders

DSS, in collaboration with OPM and ORH, led a coordinated stakeholder engagement process. This included: (1) an open written public comment opportunity from September 16 to October 9, widely distributed through multiple channels, garnering over 250 submissions; (2) three public listening sessions, two in-person in rural communities and one virtual, with a combined total attendance of over 80 attendees; (3) multiple key informant discussions, including with both federally-recognized tribes in the state; and (4) bipartisan briefings with legislative leaders and legislators, as well as legislative staff.

The proposed initiatives were directly informed and revised after the individual meetings, briefings, and discussions with a wide range of rural and rural-serving stakeholders listed in the table below, including:

Stakeholder Groups	Details
State Agencies	DSS, Office of Rural Health, Office of Policy and Management, OHS, OEC, DMHAS, DCF, DEEP, ADS, DPH, SDE, Department of Agriculture, Department of Developmental Services, Department of Consumer Protection, Office of Workforce Strategy, and the State Chief Information Officer.
State Legislators	Bipartisan groups of legislators on key committees of cognizance and legislative leadership from both major political parties.
Academic and Data Partners	University of Connecticut Health Center, Quinnipiac University, University of Connecticut School of Pharmacy, University of Connecticut School of Medicine, Tobin Center for Economic Policy, Northeast Rural Health Research Center, and DataHaven.
Local Public Health	Connecticut Association of Directors of Health and local rural health districts.
Social Services & Community-Based Organizations	Northwest Hills Council of Governments, Rural-serving Community Action Agencies, and AHEC.
Rural Serving Philanthropy	Community Foundation of Eastern Connecticut, Foundation for Community Health, Northwest Connecticut Community Foundation.
Healthcare Providers	Rural and rural-serving hospitals and FQHCs.
Professional Associations	Connecticut Hospital Association, Community Health Center Association of Connecticut, Connecticut State Medical Society, Connecticut Association for Community Action, New England Rural Health Association.
Advisory Bodies	AHEAD Advisory Committee, Health Care Cabinet.
Federally Recognized Tribal Communities	Mashantucket Pequot Tribal Nation, Mohegan Tribe.

Table 22 - Stakeholder Engagement

Consistent with the process for Connecticut's federal tribal consultation policy in the CMS-approved Medicaid State Plan, DSS reached out to tribal leadership and tribal points of contact at the two federally recognized tribes in Connecticut, specifically the Mashantucket Pequot Tribal Nation and the Mohegan Tribe. The state provided the tribes with a summary of the RHT Program approach, offered the tribes an opportunity to participate in the public engagement process, and consulted individually with each tribe. Following additional outreach, feedback was incorporated into the final implementation plan, and the tribes provided written materials directly supporting the state's planning efforts.

The overall outreach effort engaged a broad cross-section of stakeholders representing healthcare, social services, public health, community, and tribal organizations across rural Connecticut. These communications provided critical insight into the distinct healthcare challenges faced by the rural population and informed strategies to ensure that the proposed initiatives reflect the full range of rural priorities and promote sustainable partnerships.

Ongoing Engagement and Governance

In addition to the planned Rural Health Transformation Advisory Council referenced above, the state's RHT Program will establish and fund two regional collaboratives—one serving the northwest and one serving the northeast—to support program implementation and respond to ongoing input. These collaboratives will be charged with local coordination of RHT-funded initiatives and will also serve as an ongoing avenue for stakeholder and resident feedback.

VI. Metrics and Evaluation Plan

The state's RHT Plan defines a clear framework, spanning metrics, short-term outputs, and long-term outcomes by outlining specific data sources, collection methodologies, and analytical approaches to track progress against the strategic objectives outlined in the narrative, thereby facilitating continuous improvement and validating program effectiveness.

Description / Project	Metric	Measure Specifications	Baseline (if applicable)	Data Sources
Initiative 1: Population Health Outcomes				
Universal Nurse Home Visiting Expansion	Utilization of Coordinated Rural Birth Support Services	Track the number of rural families utilizing coordinated maternal health services, including Family Bridge.	Will be set in Year 1	Monthly and Quarterly Program and Data Reports; Program can provide OEC with Birthing Census Data
Milestone / Target:	• **Year 1:** Conduct planning activities, including soliciting information from providers who want to participate whether private, rural provider, community action agency. Create an RFP, designed to serve 5 towns in rural areas. Hire state-level program staff • **Year 2:** Pilot model in 2 DCF regions - 3 and 5 • **Year 3:** Evaluate family satisfaction and service utilization patterns. • **Year 4-5:** Continue evaluating. Approved Sustainability Plan for participating entities. Implement insurance reimbursement mechanisms, as approved. Increase the utilization of coordinated rural birth support services (including Family Bridge service) for 1 entity per region across targeted rural regions (DCF regions 3 and 5) of Connecticut.			
Outdoor Recreation Program	Increase Trail Utilization in Towns Containing Air Line State Park Trail	Using trail traffic counters, measure trail usage statistics and compare with usage prior to initiative.	Will be set in Year 1	Trail usage counters; Trail users' health data: Following local studies, track trail users reported health metrics related to trail usage and compare metrics to trail usage over time.
Milestone / Target:	• **Year 1:** Assess trail surface conditions and access points, design projects, and procure contractors. • **Year 2-5:** Implement minor alterations on selected trail segments and projects to promote use at public points of access in at least nine towns. • **Year 3-5:** Data/metric monitoring and measuring outcomes of projects.			
Expand ACCESS Mental Health Model to Adults	ACCESS Mental Health Expansion	Track number of rural primary care providers enrolled and using ACCESS consultation; monitor referrals and treatment follow-up.	Will be set in Year 1	CT ACCESS Mental Health Program Enrollment Records; Quarterly Consultation Utilization Logs; Primary Care Practice Demographic Data. Encounter Data Provider Enrollment.
Milestone / Target:	• **Year 1:** Develop expansion workplan and provider recruitment strategy and train providers and begin consultations. • **Year 2:** Expand statewide participation. • **Year 3:** Evaluate provider satisfaction and referral completion. • **Year 4-5:** Sustain ACCESS as a core service under rural primary care.			
Promoting Healthy Aging in Rural Connecticut Through Engaging Exercise	Participation Rate; Participant Satisfaction Scores (Pre/Post-Test)	Track the number of participating sites and number of participants per site, per session.	Will be set in Year 1	Program enrollment logs; participant assessments; DPH chronic disease surveillance; provider self-reports.

Description / Project	Metric	Measure Specifications	Baseline (if applicable)	Data Sources
Milestone / Target:	• **Year 1:** Select the program sites. Recruit volunteers or staff members to administer the program at the program sites. ADS will provide technical assistance. Two complete cycles of the program will be delivered in up 30 sites. • **Year 2-5:** Complete 3 cycles of program administration. Every cycle will be evaluated by site and facilitator with evaluation pre- and post-survey data metrics on health.			
ACCESS Mental Health ASD Service Access	Enhanced Behavioral Health Access and Crisis Stabilization for Individuals with ASD	Reduce ED and Mobile Crisis Utilization Among Individuals with ASD.	Will be set in Year 1	CHIME hospital discharge data; mobile crisis response logs; DDS/DMHAS service data; Medicaid claims (as available).
Milestone / Target:	• **Year 1:** Establish baseline utilization rates, including ED and mobile crisis utilization; develop integrated crisis response protocols. • **Year 2:** Launch community crisis diversion and behavioral support programs. • **Year 3:** Maintain program and conduct mid-point review of crisis diversion and behavioral support programs. • **Year 4:** Monitor ED and mobile crisis utilization and residential placements. • **Year 5:** Develop sustainability plan and final review of data			
ACCESS Mental Health Enhanced School-Based Mental Health Care	School-Based Behavioral Health Expansion	Track number of SBHC staff trained and number of consultations per staff role.	Will be set in Year 1	SBHC Logs; Staff Training Records; Workforce Data.
Milestone / Target:	• **Year 1-5:** Implement and expand training. Ensure workforce alignment across regions. Achieve an increase of 40% in SBHC staff trained and increase consultations per staff role by 20%.			
Mobile Clinic Pilot	Improved Chronic Disease Management and Reduced Avoidable Acute Care Use	Reduce ED Utilization and Improve Chronic Disease Management	Will be set in Year 1	Hospital discharge data; DPH Chronic Disease Registry; provider quality reports.
Milestone / Target:	• **Year 1:** RFP and contracting – partner with FQHCs or hospitals to identify areas of need. A total of four medical and four dental vans will be made available, of which one of each type will be set aside for tribal applicants. By the end of Year 1, mobile clinics will be distributed to approved applicants. • **Year 2-5:** Fully outfit the clinic and start providing services. • **Year 4-5:** Grow the number of visits to the clinic by 5% year-over-year. Monitor locations the clinic is visiting – quarterly or annual reporting.			
Initiative 2: Workforce				
Rural Residency Development Grant	Provider recruitment and scheduling optimization	Increase the number of (FTE) primary care providers per 10,000 rural residents by 10%.	Will be set in Year 1	Rural Primary Care FTE Census Data; Patient Wait Time Surveys/ Appointment Scheduling System Metrics.

Description / Project	Metric	Measure Specifications	Baseline (if applicable)	Data Sources
Milestone / Target:	• **Year 1:** RFP and contracting. $75k for start-up costs. • **Year 2-3:** Medical school develops the program. Get programs approved by ACGME to receive rest of the $25k. • **Year 3:** 100% of programs should be in the match. • **Year 4-5:** Sustainability plan and continued program administration via medical schools.			
Healthcare Provider Licensure Compact Support	Implement expedited rural licensing process	Number of applications processed through fast-track channel for all compacts the state is enrolled in.	Will be set in Year 1	State Professional Licensing Board Data; Quarterly Licensing Processing Time Reports.
Milestone / Target:	• **Year 1:** Hiring and staffing for three state positions. • **Year 2-5:** Process applications, recruit healthcare providers to join the compacts, and ensure healthcare facilities and provider locations are educated about the compacts. Identify additional potential compacts of interest for Connecticut to join to increase rural health access.			
Rural Provider Incentives (Awards) Salary Supplements for Unlicensed Healthcare Workers	Provider retention and incentive tracking framework	Number of providers retained through incentive programs.	Will be set in Year 1	DPH Licensure Data; RHT Grantee Compliance Reports on Service Obligation Fulfillment.
Milestone / Target:	• **Year 1:** Develop provider retention tracking framework and implement one cohort of incentive-based contracts. Participating providers will be determined via an RFA. • **Year 2:** Conduct mid-term retention analysis. • **Year 3:** Adjust incentive strategy based on evaluation. • **Year 4-5:** Institutionalize retention framework within human resources processes.			
Formalize CNA Training Formalize Medication Administration Training	Annual training feedback and curriculum update process	Hiring of CNAs in non-nursing home locations increases 5% year-over-year. Number of individuals dually trained as a CNA and formalized medication administration increases 5% year-over-year.	Will be set in Year 1	Annual Post-Training Surveys; Curriculum Development Logs; Internal Training Audit Reports.
Milestone / Target:	• **Year 1:** Legislation to be passed in one of the two legislative sessions. • **Year 2:** Work with Community Colleges to update CNA curriculum and establish medication administration curriculum. Establish practicum sites. • **Year 3-5:** Evaluate performance in certifying CNA with medication administration, and certifications of CNAs in general.			
Initiative 3: Data and Technology				
Health Information Exchange (HIE) Expansion for Rural Providers, EMS, & nursing homes	HIE Expansion	Track the number of rural providers, EMS, and SNFs connected; assess data quality scores for transmitted data.	Will be set in Year 1	HIE Data Logs; EHR Audit Reports; Data Quality Assurance Metrics.

Description / Project	Metric	Measure Specifications	Baseline (if applicable)	Data Sources
Milestone / Target:	• **Year 1-3:** Identify and outreach specific rural providers including behavioral health, primary care, and long-term care and recruit participants to onboard to the HIE. Have mechanism in place for providers to apply for funding. Develop a contracting process setting milestones for funding, with milestones set over a period of 18 to 24 months. Outreach, application, and contracting will occur cyclically. • **Year 4-5:** Sustain interoperability and evaluate utilization outcomes.			
Bridging the Digital Divide	Track the number of program sites, participants, and program cycles completed each year, along with measures of participant health outcomes, digital access, and engagement	Number of individuals served, number of devices distributed, and number of entities (e.g., senior centers, senior housing) receiving technology support.	Will be set in Year 1	Utilize robust data collection created during pilot program in Jot Forms. Ongoing data reporting will be required from contracted partner agencies – both numeric and anecdotal. Data will be aggregated and reported annually.
Milestone / Target:	• **Year 1:** Amend contracts with two Assistive Technology (AT) Partner agencies, purchase Jot Forms licenses, post and hire PTE. Create outreach plan with two AT Partners Review and edit data collection and overall processes, as necessary, to streamline program and ensure best practices are used. Research and select virtual platform option for purchase. • **Year 2:** Activities are fully underway, with services being provided, data reported. Begin training of entities on virtual platform. • **Year 3-4:** Activities continue to be provided, making progress towards deliverables, data collected and reported. Annual reports will be created by ADS staff. Continue rollout of virtual platform, engaging individuals to participate through the entities. • **Year 5:** Activities will continue with a plan to wind down as we near the end of the grant. All data will be reported, all deliverables will be completed. Prepare entities for continuation of virtual platform within own budgets or wind down the platform use.			
Connecticut Rural Predictive Analytics and Care – Coordination Platform (CR-PACP)	Connecticut Rural Predictive Analytics and Care Coordination Platform	Track the establishment and use of predictive analytics for care coordination and social referral tracking.	Will be set in Year 1	Training Completion Records; System Login/Usage Logs; Monthly Provider Feedback Summaries; Technical Assistance Logs; HIE Data; Referral Logs; Predictive Model Reports.

Description / Project	Metric	Measure Specifications	Baseline (if applicable)	Data Sources
Milestone / Target:	• **Year 1-2**: Identify and develop team for platform development. Develop and issue RFP, if required, for AI model procurement. • **Year 3-4:** Develop and implement data integration and analytics of the AI model, beginning with rural health providers. Launch pilot programs for predictive models and care coordination. • **Year 4-5:** Evaluate model performance. Increase annual primary care visits by 15%. Expand statewide integration with VBP and HIE systems.			
Rural Health Transformation through Shared Infrastructure and Telehealth Innovation	Establish Shared IT Services Model and Implement Telehealth Program	Increase Telehealth Adoption: Increase the monthly utilization of specialty care e-Consults and RPM services by 25% among rural providers care sites within two years of deploying new RHT-funded technology infrastructure.	Will be set in Year 1	APCD Claims Data for CPT codes related to e-Consults and RPM; HIE clinical data for encounters.
Milestone / Target:	• **Year 1-2:** Develop a grant application for provider organizations to apply for funds to procure their own telehealth platforms as well as additional options such as training residents on telehealth and developing education material for providers and patients. Establish a baseline for provider utilization. Begin providing funding to provider organizations under contracts with measurable milestones. • **Year 2-3:** Continue Year 1 awareness campaign to rural providers and expand to full regional network. Outreach and education will continue cyclically to incorporate more providers on an ongoing basis. Conduct utilization and satisfaction reviews. • **Year 4-5:** Continue to conduct utilization and satisfaction reviews. Integrate telehealth workflows into ongoing service delivery models.			
AI-Powered Virtual Care and Remote Patient Transformation	Reduction in avoidable ED Utilization	Reduction in avoidable ED utilization by 10% by Year 5.	Will be set in Year 1	Hospital discharge data; mobile crisis response logs; DDS/ DMHAS service data; APCD claims data.
Milestone / Target:	• **Year 1-2:** Identify targeted rural health providers to deliver remote care or remote monitoring interventions such as hypertension monitoring at home. Develop RFP for providers to apply for funding to develop a remote care or monitoring program. • **Year 2-3:** Begin providing funding to providers who have successfully applied to the RFP with milestone payments to deliver payments. Begin collecting baseline data on remote interventions. • **Year 3-4:** Continue cyclically awarding RFP funds. Evaluate increase in services and outcomes Such as reduction in travel time to access providers. • **Year 5:** Reduction of avoidable ED visits.			
Connecticut Healthcare Bed Capacity Tracking System	Average Transfer Wait Time	Reduce transfer wait time by 15% and assess boarding reduction.	Will be set in Year 1	Hospital EHR data; hospital performance data.
Milestone / Target:	• **Year 1:** Develop criteria for automated bed capacity tracking system based on current manual system. Develop an RFP if required and locate an appropriate vendor. • **Year 2-3:** Begin system development activities. • **Year 4-5:** Evaluate outcome.			

Description / Project	Metric	Measure Specifications	Baseline (if applicable)	Data Sources
Initiative 4: Care Transformation and Financial Stability				
Integrated Care Network	Integration of VBP and Direct Investment Models	Monitor service capacity and care outcomes under rural VBP frameworks.	Will be set in Year 1	DSS HUSKY Health Quality Metrics (HEDIS/eCQM data) tracked by zip code for rural populations.
Milestone / Target:	• **Year 1-2:** Assessment & Planning, Feasibility Assessment for a rural integrated care network. • **Year 3:** Select vendor to support integrated care network establishment. • **Year 4:** Start up and select integrated care network entity, provide technical support to selected integrated care network entity. • **Year 5:** Establish one integrated care network entity in a rural area.			
Connecticut Rural Hospital Transformation Program and Rural Health Facility Right-Sizing & Infrastructure Program	Integration of VBP and Direct Investment Models	Monitor service capacity and care outcomes under rural VBP frameworks.	Will be set in Year 1	DSS HUSKY Health Quality Metrics (HEDIS/eCQM data) tracked by zip code for rural populations.
Milestone / Target:	**Right-sizing Component** • **Year 1:** Rapid stand up and right-sizing support to priority hospitals. • **Year 2:** Select additional hospitals and facilities for right-sizing. • **Year 3:** Finalize the list of hospitals and other provider facilities receiving right-sizing and infrastructure support. • **Year 4:** Right-sizing support and monitoring continues for the selected hospitals. • **Year 5:** Follow up with sustainability plan created. Close out year for right-sizing. **Transformation Component** • **Year 1:** Select hospital transformation TA Vendor. • **Year 2:** Finalize hospital transformation participants, including first cohort for hospitals electing to participate in AHEAD to coincide with AHEAD launch. • **Year 3:** Develop hospital transformation plans coordinated with right-sizing plans. • **Year 4:** Transformation plans being finalized. • **Year 5:** Hospital Transformation plans executed according to sustainability plan, which is tied to a VBP/APM, including additional hospitals participating in AHEAD.			
Improving Primary, Maternal, Behavioral, and Dental Health through Direct Investment and VBP	Improving Primary, Maternal, Behavioral, and Dental Health through Direct Investment and VBP	Track improved access and capacity in primary, maternal, behavioral, and dental services through targeted rural investments and VBP arrangements.	Will be set in Year 1	Benchmark Data; DSS VBP Participation Reports; Provider Contracts.

Description / Project	Metric	Measure Specifications	Baseline (if applicable)	Data Sources
Milestone / Target:	**Direct Investment Component** • **Year 1**: Identify eligible practices and establish an application process for funds. • **Year 2-3**: Begin supporting rural practices. • **Year 4:** Evaluate network adequacy and access. • **Year 5:** Wind down direct investments, assess sustainability and additional needs. **VBP Component** • **Year 1-2**: Select VBP design vendor. • **Year 3**: Design or update VBP models for primary care, maternal, behavioral and dental health. • **Year 4:** Finalization of at least one VBP model. • **Year 5:** At least one complete new VBP program implemented and two in progress.			
Care Coordination Support for Primary Care Practices	Care Coordination Support for Primary Care Practices	Establish rubric and performance tracking for primary care participation in coordinated care models; monitor progress from design through evaluation.	Will be set in Year 1	Shared Electronic Referral System Logs; Case Management Outcome Reports.
Milestone / Target:	• **Years 1-2:** Plan and launch per member per month (PMPM) payment and onboarding primary care practices. • **Year 3:** Monitor care coordination related quality measures (e.g., blood pressure control, diabetes control, asthma, behavioral health, and preventable utilization). • **Year 4-5:** Continue with PMPM payments and monitor quality measures. • **Year 5:** Integrate care coordination into VBP programs for sustainability (e.g., Primary Care AHEAD).			
Adult 23-Hour Crisis Stabilization Units	Adult 23-Hour Crisis Stabilization Units	Track number of crisis stabilization units launched and operational outcomes, including ED diversion and linkage to ongoing behavioral healthcare.	Will be set in Year 1	State Mental Health and SUD Service Utilization Data; Local Crisis Stabilization Unit Intake Logs; HIE/State ED Utilization Reports (specific to Behavioral Health/SUD), Encounter Data.
Milestone / Target:	• **Year 1**: Develop statewide workplan and select pilot sites and launch one or two crisis stabilization units. • **Year 2**: Expand to all rural service areas. • **Year 3**: Evaluate utilization and continuity of care outcomes. • **Year 4-5**: Sustain model through integrated funding and policy alignment.			
Mobile Integrated Health	Mobile Integrated Health (MIH) Pilot	Establish hospital-based MIH teams in rural communities; track implementation milestones and staff capacity.	Will be set in Year 1	EMS and Hospital Reports; MIH Pilot Evaluations; Patient Encounter Logs, Encounter Data.

Description / Project	Metric	Measure Specifications	Baseline (if applicable)	Data Sources
Milestone / Target:	• **Year 1:** Release RFP open to tribal nations, local municipal, or private EMS and hospitals to provide mobile integrated health. Contract with various entities that will administer program selected through the RFP process. Distribute initial round of funding to participating providers. • **Year 2-5:** Distribute subsequent rounds of funds to entities administering services. • **Year 4-5:** State Medicaid to work with providers to determine potential of sustainability. • **Year 5:** Evaluate impact on ED visits.			
High Acuity School-Based Behavioral Health Programming	Training, participation, assessments, evaluation	Develop baseline data using the identified assessments. Monitoring progress with established benchmarks and work plan for up to 41 rural districts.	Will be set in Year 1	School Mental Health Quality Assessment, Student and staff well-being assessment, and the School Health Assessment and Performance Evaluation, pre/ post-training assessments, and Center for Connecticut Education Research Collaboration for evaluation.
Milestone / Target:	• **Year 1:** Strategic Planning and Initiation, which includes hiring two FTEs to coordinate a System of Care with rural community providers, focusing on funding and responsibilities. Also, there will be marketing and recruiting in rural school districts for funding allocation and establishment of baseline data for each district to identify strengths, areas for improvement, and develop action plans. • **Year 2:** Implementation — The project will enhance Year 1 efforts by providing mental health services in schools through a "push-in" approach and offering telehealth options for remote students, focusing on support, prevention, promotion, early interventions, and crisis. • **Year 3:** Continue to expand rural district services for broader access to vital resources. • **Year 4-5:** Promote assessment findings, training, and evaluation reports to enhance community well-being, expand access to quality mental health services, and strengthen community partnerships.			
Regional Collaboratives	Care Coordination Support for Primary Care Practices	Track collaboration among rural hospitals, FQHCs, and primary care practices implementing coordinated care models.	Will be set in Year 1	Reports and data reporting from partners.
Milestone / Target:	• **Year 1:** Develop multi-partner coordination framework and select two anchor agencies that serve as collaborative. • **Year 2:** Forums for agency and program leads to collaborate on implementation – establish and have regular meeting cadence. • **Year 3:** Collaborative participation analyzed from meeting minutes. • **Year 4-5:** Sustain partnerships. Formalize Regional Service Coordination sustainability plan.			

Table 23 - Metrics

Connecticut has access to an array of data systems and infrastructure that enables the state to collect, analyze, report, and measure outcomes to evaluate the RHT Program throughout the grant period effectively. These databases include:

Data	Source	Outcomes Measures
APCD	OHS	Statewide, provider, payer, and healthcare service category cost growth
Hospital Inpatient Discharge Data	OHS	AHRQ Quality Indicators ED Utilization
Connecticut Healthcare Cost Growth Benchmark Initiative	OHS	State the all-payer total cost of care growth target
Licensed healthcare provider electronic medical (or health) Record (EHR/EHR); Admission/Discharge/Transfer; Continuity of Care Documents; Lab and Radiology Reports; and transcribed notes	Connie (HIE), overseen by OHS	Electronic clinical quality measure (eCQM)
Connecticut Behavioral Risk Factor Surveillance System (BRFSS) and other public health surveillance and health data	DPH	Public health and health improvement
Medicaid program claims/Medicaid Management Information System	DSS	Medicaid utilization, population health status, budget savings measures, and quality reporting
State employee/retiree health plan	Office of State Comptroller	Utilization, health status, budget savings measures, and quality reporting

Table 24 - Data Sources for Outcome Measures Analyses

Connecticut anticipates that the applicant agencies currently have access to data necessary for the evaluation and monitoring of the RHT Plan implementation. Access to non-public data not readily available will be facilitated with a memorandum of agreement and/or data use agreement among program partner agencies and participants.

The state is creating a transparent, open, and fair evaluation plan that focuses on using data to drive decisions and support quicker course correction. Connecticut will engage a third-party evaluator as a review partner, applying the Post-Award Evaluation Framework. Quarterly performance reviews will assess provider recruitment, infrastructure investments, interoperability metrics, and population-health outcomes. These evaluations will inform the CMS progress reports and budget requests. For example, Connecticut will track trends that lead to successful outcomes by (1) assessing financial stability and healthcare spending change over the five years to determine the effectiveness of projects, and (2) identifying the highest-need demographics.

Connecticut will use health claims data to identify members with the highest risk of poor health outcomes. As required by the NOFO, Connecticut confirms that the state will cooperate with any CMS-led evaluation or monitoring.

In summary, the Metrics and Evaluation Plan establishes a structured, data-driven methodology that is essential to the successful execution and validation of the Connecticut RHT Plan initiatives. The Connecticut RHT Plan includes metrics and outcome measures for each Connecticut initiative to provide a firm overview of evaluating the NOFO requirements. It will offer inclusive data to ensure programs and projects are successful. While the metrics do not include every project under consideration, the metrics exceed the required number required in the NOFO. By consistently tracking the defined metrics, and short-term and long-term outcomes, we will maintain full accountability to all stakeholders and ensure the efficient deployment of resources. This detailed framework provides the evidence needed not only to measure the initiative's impact against its strategic goals accurately but also to facilitate adaptive management, enabling Connecticut to make timely adjustments and secure sustained effectiveness.

VII. Sustainability Plan

Connecticut's RHT Plan converts a time-limited federal cooperative agreement into a framework for ongoing rural health improvement. Over the course of the grant period and beyond FFY 2031, the state will continue to evaluate projects and make changes as necessary to continue to improve outcomes. During that time, the state will examine whether better health outcomes have resulted in savings that could be reinvested in the pick-up of successful initiatives and explore opportunities to support successful programs (including, as applicable, in the state budget) through a combination of Medicaid, private insurance and grant funding or public-

private partnerships, and collaborative efforts to ensure long-term benefits for rural residents. Letters of support from key partners and stakeholders demonstrating alignment and commitment to Connecticut's RHT Plan goals are included in the attachments.

Many RHT Plan initiatives are designed to make strategic, one-time investments or to build lasting infrastructure systems to provide lasting impact without requiring ongoing public funding. These efforts will strengthen rural capacity, streamline healthcare delivery, and improve coordination across the rural health landscape. Other initiatives, like PACE, can be self-sustaining because of projected savings from serving older adults in cost-effective home care settings and from avoiding/delaying more costly institutional care. Similarly, expanded 23-hour stabilization centers for adult behavioral health needs will be monitored for potential offsetting savings in avoidable hospitalizations, which will help inform future decisions on the centers' incorporation into the overarching healthcare system.

The state will assess the sustainability of the RHT Plan across the pillars of workforce expansion, infrastructure modernization, and seamless integration, in alignment with CMS and HRSA expectations. RHT initiatives that strengthen prevention, primary care, behavioral health, and maternal health access will be reviewed for potential continuation or integration into broader state strategies. Outcome reporting will provide transparency and guide improvement in cost savings, care access, chronic disease outcomes, and maternal health. Metrics will be closely monitored to capture lessons learned and guide future planning.

Initiative Specific Sustainability	
Initiative 1: Population Health Outcomes	The Population Health Outcomes initiative in Connecticut's RHT Plan focuses on preventive care, wellness, and chronic disease management, and will be monitored through outcome reporting. Efforts included in this plan, such as the ACCESS Mental Health model projects, will explore opportunities for alignment with existing payor and provider frameworks to maintain service continuity where feasible and justifiable with evidence of positive outcomes. The Family Bridge expansion and Mobile Clinic pilot will build local and regional capacity, enabling participating partners to sustain or adapt services independently using available diversified funding sources and established community networks. Collected data on outcomes, cost-effectiveness, and health impact will be used to inform future policy decisions. If

Initiative Specific Sustainability	
	successful, these models may be considered for continued state support, while others may wind down with sustainable community and system-level improvements in place.
Initiative 2: Workforce	To ensure sustainability, projects that comprise the Workforce initiative are designed to strengthen long-term training infrastructure, career pathways, interstate licensure, and retention capacity within rural communities. Training formalization projects will embed standardized CNA and medication administration curricula within existing education systems, ensuring long-term availability. Other projects constitute one-time infrastructure investments to expand projects that have demonstrated success in other areas of the state to rural regions, such as the AHEC workforce education programs, and will wind down but continue to yield sustained benefits beyond the RHT Program. Programs demonstrating measurable success and workforce impact may be considered for future state support, while others will conclude with sustainable institutional models and strengthened local capacity in place.
Initiative 3: Data and Technology	The Data and Technology initiative will focus on building durable infrastructure, data-sharing frameworks, and digital literacy that will continue to benefit rural communities beyond the project period. Projects such as the Integrated Care Network, HIE (Connie) expansion, rural health predictive modeling capabilities will align with Connecticut's existing data infrastructure and telehealth systems to promote interoperability and institutional ownership. Bed capacity tracking and consumer-facing care management tools will be implemented with scalability and adaptability in mind, enabling continued use by hospitals, health centers, and rural communities after grant completion. In particular, investments are envisioned to be maintained through fees on participating providers, ensuring that data and technology programs are self-sustaining in the long term. If proven effective, projects that are not one-time infrastructure investments may be considered for incorporation into Connecticut's broader health technology strategies, while others will wind down having strengthened local capacity, coordination, and technology utilization in rural health systems.
Initiative 4: Care Transformation and Stability	Connecticut's Care Transformation and Stability projects will focus on building resilient care delivery infrastructure, strengthening local and regional capacity, and supporting transitions to alternative payment and coordination models. Investments in crisis stabilization units, MIH, and high-acuity school-based behavioral health services are designed to integrate with existing provider networks and payor systems to ensure ongoing service delivery beyond the RHT Program. Facility right-sizing, infrastructure modernization, and PACE program development will create durable physical and operational foundations that allow providers to adapt efficiently to community needs. Projects that are proven effective throughout the RHT demonstration period may be considered for adoption within broader state reform strategies and help to inform future policy, while others will conclude with measurable improvements in system coordination, capacity, and community stability.

Table 25 - Initiative Sustainability

[1] Centers for Medicare & Medicaid Services, *Hospital Provider Cost Report* (Oct. 30, 2024), https://data.cms.gov/provider-compliance/cost-report/hospital-provider-cost-report.
[2] DataHaven, *2024 DataHaven Community Wellbeing Survey* (DCWS_Connecticut_2024_EventVersion.xlsx) (2024), https://www.ctdatahaven.org/reports/datahaven-community-wellbeing-survey.
[3] U.S. Census Bureau, *CONNECTICUT: 2020 Census*, https://www.census.gov/library/stories/state-by-state/connecticut.html.
[4] Health Resources and Services Administration, *What Is Rural?* https://www.hrsa.gov/rural-health/about-us/what-is-rural.
[5] U.S. Census Bureau, *Master Address File/Topologically Integrated Geographic Encoding and Referencing (MAF/TIGER®) Database, State Area Measurements*, Connecticut (Jan. 1, 2010), https://www.census.gov/geographies/reference-files/2010/geo/state-area.html.
[6] U.S. Census Bureau, *County-level Urban and Rural Information for the 2020 Census* (updated Sept. 2023), available at https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html.
[7] Connecticut Office of Rural Health, *Rural Definitions Map* (CT) (pdf), available at https://www.ruralhealthct.org/assets/SORH-Rural-Definitions-Map.pdf.
[8] Connecticut Office of Rural Health, *CT Rural Towns* (Feb. 2025) (PDF), available at https://www.ruralhealthct.org/towns.htm.
[9] Centers for Medicare & Medicaid Services, *Hospital Provider Cost Report* (Oct. 30, 2024), https://data.cms.gov/provider-compliance/cost-report/hospital-provider-cost-report.
[10] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Centers for Medicare & Medicaid Services Health Center Facilities Report*, https://data.hrsa.gov/data/reports/cms-facilities.
[11] National Council for Mental Wellbeing, CCBHC Locator, https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-locator.
[12] Substance Abuse and Mental Health Services Administration, FindTreatment.gov, https://findtreatment.gov.
[13] Centers for Medicare & Medicaid Services, *Provider of Services File – Hospital and Non-Hospital Facilities (Q2 2025)*, data.cms.gov (Aug. 11, 2025), https://catalog.data.gov/dataset/provider-of-services-file-hospital-non-hospital-facilities-f216f.
[14] Connecticut Department of Social Services, *Medicaid Hospital Reimbursement: DSH Audit and SPA*, CT GOV (Oct. 30, 2025), https://portal.ct.gov/dss/health-and-home-care/medicaid-hospital-reimbursement/medicaid-hospital-reimbursement/dsh-audits-and-spas?language=en_US.
[15] Connecticut Insurance Department, *Department Rejects and Modifies Every Health Insurance Rate Increase Request for 2026* (Sept. 10, 2025), https://portal.ct.gov/cid/press-releases/2025-press-releases/2025-09-10.
[16] DataHaven and Connecticut Office of Rural Health, *Rural Health in Connecticut* (Oct. 10, 2022) (PDF), available at https://www.ruralhealthct.org/images/Rural_Health_in_Connecticut%20FINAL.pdf.

[17] Connecticut Department of Labor, Office of Research, *Occupational Employment and Wage Statistics (1st Quarter 2023): NAICS Industry* (2024), available at https://www1.ctdol.state.ct.us/lmi/wages/naics2023.asp
[18] United For ALICE, *The State of ALICE in Connecticut: 2025 Update on Financial Hardship* (2025), available at https://www.unitedforalice.org/introducing-ALICE/Connecticut.
[19] Office of Health Strategy, *Statewide Health Care Facilities and Services Plan Addendum* (expected 2025), at Figure 16 ("Percentage of Adults by Educational Attainment in Connecticut, Other States, Connecticut Planning Regions, and Connecticut Demographic Groups").
[20] Rakshit Shameek, Matthew Rae, Gary Claxton, Krutika Amin and Cynthia Cox, *The Burden of Medical Debt in the United States* (Feb. 12, 2024), KFF and Peterson Center on Healthcare (Health System Tracker), https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/.
[21] *Most (and Least) Expensive States for Health Care,* Consumer Affairs (Jan. 9, 2025), https://www.consumeraffairs.com/insurance/most-and-least-expensive-states-for-health-care.html.
[22] Connecticut Office of Rural Health, *Rural Health in Connecticut* 15 (2022), https://www.ruralhealthct.org/report.
[23] Connecticut Office of Rural Health, *Rural Health in Connecticut* 12 (2022), https://www.ruralhealthct.org/report.
[24] Merianne Rose Spencer and Arialdi M. Minino, *Trends in Death Rates in Urban and Rural Areas: United States, 1999–2019*, NCHS Data Brief No. 417, at 3 (National Center for Health Stat., Sept. 2021), https://www.cdc.gov/nchs/data/databriefs/db417.pdf.
[25] Connecticut Office of Rural Health, *An Assessment of Connecticut Rural Health: Overview, Obstacles and Opportunities* 3 (2015), https://www.ruralhealthct.org/assets/CT_Office_of_Rural_Health_RuralAssessment_2015.pdf.
[26] America's Health Rankings, *Multiple Chronic Conditions (Adults)*, America's Health Rankings (2023 data), https://www.americashealthrankings.org/explore/measures/mult_chronic_conditions_sr_b.
[27] American Diabetes Association, *Connecticut Diabetes Factsheet* (Mar. 2024), https://diabetes.org/sites/default/files/2024-03/adv_2024_state_fact_connecticut.pdf.
[28] U.S. Centers for Disease Control and Prevention, *Diabetes Self-Management: Rural Policy Brief* (Jan. 2024), https://www.cdc.gov/rural-health/php/policy-briefs/diabetes-policy-brief.html.
[29] E. Crouch et al., *Rural–Urban Differences in Overweight and Obesity Among U.S. Children and Adolescents*, 20 Prev. Chronic Dis. 23_0136 (2023), https://www.cdc.gov/pcd/issues/2023/23_0136.htm.
[30] A.T. Marshall et al., *Association of Lead-Exposure Risk and Family Income with Child Blood Lead Levels*, 10 BMC Public Health *1174* (2020), https://doi.org/10.1186/s12889-020-09120-x.
[31] Dugan E, Lee CM, Jansen T, Su YJ, Silverstein NM and Song Q, *Highlights from the 2025 Connecticut Healthy Aging Data Report* 8 (Gerontology Inst., Univ. of Mass. Boston and Point32Health Foundation 2025), https://healthyagingdatareports.org/wp-content/uploads/2025/04/CT_Healthy_Aging_Highlights_2025.pdf.

[32] Connecticut General Assembly, Insurance Fund Working Group, *Final Report* (Jan. 2025), https://www.cga.ct.gov/ins/related/Insurance%20Fund%20Working%20Group%20Final%20Report/Insurance%20Fund%20Working%20Group%20Final%20Report.pdf.
[33] 2024 Falls Free CT, *Coalition Presentation on Falls Data* (Dec. 10, 2024), on file with the Falls Free CT Coalition, https://portal.ct.gov/-/media/aginganddisability/agingservices/falls-prevention/2024-12-10_falls-free-ct-meeting_agenda-and-presentation.pdf?rev=2677b4ebd6384936bf071e0d8dc58fbd.
[34] DataHaven and Connecticut Office of Rural Health, *Rural Health in Connecticut* 15, 21 (2022), https://www.ruralhealthct.org/images/Rural_Health_in_Connecticut%20FINAL.pdf.
[35] Office of Health Strategy, *Healthcare Benchmark Initiative Primary Care Spending Target Report for PY2023,* 11–14 (Mar. 31, 2025), https://portal.ct.gov/ohs/-/media/ohs/cost-growth-benchmark/benchmark-reports-py2023/ohs-hcbi-primary-care-spending-target-report-py2023.pdf.
[36] Dube, N. (2024, July 31). *Recent Changes to Connecticut's Telehealth Law* (Report No. 2024-R-0122). Office of Legislative Research, Connecticut General Assembly. https://cga.ct.gov/2024/rpt/pdf/2024-R-0122.pdf,
[37] Connecticut General Assembly. (2024). *Public Act No. 24-110: An Act Concerning Telehealth Services (Substitute House Bill No. 5198)*. https://www.cga.ct.gov/2024/ACT/PA/PDF/2024PA-00110-R00HB-05198-PA.PDF.
[38] The Commonwealth Fund, *2025 Scorecard on State Health System Performance: How the U.S. Compares State by State appendix B*, at 3 (June 18, 2025), https://www.commonwealthfund.org/sites/default/files/2025-05/AUTHOR_REVIEW_1_Radley_2025_State_Scorecard__APPENDICES_2025-05-29.pdf.
[39] David C. Radley et al., *2025 Scorecard on State Health System Performance: Fragile Progress, Continuing Disparities* (Commonwealth Fund, June 18, 2025), https://www.commonwealthfund.org/publications/scorecard/2025/jun/2025-scorecard-state-health-system-performance.
[40] Office of Health Strategy, *Behavioral Health Workforce Environmental Scan* (Sept. 30, 2024), at vi, https://portal.ct.gov/-/media/ohs/reports/ct-ohs-behavioral-health-workforce-environmental-scan.pdf.
[41] Office of Health Strategy, *Behavioral Health Workforce Environmental Scan* 11 (Sept. 30, 2024), https://portal.ct.gov/ohs/-/media/ohs/reports/ct-ohs-behavioral-health-workforce-environmental-scan.pdf.
[42] Office of Health Strategy, *Behavioral Health Workforce Environmental Scan* 42 (Sept. 30, 2024), https://portal.ct.gov/ohs/-/media/ohs/reports/ct-ohs-behavioral-health-workforce-environmental-scan.pdf.
[43] Department of Children and Families, *Urgent Crisis Centers for Children* (2023), available at https://portal.ct.gov/dcf/behavioral-health-partnership/home/urgent-crisis-centers-for-children.
[44] Office of Health Strategy, *Statewide Health Care Facility and Services Plan* (rev. March 15, 2025), Table 6.5 "Mental Health Outpatient Clinics, by Region," Hartford, CT: State of Connecticut 155, (July 2, 2025), retrieved from https://portal.ct.gov/ohs/-/media/ohs/hsp/ohs-statewide-health-care-facility-and-services-plan--march-15-2025-rev-07022025.pdf.

[45] Office of Health Strategy, *Statewide Health Care Facility and Services Plan* (rev. March 15, 2025), Table 6.1 "Behavioral Health: Statewide Bed Inventory," Hartford, CT: State of Connecticut 150, (July 2, 2025), retrieved from https://portal.ct.gov/ohs/-/media/ohs/hsp/ohs-statewide-health-care-facility-and-services-plan--march-15-2025-rev-07022025.pdf.
[46] Office of Health Strategy, *Statewide Health Care Facility and Services Plan* (rev. March 15, 2025), Table 6.6 "Behavioral Health: Substance Use Disorder Outpatient Clinics," Hartford, CT: State of Connecticut 156, (July 2, 2025), retrieved from https://portal.ct.gov/ohs/-/media/ohs/hsp/ohs-statewide-health-care-facility-and-services-plan--march-15-2025-rev-07022025.pdf.
[47] Office of Health Strategy, *Statewide Health Care Facility and Services Plan* (rev. March 15, 2025), Table 6.3 "Behavioral Health: Inpatient Psychiatric Beds by Region," Hartford, CT: State of Connecticut 152, (July 2, 2025), retrieved from https://portal.ct.gov/ohs/-/media/ohs/hsp/ohs-statewide-health-care-facility-and-services-plan--march-15-2025-rev-07022025.pdf.
[48] Alexander Thomas et al., *Forgone Medical Care Associated With Increased Health Care Costs Among the U.S. Heart Failure Population, 9 JACC: Heart Failure* 710 (2021), https://doi.org/10.1016/j.jchf.2021.05.010.
[49] Office of Health Strategy, Internal Data on Rural Hospital Discharges, SFY 2024 (showing 13,555 rural hospital discharges, 3.7% of 367,142 total discharges) (on file with Connecticut Office of Health Strategy).
[50] Office of Health Strategy, *Annual Report on the Financial Status of Connecticut's Short-Term Acute Care Hospitals, Fiscal Year 2024* (expected 2026).
[51] Connecticut Hospital Association,
New Report Outlines Continued Financial Challenges for Connecticut Hospitals and Health Syste ms (Dec. 18, 2024), https://cthosp.org/press-releases/new-report-outlines-continued-financial-challenges-for-connecticut-hospitals-and-health-systems/.
[52] Connecticut Hospital Association,
Report: Medicare, Medicaid Underpayment Burdening CT Hospitals (Dec. 2024), https://cthosp.org/daily-news-clip/report-medicare-medicaid-underpayment-burdening-ct-hospitals/.
[53] Office of Health Strategy, *Annual Report on the Financial Status of Connecticut's Short-Term Acute Care Hospitals, FY 2023* (Jan. 2025), https://portal.ct.gov/-/media/ohs/reports/ohs-annual-report-on-the-financial-status-of-connecticuts-hospitals-fy2023.pdf.
[54] U.S. Department of Health and Human Services, Health Resources and Services Administration. (April 3, 2024). Community Health and Wellness Center: Change in Scope (CIS00152648). HRSA.gov.
[55] Office of Health Strategy, *Statewide Health Care Facilities and Services Plan: June 2024* 184 (Connecticut, June 2024), https://portal.ct.gov/-/media/ohs/hsp/ohs-statewide-health-care-facilities-and-services-plan-2024.pdf.
[56] Office of Health Strategy, *Statewide Health Care Facilities and Services Plan: June 2024* 185 (Connecticut, June 2024), https://portal.ct.gov/-/media/ohs/hsp/ohs-statewide-health-care-facilities-and-services-plan-2024.pdf.

[57] Office of Health Strategy, *Statewide Health Care Facilities and Services Plan: June 2024* 57 (Connecticut, June 2024), https://portal.ct.gov/-/media/ohs/hsp/ohs-statewide-health-care-facilities-and-services-plan-2024.pdf.
[58] Office of Health Strategy, *Statewide Health Care Facilities and Services Plan: June 2024* 150 (Connecticut, June 2024), https://portal.ct.gov/-/media/ohs/hsp/ohs-statewide-health-care-facilities-and-services-plan-2024.pdf.
[59] National Rural Health Association, *Rural Workforce Recruitment and Retention Factors* (March 2025), https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/nrha-policy-brief-workforce-retention-factors-final-3-7-25.pdf.
[60] Munira Z. Gunja, *Rural Americans Struggle with Medical Bills and Health Care Affordability*, To the Point (blog), The Commonwealth Fund (July 24, 2023), https://www.commonwealthfund.org/blog/2023/rural-americans-struggle-medical-bills-and-health-care-affordability.
[61] Isabelle Dufour et al., *Factors Associated with Frequent Use of Emergency-Department Services in a Geriatric Population: A Systematic Review*, 19 BMC Geriatrics 185 (2019).
[62] Kelly Davila and Camille Seaberry, *Rural Health in Connecticut: A Comprehensive Review of Social Determinants, Community Resources, Health Outcomes, and Well-being* (June 2022), DataHaven, https://www.ctdatahaven.org/sites/ctdatahaven/files/Rural_Health_in_Connecticut.pdf.
[63] Rural Health Information Hub, *Transportation to Support Rural Healthcare*, https://www.ruralhealthinfo.org/topics/transportation.
[64] Kelly Davila and Camille Seaberry, *Rural Health in Connecticut: A Comprehensive Review of Social Determinants, Community Resources, Health Outcomes, and Well-being* (DataHaven and Connecticut Office of Rural Health June 2022), https://www.ctdatahaven.org/sites/ctdatahaven/files/Rural_Health_in_Connecticut.pdf.
[65] Department of Social Services, *Budget Justification and Narrative Attachment: Certified Community Behavioral Health Clinics* 9 (Sept. 27, 2024), https://www.cga.ct.gov/ph/bhpoc/op/related/20240101_2024/20240927/CCBHCNarrative.pdf.
[66] Connecticut Department of Mental Health and Addiction Services, Hospital Discharge Data for Individuals 18 Years and Older with a Mental Health Diagnosis 2016-2020, Connecticut (Connecticut ChimeData, 2016-2020), retrieved November 19, 2021.
[67] Connecticut Department of Mental Health and Addiction Services, Hospital Discharge Data for Individuals 18 Years and Older with a Mental Health Diagnosis 2016-2020, Connecticut (Connecticut ChimeData, 2016-2020), retrieved November 19, 2021.
[68] The Alliance and Fio Partners, *2022 State of the Connecticut Nonprofit Sector* 28 (Jan. 2022), https://fiopartners.com/images/uploads/CT-SOS-2022Report.pdf.
[69] Office of Health Strategy, *Health Information Technology Annual Report 2025* 10 (Mar. 28, 2025), https://portal.ct.gov/ohs/-/media/ohs/health-it-advisory-council/publications/ohs-health-information-technology-annual-report-2025.pdf.
[70] Butzner M and Cuffee Y, *Telehealth Interventions and Outcomes Across Rural Communities in the United States: Narrative Review*, 23 J. Med. Internet Res. e29575 (2021), https://www.jmir.org/2021/8/e29575.

[71] Office of Health Strategy, *Health Information Technology Annual Report 2025* 19 (Mar. 28, 2025), https://portal.ct.gov/ohs/-/media/ohs/health-it-advisory-council/publications/ohs-health-information-technology-annual-report-2025.pdf.
[72] Connecticut General Assembly, *Public Act No. 24-29: An act concerning the health and safety of Connecticut residents (Substitute Senate Bill No. 1),* (May 21, 2024), available at https://www.cga.ct.gov/2024/ACT/PA/PDF/2024PA-00019-R00SB-00001-PA.PDF.
[73] Office of Health Strategy, *Internal Connie Data Query* (on file with author).
[74] Connecticut Governor Ned Lamont, *Connecticut's 2024 Broadband Report Highlights Major Advancements in Digital Connectivity and Equity*, (Dec. 18, 2024), https://portal.ct.gov/-/media/deep/energy/broadband/biannual-broadband-report/deep_2024-broadband-report_low-resolution-final-pdf.
[75] Department of Energy and Environmental. Protection, *Connecticut Broadband Report 2024* 21 (Dec. 18, 2024), https://portal.ct.gov/ohs/-/media/ohs/health-it-advisory-council/publications/ohs-health-information-technology-annual-report-2025.pdf.
[76] Interstate Medical Licensure Commission, Participating States, IMLCC (2025), https://imlcc.com/participating-states/.
[77] Nurse Licensure Compact, Participating States Map, NURSECOMPACT (2025), https://www.nursecompact.com/index.page#map.
[78] Interstate Commission for EMS Personnel Practice, Home, EMS Compact (2025), https://www.emscompact.gov/.
[79] Psychology Interjurisdictional Compact, PSYPACT Map, PSYPACT (2025), https://psypact.gov/page/psypactmap.
[80] Physician Assistants Licensure Compact, Home, PA Compact (2025), https://www.pacompact.org/#compact.
[81] American Academy of Physician Assistants, PA State Practice Environment, https://www.aapa.org/advocacy-central/state-advocacy/state-maps/pa-state-practice-environment.
[82] American Association of Nurse Practitioners, State Practice Environment, https://www.aanp.org/advocacy/state/state-practice-environment.
[83] 2025 Policy Strategies for Full Practice Authority, CICERO INST. (Aug. 20, 2025), https://ciceroinstitute.org/research/2025-policy-strategies-for-full-practice-authority/.
[84] Variation in Dental Hygiene Scope of Practice by State, ORAL HEALTH WORKFORCE RESEARCH CTR. (Nov. 2024), https://oralhealthworkforce.org/infographics/variation-in-dental-hygiene-scope-of-practice-by-state/.
[85] *Connecticut State Telehealth Laws — Miscellaneous Professional Requirements*, Center for Connected Health Policy, Connecticut (Sept. 2, 2025), https://www.cchpca.org/connecticut/?category=professional-requirements&topic=miscellaneous-professional-requirements.