Project Narrative

Rural Health Transformation Program

Rural health needs and target population

Washington is made up of many rural communities with a range of cultures, geographic features, needs, and strengths. Over 85% of Washington's land is rural, ranging from the cluster of islands only accessible by ferry that make up San Juan County to the highland desert farmland of Okanogan County.[1] Washington's rural communities support robust agriculture, forest products, and energy industries that bring economic vitality to the region. These communities and the 1.1 million people living in them, including some of the 29 federally recognized Tribes and their reservation lands, face persistent and growing challenges that threaten access to health care, system sustainability, and the overall health and wellbeing of residents. The Rural Health Transformation (RHT) Program offers Washington an exceptional and timely opportunity to address the pressing health care access and system sustainability needs of these communities and to make rural Washington healthy again. It is the state's endeavor to ensure every rural resident has reliable access to quality health care in their communities and make rural Washington a desirable place for residents to consider home across their lifespan.

For a summary of Washington's rural facility and population score factors (A.1–A.7), see **Table 1 in the Other Supporting Materials (OSM) attachment**. Throughout this narrative and other supporting materials, Washington relies on two definitions of rural: the Federal Office of Rural Health Policy (FORHP) and the state's Office of Financial Management.[2] Citations make clear the definitions used to describe rural communities throughout.

Rural Demographics

Over one million Washingtonians live in rural areas (14.5% of the state's population). The population-weighted density in rural areas is 19.75 people per square mile, compared to 662.68 people per square mile in Washington's urban areas. Rural Washingtonians are older and face greater health, social, and economic challenges compared to their urban counterparts. By 2030, more than one in five Washington residents will be 65 or older; this is compared to one in seven in urban areas. The trend will continue to 2040 and beyond, shown in **OSM Figure 1**. This demographic shift means rural residents are more likely to experience multiple chronic conditions, require long-term care, and depend on Medicare and Medicaid for coverage. Rural residents are more likely to lack health insurance coverage, with 8.5% of rural residents uninsured (compared to 6% in urban areas when population weighted). Rural Washingtonians have lower median income levels, and the most common employment sectors are agriculture, manufacturing, and transportation.[3] For a summary of demographic indicators in rural Washington, see **OSM Table 2**.

Tribes in Washington

Washington works in government-to-government partnership with the 29 federally recognized Tribes[4] within the boundaries of Washington state on topics ranging from education and health care to economic development and natural resource management. Tribes oversee and manage approximately 6 million acres of reservation and trust land across the state, with lands located in Washington's geographically diverse rural and isolated areas. American Indians/Alaska Natives (AIs/ANs) experience significantly poorer health outcomes, including a persistent life expectancy gap, compared to the state's general population, due at least in part to chronic

[1] U.S. Census Bureau. 2020 Decennial Census. U.S. Census Bureau. 2020.

[2] **Washington Office of Financial Management: Population density and land area criteria used for rural area assistance and other programs**

[3] **AWB: Rural Jobs Outlook**

[4] **Tribes in Washington**

underfunding.[5] This situation necessitates strong partnerships between the state and Tribes; currently, over 80,000 AI/AN individuals are enrolled in Washington Apple Health (Medicaid), maintaining Indian Health Service (IHS) as the payer of last resort.[6] Importantly, the Portland IHS area (Washington, Oregon and Idaho) does not have any Tribal or IHS-operated hospitals, requiring reliance on non-Tribal specialty care outside of the reservation. Indian health care providers (IHCPs) function as indispensable anchors of the broader rural health system by offering comprehensive, culturally congruent care. All federally recognized Tribes in Washington are public health authorities,[7] reinforcing their essential role as government-to-government partners in driving transformational rural health access.

Health outcomes

Rural residents consistently experience poorer health outcomes than their urban peers. Nearly 80% of older adults have at least one chronic condition, and over 75% live with two or more.[8] Among rural Medicare home health beneficiaries, 35% manage seven or more chronic conditions, driving heavy use of hospital and emergency services. In all adults, those in Washington's non-metro counties experience higher rates of hypertension, diabetes, cardiovascular disease, and chronic obstructive pulmonary disease; and there are modest differences in asthma, kidney disease, and cancer (**OSM, Table 3**).[9]

Washington's support of maternal and child health reflects both strengths and continued challenges. Infants and neonatal mortality remain relatively low (4.4 and 2.8 deaths per 1,000 live births, respectively), however maternal mortality rates in Washington are higher in rural than urban areas. From 2014–2020, the maternal mortality rate in rural Washington was 23 pregnancy-related deaths per 100,000 live births (compared to 15 pregnancy-related deaths per 100,000 live births in urban areas).[10]

Behavioral health needs in rural Washington remain urgent and unmet, with limited psychiatric providers and inpatient beds forcing patients to wait in emergency departments or jails. Substance use disorders, overdose deaths, food insecurity, lack of healthy foods, and housing shortages are also more common in rural areas, compounding health risks. In 2024, the statewide rate of emergency department (ED) visits for non-fatal drug overdose was 347 per 100,000 population. In North Central Washington (made up of the rural Okanogan, Chelan, Douglas, and Grant Counties), the rate was 418 per 100,000 population.[11] Overdose deaths rose in Washington from 2013 through 2019, and some of the highest death rates and largest increases are seen in rural counties, such as Mason, Yakima, Okanogan, Whitman, Franklin, Klickitat, and Kittitas, each with over a ten-fold increase.[12] For a summary of health outcome data in Washington, see **OSM Table 3**.

Health care access

Rural Washington's widely dispersed population depends heavily on a network of 39 Critical Access Hospitals (CAHs, many of which are public hospital districts), 3 Sole Community Hospitals, 127 Rural Health Clinics (RHCs),

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[5] Northwest Portland Area Indian Health Board. **American Indian & Alaska Native Community Health Profile: Washington State.** Issued October 2024.

[6] 42 CFR 136.61 - Payor of last resort

[7] 45 CFR § 164.501 and WAC 246-101-010(38)

[8] Watson KB, Wiltz JL, Nhim K, Kaufmann RB, Thomas CW, Greenlund KJ. *Trends in Multiple Chronic Conditions Among US Adults, by Life Stage, Behavioral Risk Factor Surveillance System, 2013–2023. Preventing Chronic Disease.* 2025

[9] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS): Washington metro vs non-metro tabulations. CDC. 2023.

[10] **Washington State Maternal Mortality Review Panel: Maternal Deaths 2017-2020**

[11] **WA Department of Health Opioid and Drug Use Data Dashboard**

[12] **UW Addictions, Drug, and Alcohol Institute. Opioid Trends Across Washington State**

70 rural Federally Qualified Health Centers (FQHCs) and 13 rural community mental health centers (CMHCs), along with Indian health care providers, emergency medical services, and long-term care settings (**OSM, Table 4**). Rural Washingtonians travel farther distances than their urban counterparts to access health care. A recent study found that rural Washington patients with Alzheimer's traveled three times as far to see a primary care provider as comparable patients in metropolitan areas.[13] Likewise, 61.5% of women live over 30 minutes from a birth hospital (compared to 15.3% in urban areas).[14] Only 38.5% of CAHs currently provide obstetric services, and 24 of 39 no longer deliver babies. Of Washington's 1,260 inpatient psychiatric treatment beds, only 191 (15.6%) are located in rural counties.

Workforce shortages make bridging these geographic gaps difficult—every county in Washington is at least partially considered a Health Care Professional Shortage Area (HPSA) for primary care and mental health care and 37 of 39 are HPSAs for dental care.[15] Shortages are not slowing down given the aging nature of rural communities with many providers approaching retirement. Washington currently supports 465 family medicine residencies, but less than 10% of graduates are participating in rural communities. There are also shortages among nurses, behavioral health providers, and emergency medical responders.

Lack of transportation can cause challenges for patients in rural areas to access care. For example, a 2024 report to the State Legislature highlighted that transportation is a significant challenge in accessing behavioral health and crisis services. This was especially challenging for patients and their families who needed to travel out of their home region because inpatient behavioral health beds were unavailable locally.[16] In our stakeholder engagement process, numerous providers expressed that transportation, including non-emergency transportation, is a hindrance to patient care and expressed interest in purchasing vehicles to provide patient rides and to better leveraging Emergency Medical Service (EMS) transportation service.

Rural facility financial health

Consistent with national trends, many of Washington's rural providers are under financial strain. Between 13 and 17 of Washington's 39 CAHs are currently experiencing distress based on Flex Monitoring Team profitability indicators.[17] High turnover, reliance on traveling staff, and strained emergency services threaten continuity and quality of care. Community Health Centers (CHCs), that are central to preventive service access for rural communities and low-income populations face unique challenges related to their high volumes of patient care and heavy public payer mix. Sixteen of Washington's 28 CHCs operate primarily in rural counties. These served over 570,000 patients in 2024, of which over 75% were uninsured or insured by Medicare, Medicaid, or Children's Health Insurance Program (CHIP).

Rural hospitals face a challenging dynamic: they see a lower volume of patients relative to higher-density areas; the day-to-day demand for services may be low (therefore generating limited revenue on a fee-for-service basis), but the capacity to provide emergency labor and delivery, and other services remains integral. On average, 67% of patients treated at Washington's CAHs are enrolled in Medicaid or Medicare, and a quarter of CAH's have a patient mix reaching nearly 75% Medicare and Medicaid.[18]

Washington's hospitals face a mounting uncompensated care burden that continues to impact financial stability, especially in rural facilities with thin margins. In 2024, Washington hospitals reported $2.38 billion in

[13] Amiri S, Keffeler JI, Crain DR, Denney JT, Buchwald D. Alzheimers Dement. 2024 May;20(5):3671-3678. Epub 2024 Mar 20. **Distance to physicians among decedents with Alzheimer's disease and related dementias in Washington State**.

[14] **March of Dimes: Maternity Care in Washington**

[15] **Washington Department of Health: Data, Maps, and Other Resources**

[16] **Rural Access Study, Report to Legislature. November 2024.**

[17] Flex Monitoring Team. **CAH Financial Indicators Primer and Calculator Resources**. May 2025.

[18] Washington State Discharge Dataset, calendar year 2024. *Payer mix summary statistics for 39 Critical Access Hospitals*.

uncompensated care ($838M of bad debt and $1.55B in charity care). This equaled nearly 7% of operating expenses and marked a 22% increase from 2023, with further growth of uncompensated care expected in 2025.

Target population

The RHT Program will help Washington's 1.1 million rural residents across 30 counties. Particularly, the focus of the state's RHT plan and funding are on the following populations:

- Residents of rural, high need counties, aligned with the FORHP definition.
- Frontier communities and EMS agencies in sparsely populated areas.
- Adults in all rural areas who are aging and/or have multiple chronic conditions and face high obstacles to care.
- Families who need maternal and child health services.
- Tribal populations who face longstanding health and access challenges.

Rural health transformation plan: Goals and strategies

Vision

We want to make rural Washington a desirable place for our residents to consider home across their lifespan. We endeavor to ensure every rural Washingtonian has reliable access to quality health care in their rural communities. The RHT Program funds will enable targeted investments aligned explicitly with the goals and strategies of the RHT Program: make rural Washington healthy again, sustainable access, workforce development, innovative care, and tech innovation. Washington will achieve rural health transformation through five strategic pathways.

Strategy 1: Create opportunities for health in rural Washington

Addressing improving access, improving outcomes

RHT Program goal alignment: make rural America healthy again, sustainable access, workforce development, and tech innovation.

Access to preventive care, disease management, and other health care services is central to maintaining the health and productivity of the state's rural communities. To expand how and where services can be accessed, Washington will utilize RHT Program funding to support a range of programs:

- Embedding health care resources in community settings (Initiative 2).
- Investing in community workforce development for Tribes (Initiative 3).
- Expanding access to remote services and telehealth through technology (Initiative 4).
- Investing in nursing and family medicine education programs, including new investments in Washington's two major medical schools (Initiative 5).
- Expanding mobile behavioral health services (Initiative 6).

Strategy 2: Foster partnerships across the rural health care delivery system

Addressing partnerships, financial solvency strategies, cause identification

RHT Program goal alignment: sustainable access, innovative care, and tech innovation.

Local and regional strategic partnerships will enable rural Washington's health care system to thrive. Such partnerships can increase operational efficiency, create forums to share best practices, and identify the right size of health care resources in each community. Washington will tap into the expertise of existing rural health partnerships (The Rural Collaborative, State Office of Rural Health) to serve as a starting point for maximizing regional-level strategic planning, and for disseminating technologies and best practices. The state will create an advisory committee comprised of rural community members and providers who can lend their expertise towards recommendations for investments in future years of the program. Example activities under this strategy include:

- Expanding the capacity and capabilities of a rural health network of independent hospitals (Initiative 1).
- Co-designing a new payment model for low-volume rural hospitals with providers, community organizations, and payers (1).
- Expanding inter-facility EMS tracking and coordination (2).
- Enhancing care coordination between Tribes and rural hospitals (3).
- Building partnerships between clinical settings and educational institutions with grow-your-own training programs and embedding nurse faculty into rural care settings (4).
- Expanding multidisciplinary teams for mobile behavioral health crisis response care (6).

Strategy 3: Grow Washington's workforce

Addressing workforce

RHT Program goal alignment: sustainable access, workforce development, and tech innovation.

A robust rural health workforce is the backbone of the rural health care system. Throughout stakeholder engagement, Washington heard particular concern for the following essential health care providers: maternity services, primary care, behavioral health, long-term care workers, tribal providers, dental hygienists, and other mid-level providers that can help right-size the rural workforce. Washington has a history of training providers locally, and will build on multiple approaches to growing, supporting, and retaining rural workforce across the state. RHT Program investments will bolster preventive and behavioral health care access, ensure maternity services can be accessed within rural communities, and will leverage technology to bring high-acuity specialty care to rural settings that have insufficient patient volumes to retain certain provider types. These investments include:

- Growing the community health and long-term care workforce (Initiative 2).
- Supporting tribal workforce development and the Tribal Community Health Provider Program (3).
- Increasing funding for new family medicine residencies that support Washington, Wyoming, Alaska, Montana and Idaho through the University of Washington WWAMI program (5).
- Expanding rural nurse education (5).
- Providing recruitment and retention funds for rural opioid treatment providers (6).

Strategy 4: Deploy technology and data-driven solutions to empower communities with healthy opportunities, increased efficiencies, and connectivity

Addressing technology use, data-driven strategies

RHT Program goal alignment: make rural America healthy again, sustainable access, and tech innovation.

Technology and data can create opportunities to transform the rural health care delivery system and empower individuals to manage their personal health. Washington will use RHT Program to invest in new and emerging technologies to close geographic gaps in access and modernize rural health care. Investments will help support providers with up-front capital that is necessary and often lacking in rural communities, to transform care delivery and connect care settings. Each investment will translate to more efficient and higher quality patient care by increasing patient monitoring, bringing more specialty care access, and freeing up the time and capacity of rural providers to use data tools to target interventions to highest or rising risk patients. This will include funding for:

- Quality performance monitoring tools and technical assistance from a rural health network to promote shared learning across hospitals (Initiative 1).
- Artificial Intelligence (AI), new data platforms, telehealth technology, cybersecurity, and remote patient monitoring that can keep a patient in their home and community (1).
- Remote care specialty services through Project Extension for Community Healthcare Outcomes (ECHO) (4).
- AI tools to increase provider efficiency and decrease provider burden for non-hospital settings (4).
- Consumer-facing wearables, patient monitoring and diagnostic kits (4).
- Population health tools that allow providers to monitor quality of care and increase chronic disease management (4).

Strategy 5: Improve financial solvency

Addressing financial solvency strategies, cause identification

RHT Program goal alignment: sustainable access, innovative care.

Many independent rural hospitals across Washington state are at risk of reducing service lines or closure, in line with national trends. This is driven by low volume of patients, high fixed costs, payment methodologies built to reward volume of care, payer mix, and other challenges unique to rural areas. To address these root causes, Washington will use RHT funding to invest in the following:

- Building the capacity of a rural health network to offer shared services (Initiative 1).
- Co-designing a new payment model for low-volume rural hospitals (1).
- Using technology to increase hospital and provider cybersecurity and operational efficiencies (1 and 4).
- Building health care career pathways for rural residents to sustain the workforce (2 and 5).
- Planning to transition behavioral health facilities to the Certified Community Behavioral Health Clinic (CCBHC) payment model (6).

These critical investments will help address the root causes of financial instability in rural health care settings. Co-design and implementation of innovative value-based payment models will address the unique needs of low-volume providers and promote long-term sustainability of a transformed system beyond the five-year RHT Program. Likewise, technologies that enable efficiency gains and decrease administrative burden will help retain a highly skilled workforce.

Program key performance objectives

Washington seeks to achieve measurable progress in sustaining and advancing the rural delivery system by the end of the RHT Program. The state's initiatives focus on growing the rural workforce, deploying technology, driving participation in innovative payment models, and increasing the ways that residents can access care.

Washington will evaluate progress based on utilization patterns, provider uptake of new technologies, workforce deployment, payment model adoption, among other considerations. Tracking these metrics will provide unique insights into the value and effectiveness of RHT funding and help the state redistribute funding within the RHT plan in years three, four, and five of the program to ensure tangible improvement of health and access.

The state's measurable performance outcomes from RHT Program investments will include:

- Drive 50% of rural hospitals to engage in an advanced payment model co-design process and 25% of rural hospitals to participate in the value-based advanced payment model before the end of the RHT Program,
- Ensure no additional rural hospitals close their obstetric units,
- Increase mobile health utilization by 5% per year beginning in year 2 of the program,
- Enroll 5% more community health workers per year in training to increase CHW deployment and the care coordination these providers' support,
- Add four new clinical residencies in Washington before 2030, and
- Support at least two new behavioral health clinics in changing to the CCBHC payment model.

Where baseline data is unavailable or was inaccessible during the RHT application development process, Washington will use year one of RHT Program to develop measurable targets for the state to pursue prior to FFY 2031. This work will include:

- Assessing current levels of provider adoption of integrated AI and population health management analytic tools and establishing a target for increased utilization to measure success of primary care and other provider-side technology investments.
- Assessing current utilization of consumer-facing wearables amongst rural patient populations and establishing targets for measurable increases in utilization; and
- Establishing measurable targets for increasing utilization of telehealth services for at least three service types before the end of 2029, to assess provider-uptake of telehealth following behavioral health and technology related investments.

By the end of the RHT Program, through metrics tracking and reporting, the state will be able to show how the investments in Washington bolstered the rural workforce, advanced the deployment of technology, sustained access to tribal health care, increased mobile supports, and increased access to behavioral health services. The state will seek to ensure these funds allow people to stay in their rural communities through their lifespans and sustain the vitality of Washington's rural economy.

Other required information

State policies

Washington has made numerous commitments to creating expansive access to health care and a flexible regulatory environment for providers and patients. The state has taken or is contemplating the following regulatory steps that align with the RHT Program's state policy action technical scoring factors.

B.3. SNAP Waivers

Washington restricts using SNAP benefits for certain items that may meet the RHT Program's definition of "non-nutritious," such as tobacco products, alcoholic beverages, food or drinks with controlled substances, and hot ready-to-eat foods such as hot dogs or pizza. Since 2015, the state has partnered with the U.S. Department of Agriculture and local and private entities to administer a Fruit and Vegetables Incentives Program, which helps Washington families afford healthy produce. The program includes:

- Match funding for shoppers at participating farmers markets and farm stands,
- Prescriptions at select health care sites which patients use to buy fruits and vegetables, and
- Distribution of coupons to save on fruit and vegetable purchases when a SNAP customer purchases fresh produce at a participating grocery store.[19]

B.4. Nutrition Continuing Medical Education

Physicians licensed in Washington must complete 200 hours of continuing medical education (CME) every four years.[20] The state has no current requirements that CME include nutrition as a component but is exploring regulatory steps to incorporate nutrition into CME requirements in future years.

C.3. Certificate of Need

Washington values the role of Certificate of Need (CON) in controlling costs while supporting access to critical facilities and services. The appropriate score for Washington based on the Cicero State Rankings Report is 60. Cicero gives Washington a score of 100 in its report[5] based on a 2013 small business economic impact analysis related to CON definitions, **which contains several factual inaccuracies for Washington**:

- Washington CON does not regulate outpatient behavioral health facilities.
- Washington CON does not regulate ancillary services.
- Washington CON does not regulate imaging services.
- Washington CON does not regulate substance addiction treatment centers, clinical labs, central services, and acquisition of major medical equipment. **WA discontinued regulation of major medical equipment in the 1990s.**
- Washington CON does not regulate day services for home health agencies.

Of note, Washington factors in nursing-home-comparable home and community based long-term care capacity in determining unmet need for additional nursing home beds. This ensures that access to community residential and in-home care are a part of determining when additional nursing home beds are needed in the state. In

[19] Washington State Department of Health. **Washington's Fruit and Vegetable Incentives Program**.

[20] Washinton State Department of Health. **Physician and Surgeon (MD) Continuing Education Requirements**.

addition, Washington just completed a comprehensive review of the CON program in July 2025 with recommendations to enhance and improve the program in future years.[21]

D.2. Licensure Compacts

Washington was an early adopter of interstate licensure compacts. The state actively participates in several compacts, including:

- Interstate Medical Licensure Compact—RCW 18.71B
- Interstate Nurse Licensure Compact—RCW 18.80
- Psychology Interjurisdictional Compact—RCW 18.83A
- Physician Assistant Licensure Compact—RCW 18.71C
- Physical Therapy Licensure Compact—RCW 18.74.500
- Social Worker Licensure Compact—RCW 18.321
- Occupational Therapy Licensure Compact—RCW 18.59.180

While Washington does not currently participate in the EMS Compact, the state recognizes that compacts improve provider mobility and patient access to critical services. The state will continue to explore participation in additional compacts in future years.

D.3. Scope of Practice

Washington believes in allowing health care providers to practice to the bounds of their training, when supported by their education and skills. Washington's national leadership in this space has broadened access to services in rural communities, lowered costs of care, and freed capacity of the most skilled professionals to serve higher-acuity patients. Washington's scope of practice for individual professions is as follows:

- Physician Assistants—**Advanced**, according to AAPA[7]
- Nurse Practitioners—**Full Scope of Practice**, according to AANP[8]
- Pharmacists—**Score of 4**, according to Cicero Institute[9]
    - While pharmacists do not have the ability to independently prescribe in Washington, they do have prescriptive authority for legend drugs and controlled substances through collaborative drug therapy agreements.[10]
- Dental Hygienists—Can provide **five of eight** allowable tasks, according to the Oral Health Workforce Research Center (OHWRC)[11]
    - OHWRC lists Washington as one of only 10 states with an **Excellent** rating.
    - Washington has taken other steps to expand access to dental services such as licensure of Dental Therapists.
- Long-Term Services and Supports workers can be delegated **21 of 21 health maintenance tasks** under training and supervision of registered RNs according to AARP LTSS Scorecard.

E.3. Short-term limited duration insurance

Washington permits short-term health plans. Current rules went into effect in January 2019 and limit the total duration, including renewals, to three months.[22]

[21] Washington State Department of Health. Certificate of Need Program Health Systems Quality Assurance. **Report to the Legislature: "Certificate of Need Modernization."** July 2025. Chapter 376, Laws of 2024, Sec.222(138).

[22] Washington Office of the Insurance Commissioner. **What you need to know about short-term medical plans**.

F.1. Remote care services

Washington is broadly supportive of expanding access to remote care and telehealth services. Washington reimburses (and has required commercial insurers reimburse) live video, store-and-forward, remote patient monitoring, and audio-only telehealth.[23]

Data factors

Factor A.2. Certified Community Behavioral Health Clinics

Washington has 12 active Certified Community Behavioral Health Clinics as of September 1, 2025. A complete list of entities is in **OSM, Table 5**.

Factor A.7. Disproportionate Share Hospital (DSH) payments

Washington had 43 hospitals receive Disproportionate Share Hospital (DSH) payments in SFY2023 (measured in FY2025). A complete list of the hospitals is in **OSM, Table 6**.

[23] **Center for Connected Health Policy**

Proposed initiatives and use of funds

Initiative 1: Ignite innovation in Washington's rural hospitals

Under the RHT Program, Washington has a unique opportunity to work with rural hospitals to develop new and innovative business models. New technology, new forms of cooperation, and payment models that align incentives to health and wellbeing will enable sustainable access to hospital care. This initiative will help support rural facility financial health and improve access.

Activities

1.1 Expand a rural health network.

Washington proposes utilizing $6 million per year of RHT Program funds to strengthen a rural health network. The Rural Collaborative (TRC) is a network of 30 independent public hospitals in Washington. Formed in 2003, TRC has a shared governance model that allows its members to act collectively while maintaining local autonomy—independence through interdependence. TRC supports shared staffing, peer learning, group purchasing, joint contracting, and quality improvement initiatives.[24] Funds from RHT Program will help TRC create greater efficiencies and broaden the pathway for hospitals to participate in value-based care arrangements.

TRC will use sub-awarded RHT Program funds to invest in three critical areas of network development that TRC member hospitals have declared are necessary to more effectively serve their patients. First, TRC will build capacity to support improved revenue cycle management, including leveraging common revenue cycle technology and providing root cause analysis and benchmarking to achieve improved revenue cycle outcomes across all network members. TRC will also develop a peer-to-peer learning network to cultivate partnerships across the network. Second, TRC will create more access to care and improve the value of clinical care by enabling TRC members to adopt new technology such as tools for remote patient monitoring, point-of-care imaging and decision-making, and shared diagnostic tools, and AI tools to reduce administrative burden (like charting and scheduling). Third, TRC will implement shared tools and resources that allow the rural health network to act like an integrated system and increase operational efficiencies. These include the following: quality reporting tools, payer performance monitoring, business development analysis, analyzing and disseminating best practices, and shared staff in key operational and clinical roles (billing and coding professionals, information technology support, and certain clinical specialists).

1.2. Co-design a payment model for long-term sustainability.

Washington proposes to use $2–5 million per year in RHT Program funds to bring payers and providers together to co-design value-based payment (VBP) models that promote long-term sustainability of essential services, improvements to health outcomes, quality, and efficiency of care. Such payment models will require payers and providers to more intentionally share financial risk and accountability to ensure rural residents can access high quality care within a sustainable rural health infrastructure.

The state has significant experience striving towards value-based care. For nearly a decade, HCA has incentivized VBP adoption for both Medicaid managed care organizations (MCOs) and commercial carriers that cover state employees. Roughly 80% of the state's health care spending for these clients is tied to some kind of quality performance expectation.[25] The state participated in the Center for Medicare and Medicaid Innovation's Community Health Access and Rural Transformation (CHART) Model and the Making Care Primary Model. Washington's payers and providers know that alternative payment models have the potential to financially

[24] **The Rural Collaborative**.

[25] HCA, **Tracking success of value-based purchasing**.

sustain services and improve clinical provider satisfaction by aligning incentives towards maximizing health instead of service volume.

Washington proposes engaging the Rural Health Redesign Center (RHRC) to support the payment model design.[26] RHRC supported the design and implementation of the Pennsylvania Rural Health Model (PARHM), a two-sided risk model. RHRC will facilitate payers and providers to define essential services, shared goals, and alternative payment frameworks to ensure sustainability.

RHRC will support hospitals to evaluate their financial performance under an alternative payment model to assess the best options for their sustainability, as well as define community-driven transformation approaches. Washington aims to have the co-designed payment model fully developed and adopted for Medicaid clients before the end of the RHT Program. Additionally, the state would explore incentives for commercial payers to adopt the model within the RHT period.

Additionally, RHRC will help hospitals assess alternative organizational structures, like the Rural Emergency Hospital (REH) designation, to see if this federal designation would sustain hospitals with low inpatient utilization. Washington will work with RHRC to assess if there is an opportunity for a fixed payment infrastructure for non-Medicare beneficiaries like what the Medicare REH program provides to hospitals seeking this designation.

1.3 Invest in critical technology infrastructure and maintenance needs.

Low-volume, rural hospitals often struggle to make investments in expensive infrastructure that require significant one-time expenditures or ongoing time and cost. Some rural hospitals have begun investment in ambient artificial intelligence (AI), clinical data intelligence, and bot automation AI usage, through support of vendors that include Spheregen, Oracle, and Microsoft. However, in a 2025 survey conducted by the Washington State Hospital Association, over 80% of rural providers reported that insufficient funding prevents them from upgrading IT infrastructure or investing in new technologies. Under this initiative, Washington proposes to use $32–42 million per year in RHT Program funds to support critical investments in AI, cybersecurity, revenue cycle management, and governance to sustainably improve hospitals' efficiency and capacity.

Washington proposes to create an infrastructure fund to invest in enabling technologies and critical maintenance needs. The fund will focus on technological advancement. Hospitals may use funds to invest in AI tools, data platforms, population health tools, improved telehealth and remote patient monitoring tools, and cybersecurity technologies, services, and training (like Microsoft's Rural Health Resiliency program[27]). Adopting burgeoning technologies like AI can help hospitals streamline operations, reduce administrative burden, and improve their revenue and cost management. Hospitals may also use infrastructure funds to support critical facility maintenance that addresses aging infrastructure and ensures long-term sustainability of these essential community buildings.

The Washington State Hospital Association (WSHA) will administer the infrastructure fund. WSHA is best positioned to support hospitals to identify critical infrastructure needs that RHT Program funds can address. WSHA can also, when appropriate, negotiate favorable business arrangements for the purchase of technologies and technical assistance. The state will direct the allowable uses of funds, program expectations, monitoring, and reporting requirements in alignment with the RHT Program Cooperative Agreement and NOFO.

1.4. Sustain and strengthen maternal, emergency, and specialty services at risk in rural areas.

Washington proposes to use approximately $10–12 million per year in RHT Program funds to incentivize hospitals to develop comprehensive strategies to sustain and maintain essential services—including maternity

[26] **The Rural Health Redesign Center**.

[27] Microsoft. **Rural Health Resiliency**.

and obstetrics care, emergency services, and other specialty care. For example, a hospital may request funds to support developing remote monitoring capabilities for low-risk pregnancies, paired with capacity payments for midwives and birth centers located in rural areas. Incentive funds would support start-up and implementation costs for hospitals and would require a long-term sustainability plan. Sub-awardees will be selected through a competitive review process, as described in the implementation plan. Awards will be based on financial and community need, readiness, sustainability plans, alignment with value-based care, community partnerships, and innovation. All awards will adhere to federal and state procurement and reporting requirements.

Other considerations

As described in the background section, Tribes in Washington are central to the state's rural regions. Washington will ensure that Tribes have an opportunity to engage in activities of The Rural Collaborative and the payment model design efforts, and the state will ensure that the activities in this initiative benefit Tribal members. Washington will also ensure rural hospitals that serve a higher percentage of Native Americans engage in Initiative 1 activities.

Infrastructure funds (primarily technology investments) in Initiative 1.3 will focus on rural hospitals. Washington will be mindful of the interactions between the infrastructure fund used for this initiative and the provider technology fund (4.2) to coordinate and maximize investments. Infrastructure fund spending (1.3) will comply with all funding limitations specified in the NOFO. Infrastructure spending will be limited to permissible renovations or alterations and will not exceed spending limit. The process for selecting subcontractors is described in the implementation plan.

Washington intends to offer financial incentives to improve access to maternity care and obstetric services (Initiative 1.4). This incentive program will be supported by our workforce recruitment and retention efforts (Initiatives 5.1 and 5.5). The program will be compliant with limits to provider payments specified in the NOFO.

Table 1: Initiative 1 supporting detail

Main strategic goal	Make rural America healthy again, sustainable access, innovative care, tech innovation
Uses of funds	D, F, G, I, J, K
Technical score factors	B1, C1, C2, E1, F1, F2
Key stakeholders and partners	Washington's rural hospitals, sovereign Tribal nations, the WSHA, TRC, State Office of Rural Health, Microsoft
Outcomes	• Increase hospital operating efficiency • Increase availability of maternity and obstetric services • Increased participation of Washington's rural payers and providers in value-based payment models • Increased participation of Washington's rural hospitals in regional provider collaboratives or integrated care networks
Impacted counties	• Washington will offer these activities for all providers in a rural area, following the guidance of the Federal Office of Rural Health Policy (FORHP). • FORHP designates 22 Washington counties that are "fully rural," and 17 counties that are "not fully rural." The list of counties is in **OSM, Table 7**.
Estimated required funding	$53–61 million per year

Initiative 2: Prevent disease and manage care in community settings

Under this initiative, Washington will use RHT Program investments to build and expand programs and workforce in settings outside the walls of clinical systems. Rural residents will be able to access the right level of care at the right time, delivered by the right provider in cost-effective ways that take pressure off clinical systems. The state will augment community-based mobile health, technology, community-based workforce, and emergency medical services to engage people in prevention early, connect them to services for social needs, care for them as they age, and transport them efficiently to clinical settings when they need acute care.

Activities

2.1. Expand the community-based workforce.

Through the RHT Program, Washington will invest resources to increase opportunities and remove obstacles for workforce to support rural residents outside of clinical settings.

First, Washington proposes using $2–4 million per year of RHT Program funds to increase training and hiring opportunities for community health workers (CHWs). Washington will add modules for training related to rural health, telehealth, and digital navigation to the existing CHW learning management system (LMS). Digital navigation services can provide support to community members in accessing their virtual appointments, completing any tech-related set-up, and accessing low-cost internet services. Washington will expand capacity in the CHW LMS to increase the number of training slots available and recruit staff like pharmacy technicians to receive CHW training. The state will provide stipends to rural hospitals to include CHWs and digital navigators in care planning. Washington will also embed this community-based workforce into an existing infrastructure that includes rural social care networks, a WA 211 call center, and a developing community information exchange (CIE) system. Washington may consider opportunities to support this burgeoning CIE system, which is slated to launch in 2027 under the Medicaid Transformation Project 2.0 (via 1115 waiver authority). The state will consider using RHT Program funds to target technical assistance and training for rural providers and community-based workers to maximize the use of the CIE to document patient encounters and to enable coordination across the health care system.

Second, Washington proposes using $4 million per year of RHT Program funds to invest in removing obstacles for aspiring long-term care workers (LTCWs) to complete testing after training by embedding testing into training sites in rural areas. Currently, only 21% of the total long-term care workforce in Washington (including personal care aides, home health aides, and nursing assistants) are in rural counties. Aligning training and testing sites will reduce rural workers' need to travel long distances to complete certification steps. It will also increase completion rates, reducing vacancies and turnover of these essential workers. The state successfully piloted the embedded testing and will use funding to expand to all training sites statewide. Washington will also invest in CareLearn, a LMS platform that allows LTCWs to take continuing education classes so they can maintain certification in a way that is convenient for them, improving staff retention.

2.2 Expand dementia resources and build dementia capable communities.

Washington recognizes that rural areas are experiencing the steepest aging trends in the state. The state proposes investing $3–4 million per year of RHT Program funds in the Building Dementia Capable Communities (BDCC) program, developed as a pilot by Area Agencies on Aging (AAA) to enhance the support network for people living with dementia and their caregivers.[28] A recent evaluation of the BDCC pilot identified positive impacts such as expansion of early-stage dementia support availability, enhanced professional knowledge and capacity, and strengthened community partnerships. These resources will broaden the services currently offered in three existing AAAs and expand the availability of dementia support services and competencies to ten

[28] **Building Dementia Capable Communities**.

new AAAs, develop professional training programs, create new community partners, and increase community awareness around dementia resources (like Amy's Place).[29]

2.3 Expand EMS inter-facility transport and support for trauma designated facilities in rural communities.

Washington proposes using $2.8 million per year of RHT Program funds to modernize EMS and transport services and strengthen regional transfer agreements, reducing delays for trauma, cardiac, stroke, and other time-sensitive emergencies. Increased funding would allow the state to leverage the Washington Medical Coordination Center (WMCC) infrastructure and existing data systems (WA Health, WATrac) to support bed tracking and coordination and a statewide interfacility (IFT) component. The strategy builds capacity within rural EMS systems by exploring a statewide EMS contract to reimburse long-distance rural transfers, define qualifying criteria, and establish funding models that strengthen rural EMS sustainability through contracts with EMS agencies.

2.4. Triage individuals, families and caregivers in rural areas to the appropriate level of services and care in their neighborhoods.

Guiding residents to what they need, when they need it, close to home is a cost-effective way to improve health in rural communities. Washington proposes using $10.5 million per year of RHT Program funds for this initiative's activities.

First, the state will use RHT Program funds to expand mobile health services to promote prevention, disseminate critical health information, and conduct outreach, providing access to isolated communities and helping individuals better prevent or manage chronic conditions. Washington will expand current mobile health capacity (Department of Health's Care-A-Van (CAV) program, DSHS's AAA Mobile Assistance Van program) to connect residents with chronic disease screening and self-management programs, naloxone and opioid prevention education, mental health screening, dental services, telehealth referrals, and consumer wearables. Increasing the number of vans in rural communities will allow for expansion to additional services such as maternity supports, meal delivery, or transportation of residents to appointments.

Second, Washington will convert community gathering spaces like senior centers, churches, schools and libraries into family and community engagement hubs to support health. These organizations can serve as places for people to:

- Learn and receive support on health issues via evidence-based programs such as falls prevention; Chronic Disease Self-Management Education; Program to Encourage Active, Rewarding Lives; and Silver Sneakers;[30,31]
- Receive support on using technology from a company like GetSetUp to support senior health and wellness;[32]
- Receive health screenings, digital wearables, and social services from care coordinators;
- Access providers in person or via telehealth or mobile health; and
- Receive caregiver supports and address social isolation.

These spaces offer strong collaboration and programing opportunities with infrastructure to recruit and train volunteers and to establish places for medical, rehabilitative, and behavioral health professionals to monitor and work with community members creating sustainable funding sources for rural providers. Funding will

[29] **Amy's Place | Dementia Support NW**

[30] **Evidence-Based Chronic Disease Self-Management Education Programs.**

[31] **Program to Encourage Active Rewarding Lives (PEARLS)**

[32] **Live classes for older adults- GetSetUp**

purchase technology to connect to telehealth and supply and support use of small digital devices; outreach and engagement; education materials; and workshop facilitation.

Third, the state will increase access to WA 211 for rural counties. WA 211 is a free, confidential helpline that connects individuals and families to local community services and operates in concert with 988 (for behavioral health services), 911 (for emergency services) and Community Care Hubs in Accountable Communities of Health[33] for care coordination. Funding will increase rural counties' access to WA 211 services to triage callers to the right services and level of care before issues become crises. This includes increasing knowledge in communities about the service through engagement and communications; strengthening the digital resource directory entries for rural counties; and recruiting, hiring and training community resource specialists from rural counties to reach people who may experience challenges to accessing services. Capturing this data about calls from rural county residents will help provide an early indicator of community needs and gaps.

Other considerations

Sub-awardees for Initiatives 2.1, 2.3, and 2.4 will be selected through a competitive review process, as described in the implementation plan. Awards will be based on community need and partnerships, evidence-based activities, readiness, and sustainability plans. All awards will adhere to federal and state procurement and reporting requirements.

Community workforce recruitment and training (2.1) will focus primarily on CHWs and digital navigators. We will be mindful of interactions between this initiative and other workforce recruitment efforts (5.4, 5.5). The process for selecting subcontractors is described in the implementation plan. RHT Program funding for CHWs (2.1) will not replace insurance coverage or increase payment amount from source of insurance coverage; rather, funding will focus on recruitment and training. In addition, RHT Program funds used to add digital navigation-specific training to CHW training modules (2.1) will only cover the development of specific, new content. They will not duplicate existing Department of Health (DOH) funding sources. Washington will work closely with its advisory committee and community-based worker associations to ensure RHT Program funds match community needs.

Table 2: Initiative 2 supporting detail

Main strategic goal	Make rural America healthy again, tech innovation
Uses of funds	A, C, E, G, I, K
Technical score factors	B2, C2, E2, F1, F2, F2, F3
Key stakeholders and partners	State agencies, sovereign Tribal nations, State Office of Rural Health, local health departments, community-based workers (community health workers, long-term care workers, home health aides, community health aides), schools, libraries, senior centers, community members, family caregivers, social care organizations, Area Agencies on Aging, SEIU 775 Benefits Group, health care delivery system partners and payers, EMS providers, WA 211
Outcomes	• Increase the number of trained community-based providers • Reduce testing wait times and increase certification pass rates for Long Term Care Workers • Increase health outcomes for people living with dementia and support for their caregivers • Increase the number of preventative and telehealth services delivered through mobile health • Increase utilization of WA 211

[33] HCA. **Community Care Hub Referral Pathways**.

	• Reduce wait times for EMS through modernization and strengthened regional transfer agreements
Impacted counties	Systems approaches such as access to training for community-based staff, augmentation of WA 211, CAV and EMS will scale up to impact all rural counties. Investments into community-based settings and programs will be made in limited counties, to be determined.
Estimated required funding	$25–26 million per year

Initiative 3: Invest in the health of Native families

The state will reserve a portion of the RHT Program funds for sovereign Tribal Governments to make critical investments to improve the health and wellbeing of Native families. Washington proposes using $20 million per year in RHT Program funds to invest in the health of Tribes.

Activities

3.1. Invest in Native workforce.

Individual Tribes in Washington have begun providing Native support for Native families, especially as they must navigate non-Tribal health systems off reservation. RHT Program funds would support training and hiring of Community Health Representatives (CHRs), doulas, care coordinators/case managers, behavioral health aides/practitioners (BHA/P) or community health aides/practitioners (CHA/P) based on the individual needs of each Tribe.[34] A home-grown workforce is vital for Native communities, as providers unfamiliar with the community and the complex Indian health care delivery and payment system, the challenges of pregnancy and birthing in rural Washington, or navigating specialty care from a reservation often fail to meet the needs of Native families. RHT Program funds will expand these workforce programs, such as the Tribal Community Health Provider Program, systematically, so every Tribe has the opportunity to develop a program to support Native families through accessing care on and off the reservation.[35]

3.2 Establish care coordination agreements as the foundation for strategic partnerships.

State Health Official Letter #16-002, Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives, provides the opportunity to build strategic partnerships between Tribes and local hospitals with written care coordination agreements. This is critical to Tribes, as there are no IHS hospitals or hospitals owned by Tribes in Washington, Idaho or Oregon (IHS Portland Area). Per the referenced SHO letter, there are specific requirements regarding care coordination agreements and, under the RHT Program, Tribes and rural hospitals, with support from Washington, will go beyond those requirements. Written care coordination agreements between the Tribes and rural hospitals will create clear expectations around discharge planning, follow-up care, exchange of health information and expectations should there be an emergency. Funds would support the expansion of these care coordination agreements so that every Native encounter at a hospital in the state falls under such an agreement. The relationships built between Tribes and hospitals in developing these written care coordination agreements will also serve as the foundation for Tribes to be engaged in Initiative 1 of Washington's RHT Program, as Washington discusses alternative payment methodologies involving Tribes and hospitals.

[34] **Health Aides of Alaska**

[35] **Tribal Community Health Provider Program**

3.3. Investments to support health information exchange (HIE).

Part of successful and meaningful care coordination is the ability to electronically exchange information. Tribes across the state are constantly contending with different electronic health record (EHR) and HIE programs, some of which are proposing new EHR solutions, such as the IHS Health IT Modernization Program, and some of which are about exchanging information, such as Washington's community information exchange efforts. RHT funding will augment initiatives already underway, as well as advance new technology related to remote care or provide needed investment for Tribes to access additional technological support.

Other considerations

Tribes are central to delivery of rural health care services in Washington, as there are parts of the state where the Tribe is the only primary care provider. This makes investment in Tribes critical to the overall success of Washington's RHT Program. Tribes will be engaged as partners throughout Washington's RHT Program and may be eligible for funding under other applicable initiatives. Washington will partner with the Tribes to ensure that funding is not duplicated across existing programs or across initiatives. The process for selecting subcontractors is described in the implementation plan.

Table 3: Initiative 3 supporting detail

Main strategic goal	Make rural America healthy again, sustainable access, workforce development, innovative care, tech innovation
Uses of Funds	B, E, F, K
Technical score factors	C.1, D.1, F.2
Key stakeholders and partners	Tribal Nations, Indian health care providers, health care providers that serve Native American/Alaska Native clients, Governor's Indian Health Advisory Council (GIHAC), American Indian Health Commission (AIHC), Northwest Portland Area Indian Health Board (NPAIHB).
Outcomes	• Increase Tribes with the appropriate staff to support Native families through accessing care off reservation, including working with hospitals during inpatient stays • Increase the number of Tribes participating in the Tribal Community Health Provider Program • Increase the number of care coordination agreements between Tribes and hospitals to support discharge planning and follow-up visits • Increase care coordination through expanded utilization of electronic information exchanges
Impacted Counties	• Washington will offer these activities for all providers in a rural area, following the guidance of the FORHP. • FORHP designates 22 Washington counties that are "fully rural," and 17 counties that are "not fully rural." The list of counties is in **OSM, Table 7**.
Estimated required funding	$20 million per year

Initiative 4: Adopt technology and data solutions to enable health improvements

The technology investment initiative will provide start-up funding and technical assistance for new, emerging, and proven technologies that can increase efficiency, access, and quality in Washington's rural health care system.

Activities

4.1. Project ECHO.

Washington proposes to use $4 million per year of RHT Program funds to expand existing remote care service and provider mentorship/education offered through Project ECHO.[36] The University of Washington (UW) School of Medicine's Project ECHO program offers a multidisciplinary tele-monitoring and education platform for Washington clinicians. UW Project ECHO currently offers health care ECHO programs that help providers deal with complex and specialized patient issues (dementia, chronic disease, etc.), infectious diseases, psychiatry and behavioral health, and intellectual and developmental disabilities. RHT Program funds will enable the expansion of existing ECHO programs (e.g., implementation in additional clinics or health care facilities) and the addition of new ECHO programs, such as perinatal psychology, chronic kidney disease, and chronic respiratory disease.

4.2. Provider technology fund.

Washington proposes using $15–18 million per year of RHT Program funds to create a provider technology fund under the RHT Program that will enable providers to sustainably expand access to high quality care. Providers may qualify for funds to purchase new technologies (or to obtain technical assistance for those technologies) to improve operational efficiencies, enable remote services (including telehealth and remote patient monitoring), and achieve improvements in population health via data and analytics.

First, the technology fund will support rural practices investing in up-front costs for integrating technology that support sustainable operational improvements. For example, providers could use funds to integrate AI tools into the administrative components of hospital and clinic workflows. This may include ambient listening, charting, appointment scheduling, note generation, claims processing, communication, and generating reports. AI-powered analytics will also promote financial stability by enabling hospitals to identify and recover underpayments and support proactive contract modeling and forecasting. Washington may leverage the experience of The Rural Collaborative members to recommend vendors and services that have proven effective and will use regional collaboratives to disseminate learnings about best practices during the RHT Program.

Second, the technology fund will invest in strategic, state-wide telehealth and remote monitoring services that bring expertise to rural communities, regardless of provider location. Telehealth expansion will enable accessible specialty care, including behavioral, perinatal, and palliative care. This may involve hub-and-spoke models and technical assistance for providers and non-clinical staff on telehealth best practices, such as Link to Care WA.[37] Potential partners will include the University of Washington Medicine's eConsult program and private telehealth companies, many of which have experience with Washington's providers and in rural areas. The targeted technology fund will also support rural practices investing in the up-front costs to enable remote patient monitoring, including consumer-facing technologies like wearable devices and home diagnostic screening and testing kits. These technologies will promote chronic disease prevention and escalation, monitoring of OB patients, proactive provider intervention, family caregiver support, and increased awareness of health status.

Lastly, the provider technology fund will invest in providers' data infrastructure to enhance population health analytics, quality performance measurement, and monitoring. This data infrastructure will also support closed-loop referrals and improve partnerships between the health care system and community organizations (like the Family Caregiver Learning Portal).[38]

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[36] University of Washington Medicine. UW Medicine Project ECHO. UW Medicine. 2025.

[37] **Link to Care WA**

[38] **Family Caregiver Learning Portal**

Other considerations

The provider technology fund (4.2) will focus on non-hospital rural health providers, unless the funds support a collaborative of providers that may include a hospital. Washington will be mindful of interactions between the technology fund used for this initiative and the hospital infrastructure fund (1.3) to coordinate and maximize investments. Technology funds may be used for up-front costs of purchasing and licensing technology tools, technical assistance to support use of and billing for services with new technology, and other coordination. If technical assistance is delayed, it is possible that providers' ability to leverage technology effectively will be slowed. Provider technology funding (4.1) will be in compliance with all NOFO requirements, including specified limitations for EHR systems, purchase of covered telecommunications and video surveillance equipment, and spending similar to the "Rural Tech Catalyst Fund Initiative." Sub-awardees will be selected through a competitive review process, as described in the implementation plan. Awards will be based on financial and community need, readiness and capacity to maximize use of technology, sustainability plans, alignment with value-based care, community partnerships, and innovation. All awards will adhere to federal and state procurement and reporting requirements.

Table 4: Initiative 4 supporting detail

Main strategic goal	Make rural America healthy again, sustainable access, workforce development, tech innovation
Uses of funds	C, D, E, F, H
Technical score factors	B1, C1, F1, F2, F3
Key stakeholders and partners	Hospitals and other rural health providers, the University of Washington and other medical centers, health technology vendors and other private companies, community organizations, State Office of Rural Health, and sovereign Tribal nations.
Outcomes	• Improve access to specialty care for rural communities through increased use of telehealth and increased Project ECHO offerings • Increase number of clinics using AI tools to support operations and reduce administrative burden • Increase number of clinics adopting population health management analytic platforms to improve analytics and expand closed-loop referrals • Increase use of wearables and other consumer-facing technologies to support patient monitoring
Impacted counties	• Washington will offer these activities for all providers in a rural area, following the guidance of the FORHP. • FORHP designates 22 Washington counties that are "fully rural," and 17 counties that are "not fully rural." The list of counties is in **OSM, Table 7**.
Estimated required funding	$19–22 million per year

Initiative 5: Develop Washington's rural workforce to support rural communities

Rural hospitals, Rural Health Clinics and other rural health care providers are increasingly unable to recruit and retain qualified health care professionals, posing a significant threat to the stability of care in these communities. Data from the Washington Sentinel Network highlights registered nurses as the most urgently

needed, with prolonged vacancy periods that hinder service delivery.[39] Washington is projected by the Health Resources and Services Administration (HRSA) to face the most severe nursing shortage in the nation by 2037.[40] Other rural workforce shortages include primary care practitioners, maternity care providers, behavioral health care, dental hygienists, and long-term care and community-based workers.[41] As a result, many rural facilities rely on locum tenens providers to fill staffing gaps, an expensive solution that disrupts continuity of care, impacts quality and prevention of health care crises and strains limited resources.

Activities

Under the RHT Program, Washington will launch a comprehensive strategy to strengthen the rural health workforce, focusing on key health roles such as nurses, primary care providers, maternity care providers (including midwives and doulas), dental hygienists, long-term care workers, and community-based care professionals. Tailored approaches will be deployed based on specific regional needs.

5.1 WWAMI Rural Family Residency Network.

Washington proposes to use $3.5–5 million per year to support the broader Washington, Wyoming, Alaska, Montana, and Idaho regional collaborative (WWAMI). There are currently 465 family medicine residents in training across Washington State, spanning all three years of residency. Of these, 48 residents (10%) are enrolled in Rural Training Tracks. Among the 157 residents who graduated in 2024, 15 (9.5%) are now practicing in rural Washington communities, and only 4 of those 15 (26%) completed a Rural Training Track.[42] The WWAMI Family Medicine Residency Network (FMRN) supports the development, growth and sustainability of family medicine residency programs across Washington State and the greater WWAMI region, including guiding students towards rural workforce participation. WWAMI FMRN strengthens the rural primary care workforce by developing well-trained physicians who are prepared to practice full-spectrum family medicine in rural communities. Funding will support the development of four new rural family practice residency programs to include a combination of financial assistance, consultation, faculty development, and accreditation guidance.

5.2. Washington State University (WSU) rural practitioner training programs.

Washington proposes to use $2.4 million annually of RHT Program funds to support WSU's rural health education programs. WSU has established numerous training programs with rural providers in Eastern Washington. These funds would support WSU to expand its development of a rural health curriculum—including its Indigenous Health Perspectives program co-developed with elders from local Tribes. The funds would also support expanding the rural nursing pathway program in which medical assistants and other professionals can continue their clinical roles while remotely studying for a bachelor's in nursing. Further, WSU would invest in expanding nursing faculty in rural clinical settings to grow additional health care practitioners.

5.3 The Rural Nursing Education Program (RNEP).

Washington proposes to use $3.5–$5 million of RHT Program funds to support RNEP. RNEP is a place-based nursing education initiative that helps students live, work, and learn in their rural communities while training to become registered nurses. RNEP addresses the critical nursing shortage in rural Washington by fostering partnerships between rural health care facilities, schools, and future nurses. Its vision is to establish a grow-your-own remote nursing program grounded in a transformative model of community-based collaboration, reducing obstacles for rural students by providing support for childcare, transportation, and more. RNEP currently has eight students from four rural communities participating in this innovative education model with

[39] **Washington Sentinel Network. (2025, Spring).** ***Findings brief: Nursing occupations*** **[PDF]**

[40] Health Resources and Services Administration. **Health Workforce Projections**.

[41] **WWAMI Rural Health Research Center. (2024, October).** ***Trends in the health workforce supply in the rural U.S.*** **[PDF]. University of Washington**

[42] Washington State Department of Health. Family Medicine Residency Report: Report to the Legislature. 2024.

one community college acting as the academic partner. Funds will expand the program to sixty additional students.

5.4. Grow-your-own training programs.

Washington proposes using $12–16 million per year of RHT Program funds to establish a fund for innovative, grow-your-own training programs established by rural providers or community organizations such as apprenticeships, on-the-job training and other strategies as outlined in DOH's Rural Grow Your Own Toolkit and the Rural Healthcare Partnership Toolkit.[43, 44] Training programs would focus on expanding rural programs including: hybrid dental hygiene, pharmacy, Advanced Practice Nurse, community paramedicine, and midwifery. For example, NEW Health, a Community Health Center located in northeastern Washington, launched NEW Health University in partnership with local high schools, universities, and school board.[45] This community-based program provides on-the-job training that is accessible to low-income and rural students, including a Medical Assistant Apprenticeship, Pre-Apprenticeship, and Dental Assistant Training Program, and dedicated monthly education time for all employees. A strong advantage of apprenticeships and other grow-your-own programs is that the training provided is community-based and tailored to the clinic or health care facility, which increases the likelihood of the trainee staying in those settings.

Washington's grow-your-own workforce fund will also support the development and scaling of health career exploration programs targeting rural middle and high school students. These initiatives will provide early, hands-on exposure to health care professions that offer living-wage employment, with a focus on establishing health-related Career and Technical Education (CTE) tracks and/or Health Occupation Students of America (HOSA) chapters in rural high schools.

Washington will invest in a pilot project to establish a state-registered long-term care worker (LTCW) apprenticeship in rural counties. The pilot program will build a skilled and resilient workforce to systematically address critical workforce shortages in specialized fields of care such as intellectual development disabilities, geriatric care, chronic disease management, and challenging behaviors among others. This effort would position successful LTCWs for career advancement through employer-sponsored pipelines to build a vibrant and stable workforce.

5.5 Rural workforce incentive programs.

Washington proposes using $9–10 million per year of RHT Program funds to establish a financial incentives fund for health professionals who commit to a minimum five-year service obligation in rural communities. These incentives will improve recruitment and retention in rural areas. Incentives could include conditional scholarships, sign-on bonuses, retention bonuses, childcare or housing subsidies, or other evidence-based approaches to support recruitment and retention.

Other considerations

In all workforce strategies under Initiative 5, Washington will find opportunities to maximize funding, such as regional sharing of resources and information. Funds may be used for technical assistance on implementing workforce strategies (Initiative 5.5), expansion of existing successful programs (5.1, 5.2, 5.3, 5.4), and costs associated with the development of new programs (5.1, 5.4). Building capacity through training (5.1, 5.2, 5.3, 5.4), providing financial support through rural workforce incentive programs (5.5), and lowering obstacles to training (5.3, 5.5) can help reduce risk of provider burnout and reinforce the rural workforce. Washington will monitor that incentives in Initiative 5 are not duplicative and do not supplant any existing state programs. Likewise, Washington will distinguish the incentives in Initiative 5 from the community-based workforce

[43] **DOH's Rural Grow Your Own Toolkit**

[44] **Rural Healthcare Partnership Toolkit**

[45] **NEW Health University**

programs (Initiative 2.1), the Community Health Aide Program (3.1), and opioid treatment provider program (6.4). The process for selecting subcontractors is described in the implementation plan.

Sub-awardees for Initiatives 5.4 and 5.5 will be selected through a competitive review process, as described in the implementation plan. Awards will be based on documented workforce needs, geographic distribution, financial and community need, readiness for implementation (including established partnerships between employer and educational institutions when required), sustainability plans, and innovation. All awards will adhere to federal and state procurement and reporting requirements.

Table 5: Initiative 5 supporting detail

Main strategic goal	Making Rural Healthy Again, sustainable access, and workforce development.
Uses of funds	D, E, G, K
Technical score factors	B.1, C.2, D.1
Key stakeholders and partners	Sovereign Tribal nations, Washington's rural hospitals, Rural Health Clinics, Federally Qualified Health Centers, rural long-term care facilities, other rural health care facilities and providers, the State Office of Rural Health, health professional associations, health professions training programs, Educational Service Districts, and Area Health Education Centers.
Outcomes	• Increase the number of rural medical residencies training physicians in rural Washington • Expand the Rural Nursing Education Program to decrease the number of nurse vacancies in rural hospitals and clinics. • Increase the number of health care graduates prepared for rural practice produced by Washington State University by addressing rural students' obstacles to accessing education. • Expand grow-your-own training programs to increase rural middle and high schoolers' exposure to health careers. • Increase the use of provider incentives to encourage long-term commitment to serving Washington's rural communities. • Increase availability of LTCW with skills and competencies to serve individuals with special long-term care needs. • Increase ability of older adults and individuals with disabilities to receive care in their communities by reducing service wait times, staff turnover and increasing worker competence in serving those with complex needs.
Impacted counties	• Washington will offer these activities for all providers in a rural area, following the guidance of the FORHP. • FORHP designates 22 Washington counties that are "fully rural," and 17 counties that are "not fully rural." The list of counties is in **OSM, Table 7**.
Estimated required funding	$33–35 million per year

Initiative 6: Expand and sustain Washington's rural behavioral health system

Behavioral health challenges, which are pervasive around the country and throughout Washington, are particularly acute in rural communities. Despite significant investment in recent years, there remain limitations on providers, available beds, and mobile services. A 2025 Rural Behavioral Health Access Study found that

Washington's rural communities have documented wait times for many services, particularly for inpatient and youth services, and that demand for mobile crisis services exceeds staffing capacity.[46] The rate of overdose deaths in rural Washington is over 10% higher than the statewide average (54.28% for FORHP rural communities compared to 41.9% statewide).[47] In the state's solicitation of feedback as part of the RHT Program application process, respondents focused on needs to invest in workforce development, payment reform (including the Certified Community Behavioral Health Clinic (CCBHC) model), expansion of mobile crisis and non-emergency transportation, and investment in telehealth.

Activities

6.1. Expand mobile crisis supports.

Washington proposes utilizing $10 million per year of RHT Program funds to invest in mobile crisis response and mobile stabilization services, in alignment with Substance Abuse and Mental Health Services Administration's (SAMHSA) National Behavioral Health Crisis Care Guidance framework.[48, 49] This would include investment in EMS which would provide mobile support for behavioral health crisis by establishing Buprenorphine Administration programs (based on the Everett Fire Department Pilot Program), purchasing and distributing naloxone for EMS use, and funding training for EMS providers on evidence-based opioid response practices.[50] HCA would award subgrants and contracts to leverage and expand multidisciplinary teams, such as Program for Assertive Community Treatment, to enhance the quality of patient care.[51] These efforts are targeted to improve rural behavioral health outcomes and reduce the strain on rural hospitals from emergency room utilization from behavioral health crisis.

6.2. Supporting providers to transition to the CCBHC model.

Washington proposes utilizing $3 million per year of RHT Program funds to support transition of behavioral health clinics to the CCBHC model.[52] HCA will offer increased resources and technical assistance to increase CCBHC participation. Clinical participation in the model will support access to care, strengthen care coordination, and help sustain behavioral health providers who may see fluctuating patient volumes with varying needs within their rural community. Supporting investment in this innovative reimbursement model will help transform how behavioral health services are paid for in rural Washington.

6.3. Supporting youth in rural communities.

Washington proposes utilizing $4.8 million per year of RHT Program funds to improve access to school-based behavioral health care services to better support rural youth. In 2022–23, there were 62 schools and school districts participating in Washington's Medicaid School-Based Health Services program and billing for behavioral health services. RHT funding would support technical assistance to schools to build capacity to bill insurance, inclusive of Medicaid and commercial insurance, and in alignment with Washington's work under the CMS Implementation, Enhancement, and Expansion of Medicaid and CHIP School-Based Services (SBS) grant

[46] **Rural Behavioral Health Access Study**. HCA. 2025

[47] Department of Health Death Registry, county-level 2023 data. *Age-adjusted rate of any drug and overdose deaths per 100,000*.

[48] **Mobile Response and Stabilization Services**

[49] **National Behavioral Health Crisis Care Guidance**. Substance Abuse and Mental Health Services Administration. 2025.

[50] **Everett Fire Department Pilot Program**

[51] **Programs for Assertive Community Treatment**

[52] **Certified Community Behavioral Health Clinics**

that continues through 2027.[53] The funding would allow Washington to increase technical assistance to school districts, starting support for those with system readiness and expanding to school districts that build out capacity to bill through state facilitated technical assistance. These funds would support technical assistance for billing and contracting and would also be available to support schools in need of recruiting and hiring school-based providers. Investment in school and school district capabilities will leverage existing settings to expand access to services in a manner that can be sustained beyond the 5-year duration of the RHT Program.

6.4 Rural Opioid Treatment Provider recruitment and retention.

Washington proposes utilizing $6 million per year of RHT Program funds to establish a workforce incentive program for rural opioid treatment providers (OTPs). OTPs are a specific substance use disorder behavioral health agency (SUD BHA) setting type defined in federal law under 42 CFR Part 8, and Washington state law under RCW 71.24.590. OTPs are central to supporting patients who are in need of medications for the treatment of opioid use disorder, and these funds will help stabilize and grow the provider workforce and ensure access to essential OTP services in rural Washington. The program would fund recruitment bonuses, relocation support, childcare stipends, capacity payments, and other approved incentives tied to a five-year service commitment. Rural OTP clinicians that would be eligible to apply for funding include: substance use disorder (SUD) counselors, mental health counselors, nurses, perinatal providers, medical prescribers (e.g., physicians, NPs, PAs), pharmacists, SUD peers allowed to provide Medicaid covered services in an OTP setting, and any other member of an OTP multidisciplinary medical treatment team.

Other considerations

Sub-awardees for Initiatives 6.1–6.4 will be selected through a competitive review process, as described in the implementation plan. Awards will be based on financial and community need, documented need for behavioral health care access, readiness for implementation, sustainability plans, community partnerships, and innovation. All awards will adhere to federal and state procurement and reporting requirements.

RHT Program funds will not replace or duplicate funding for existing behavioral health programs. Funds will create and grow avenues for rural communities to receive behavioral health coordination and treatment and will align with rules limiting the amount of RHT Program funds used for provider payments. Technology funds in this initiative will focus on rural behavioral health. Washington will be mindful of the interactions between technology funding used for this initiative and Initiative 4.

If hiring is slower than anticipated, it could slow expansion of mobile crisis supports and multidisciplinary teams (Initiative 6.1). This can be mitigated through expanding the community-based workforce (2.1) and the broader rural practitioner workforce (5).

Table 6: Initiative 6 supporting detail

Main strategic goal	Make rural America healthy again, workforce development
Uses of funds	A, C, E, G, H
Technical score factors	C.1, D.1, E.1, E.2, F.1
Key stakeholders	Rural hospitals, Federally Qualified Health Centers, Rural Health Clinics, community mental health centers, Behavioral Health Agencies, rural Certified Community Behavioral Health Clinics, Schools, School Based Health Centers, State Office of Rural Health, and sovereign Tribal nations.
Outcomes	• Increased access to mobile crisis and stabilization services

[53] CMS, **CMS Announces $50 Million in Grants to Deliver Critical School-Based Health Services to Children**

	• Increase level of follow-up after emergency department visits for mental health or SUD treatment • Increased access to behavioral health care, including counseling, in school settings • Supporting at least two new clinics in transitioning to the CCBHC payment model to sustain financing and expand comprehensive care access through rural behavioral health providers
Impacted counties	• Washington will offer these activities for all providers in a rural area, following the guidance of the FORHP. • FORHP designates 22 Washington counties that are "fully rural," and 17 counties that are "not fully rural." The list of counties is in **OSM, Table 7**.
Estimated required funding	$24 million per year

Implementation plan and timeline

Washington will begin implementation of the six initiatives immediately upon receipt of RHT Program funds. A detailed Gantt chart in Table 7 (below) includes the timeline for each initiative activity's five project stages. Specific milestones for each initiative are included in the metrics and evaluation plan. Considerations for legislative and regulatory actions are described in the state policies section.

Table 7: Implementation Gantt chart

#	Program/ Project	2026				2027				2028				2029				2030				2031			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1	Ignite Innovation in WA's rural hospitals																								
1.1	Expand a rural health network																								
1.2	Co-design a payment model for long-term sustainability																								
1.3	Invest in critical technology infrastructure and maintenance needs																								
1.4	Sustaining and strengthening maternal, emergency, and specialty services at risk																								
2	Prevent Disease and Manage Care in Community Settings																								

#	Program/ Project	2026				2027				2028				2029				2030				2031			
2.1	Expand the community-based workforce																								
2.2	Expand dementia resources and build dementia-capable communities																								
2.3	Expand EMS Inter-facility Transport and Support for Trauma Designated Facilities in Rural Communities																								
2.4	Triage residents to appropriate level of care in their neighborhoods																								
3	Invest in the Health of Tribes																								
3.1	Invest in Native workforce																								
3.2	Care Coordination Agreements																								

#	Program/ Project	2026				2027				2028				2029				2030				2031			
3.3	Investments to support health information exchange																								
4	Adopt Technology and Data Solutions to Enable Health Improvements																								
4.1	Project ECHO																								
4.2	General fund: Provider technology fund																								
5	Developing Washington's Rural Workforce to Support Rural Communities																								
5.1	WWAMI Rural Family Medicine residency programs, and WSU																								
5.2	WSU rural practitioner training programs																								
5.3	RNEP																								
5.4	General fund: Grow-your-own training programs																								
5.5	General fund: Rural workforce incentive programs																								

#	Program/ Project	2026				2027				2028				2029				2030				2031			
6	Expand and Sustain Washington's Rural Behavioral Health System																								
6.1	Expand mobile crisis supports																								
6.2	Planning to transition facilities to CCBHC model																								
6.3	Supporting youth in rural communities																								
6.4	General fund: Rural OTP recruitment and retention																								

Gantt chart key

Stage 0	Project planning is underway, but no work on executing the project plan and implementing the initiative has begun.
Stage 1	The project plan has been created, and staff have been assigned. Initial work on implementing the initiative has begun.
Stage 2	The implementation of the project plan and goal achievement are underway. The original project plan has been refined and adjusted.
Stage 3	The implementation of the project plan and goal achievement are halfway complete and continuously being worked on.
Stage 4	Deliverables are being finalized, and proposed goals are nearly achieved.
Stage 5	The initiative is fully implemented, the initiative's goals have been completely achieved, and the initiative is producing measurable outcomes that can be reported on.

Key implementation steps

Q1 2026: Hire staff and establish governance.

Washington's governance plan for the RHT Program is described in detail below. Prior to RHT Program fund allocation, the state will prepare job descriptions to recruit RHT Program positions, recruit advisory committee members, and begin drafting scopes of work for identified subcontractors. Once funds are allocated, the state will hire staff, establish advisory committee meetings and project charter, and establish executive and consulted leadership team governance committees. The state will engage its advisory committee to help prioritize initiative activities following the budget reconciliation process and for activities that require competitive bid processes.

Q2 2026: Rapid contract execution.

Where appropriate, Washington will leverage existing state programs or contracts to rapidly execute initiative activities (see Table 8).

Table 8: Activities and subcontractors that will expand upon existing programs

Initiative activity	Subcontractor
2.1 Embed LTCW testing at training sites	SEIU Training Benefit Group
2.2. Expand dementia resources	AAAs
2.4 Triage residents to appropriate care setting	Mobile Care-A-Van, WA 211, AAA Mobile Assistance Van Program
4.1 Project ECHO	University of Washington
5.3 Expand Rural Nursing Education Program (RNEP)	RNEP
6.4 Expanding opioid treatment provider capacity	Opioid treatment providers identified by HCA

Likewise, the state will rapidly execute contracts with sub-contractors identified in its initiative activities, including: the Rural Collaborative (Initiative 1.1), the Rural Health Redesign Center (1.2), Washington State Hospital Association (1.3), University of Washington WWAMI (5.1), and Washington State University (5.2).

Q2 2026 (repeated annually as funding allows): Competitive bid process.

The state will roll out a competitive bid process for the funds described in the initiatives (see Table 9).

Table 9: Initiative activities executed via a competitive bid process

1.4 Incentive program to establish or grow OB care or other essential service lines
2.1 Recruitment and placement of community-based workers
2.3 Expand EMS inter-facility transport
2.4 Community-based mobile services and care coordination hubs
4.2 Provider technology fund
5.4 Grow-your-own workforce programs
5.5 Workforce incentive programs
6.1 Expand EMS opioid treatment capabilities
6.2 Supporting providers to transition to CCBHC model

6.3 Pilot program for school districts to expand school-based services

6.4 Opioid treatment provider recruitment and retention incentives

The state will post detailed requests for proposal (RFP) following state law for requirements for RFP processes, as well as NOFO and Cooperative Agreement requirements for the RHT Program. Health care facilities and community organizations will apply for funds in these initiatives with detailed plans about implementation, monitoring, and potential risks and challenges. Scoring criteria will include rurality, need, readiness to implement, community partnerships, sustainability, and data reporting capacity. Some programs will be selected for multiple years of funding, while some may be one-time. Depending on availability of funds, the competitive bid process may be repeated each year. The state will post RFPs prior to the start of the Federal Fiscal Year to ensure timely distribution of funds and activities. For RHT Program Year 1, the state will post the RFPs in the first calendar quarter of 2026 after funds are distributed. For the provider technology fund (Initiative 4.2), the state may consider soliciting an administrator for the fund, pending further discussions with professional associations and other key stakeholders. That engagement will occur in November-December of 2025 and be rapidly executed after fund allocation.

Throughout RHT Program: Respecting Tribal sovereignty. Washington expects that the Governor's Indian Health Advisory Council (GIHAC) will decide how Initiative 3 funding will be divided between the state's 29 sovereign Tribal nations. This council—whose members include representatives from the Tribes, state agencies, state legislators and the Governor's office– is a decision-making body that addresses health-related policy and funding concerns facing Tribal nations. For the Tribes that GIHAC selects to receive RHT funds, HCA will incorporate these amounts into their existing Sovereign Nation Agreements (SNA). The progress and performance of these agreements will be monitored and managed by the Tribal Liaison.

Throughout RHT Program: Ongoing monitoring/collaboration. As described in the monitoring and evaluation plan, Washington will maintain ongoing communication with funding recipients, conduct monitoring, and collaborate with CMS and state stakeholders to ensure that initiatives are producing measurable outcomes and goals are achieved.

Governance

Washington State has developed a governance structure that leverages existing rural health care expertise amongst multiple executive branch agencies and external partners. **The Washington State Health Care Authority (HCA) will serve as the lead agency.** However, the state's governance and staffing approach includes oversight from partners at the Governor's Office, Department of Health (DOH), and Department of Social and Health Services. (DSHS). **OSM, Table 8** summarizes the governance structure for the RHT Program.

- HCA serves as Washington's Medicaid Agency and Behavioral Health Authority.
- DOH oversees public health, licensing, scope of practice, and facility regulation. The State Office of Rural Health is embedded at DOH.
- DSHS oversees and administers long-term services and supports, food assistance, housing, employment supports, and various other social services programs.

Staffing model

Washington envisions hiring a minimum of 37 FTE to support administration of the RHT Program, detailed in the budget narrative. HCA will hire a program lead to oversee a project team made up of policy analysts, fiscal analysts, contract managers, project manager, and data/evaluation analysts, outlined in **OSM Table 9**. The program lead will be responsible for coordination across agencies. State agencies will craft specific job descriptions during CMS's application review period (November-December 2025) and will begin hiring staff as soon as funding is available. Within the parameters permitted for administrative expenditure, staffing plans are subject to change pending funding and as needs shift during the RHT Program. Washington will contract with a

strategic consultant to provide administration and project management support. Additional details are in the budget narrative.

Advisory committee

Washington will establish an advisory committee made up of representatives from the state executive branch, Tribes, rural health professionals, and communities (**OSM Table 9**). DOH will manage and staff the committee, in alignment with its function to lead the planning of the State Health Improvement Plan. The committee will provide recommendations on prioritizing projects and funding for Washington's RHT Program plan and will make recommendations to the state Legislative and Executive branches about opportunities for policy and regulatory alignment with RHT Program learnings.

Stakeholder engagement

Following passage of H.R. 1, the state executive branch engaged the public, Tribes, key delivery system stakeholders, and state lawmakers in planning for the RHT Program. This included two dozen stakeholder meetings, multiple listening sessions and formal Consultation with Tribes, hosting three public webinars, and briefings for state legislators. In August 2025, HCA posted a Request for Information (RFI) to allow stakeholders and members of the public an opportunity to provide written comments to the state, including priorities for rural health needs. The following table outlines the types of groups that have participated to date:

Submitter types	
Nonprofit organizations	Rural hospitals and hospital districts
Non-hospital health care provider groups	Health care education programs
State and national associations	State agencies
Interested individuals	Colleges and universities
School districts	Tribes
EMS and firefighters	Public Health Departments

From August 8 to September 26, the state received 310 written responses. The public's feedback shared local needs and suggested funding priorities for rural communities. Stakeholders placed emphasis on provider shortages, technology needs, geographic challenges to access, and the need for infrastructure and other financial supports in their communities. They also suggested unique opportunities for funding to address these challenges that are reflected in the initiatives.

Using the DOH's Community Engagement Continuum framework (Table 10 below),[54] Washington will continue to engage with rural communities, Tribes, and providers regularly. To maintain community support and ensure program flexibility to adapt with community needs, the state will also be incorporating rural community members, providers and patients, into an ongoing Washington RHT Program Advisory Committee. See the Governance section for details about staff and the structure of the advisory committee.

Table 10: RHT Program Community Engagement Framework

Category	Engagement Methods
Inform Update communities and providers	• Post information on webpages and social media regularly • Host webinars to inform the public and request feedback • Distribute emails to stakeholders • Make communication materials publicly available, including RHT Program annual status reports
Consult Receive and consider feedback	• Conduct surveys and RFIs to gather new ideas and public feedback on progress and impact • Hold focus groups and interviews for in-depth discussions
Involve Ensure community interests are included	• Advisory committee provides guidance and recommendations • Host a public listening session at least once per year • Hold individual and group stakeholder meetings for feedback

[54] Washington Department of Health Community Engagement Guide.

Collaborate Partner in planning and sharing in the decision-making	• Establish partnership agreements with subject matter experts • Co-design projects and collaborate on monitoring and evaluation with stakeholders • Host virtual convenings for information and best practice sharing across stakeholders
Empower Support and follow the community's lead and support implementation	• Provide resources and templates based on best practices and lessons learned • Offer technical assistance and client support • Encourage community mobilization for long-term adoption and sustainability of RHT Program initiatives • Engage in Tribal listening sessions and formal Tribal Consultations

Metrics and evaluation plan

Washington state intends to utilize a mixture of existing data and reporting infrastructure and new reporting mechanisms to evaluate the performance of RHT Program investments. The state will primarily be leveraging data and analytics experts under the Chief Data Officer at HCA and with the Research and Data Analysis (RDA) division of DSHS, supplemented by external contractor support where necessary. HCA's Data Division has expertise engaging with claims data and other provider and payer data in support of the Medicaid program. HCA staff also support operations for Washington's All Payer Claims Database. RDA provides data, analytics, and decision support tools in support of multiple Washington clients and has worked extensively in development and tracking of health care and human services related metrics. The state may also employ external consultants and contemplate engagement with institutions of higher education such as the University of Washington or Washington State University, if additional expertise or capacity becomes necessary throughout the duration of the RHT Program.

For each of the six initiatives, Washington has identified at least four metrics to develop and utilize for evaluation. The metrics support alignment of proposals for funding with the RHT Program goals set out by CMS and established in this application. Where possible, the state intends to leverage existing data, such as Medicaid claims or federal and state facility reporting, and will supplement with contractor reporting (on an annual basis unless otherwise specified) as deliverable requirements attached to receipt of funds. The tables below outline the metrics, data sources, and plan for evaluation for each initiative.

Initiative 1: Ignite innovation in Washington's rural hospitals

Metrics	Data source	Milestones	Measurement
Number of rural providers participating in co-design process	Agency reporting	Measure in Years 1–3. By Year 3, 50% of rural hospitals in the state will engage in the payment model co-design process.	Statewide
Number of rural providers participating in VBP models	Payer reporting (on provider network)	Measure in Years 4 and 5. By Year 5, have participation of at least 25% of rural hospitals in VBP model.	Statewide
Number of rural hospitals participating in regional provider collaboratives.	Agency reporting	By end of year 1, set target for number of hospitals participating in regional provider collaboratives or integrated care networks.	Regionally
Number of hospitals without obstetric units (no labor and delivery)	Hospital Reporting	WA currently has 25 rural hospitals with no L&D unit. Maintain or improve upon baseline level throughout duration of the RHT Program.	By county

Initiative 2: Prevent disease and manage care in community settings

Metrics	Data source	Milestones	Measurement

Number of community gathering events held, focused on supporting use of technology and receiving health screenings.	Contractor reporting	Offer 20 new community gatherings in rural communities within first two years of the RHT Program.	By service setting (Ex. senior living, schools, churches, etc.)
Number of preventive and telehealth services delivered via mobile health	Claims data, contractor reporting, DOH reporting	Starting in Year 2, increase services delivered via mobile health by 5% each year.	By county
Increased utilization of WA 211	WA 211 call center data	By the end of year 2026, establish baseline of WA 211 utilization by rural communities and increase call volume by 3% per year in 2027-duration of the RHT Program.	By county
Increase training for community-based providers.	Contractor and agency reporting on # of people trained	Increase by 5% per year the number community health workers, long-term care workers, or other community providers in rural communities across each year of the RHT Program.	Statewide

Initiative 3: Invest in the health of Native families

Metrics	Data source	Milestones	Measurement
Number of Tribes with specific staff to support relationships with hospitals	Contractor reporting	By year 5, all Tribes who want one, will have the staff to support relationships with hospitals across the state.	By Tribe
Number of care coordination agreements in place	Agency reporting	Increase the number of care coordination agreements by 20% each year of the RHT Program.	Statewide
Number of Tribes with access to HIE tools	Contractor reporting	By Year 5, increase number of Tribes using HIE tools by 30%.	Statewide
Number of hospital encounters for AI/AN persons that Tribes receive discharge information	Contractor reporting	By end of year 1, set target for improving discharge information sharing.	Statewide

Initiative 4: Adopt technology and data solutions to enable health improvements

Metrics	Data source	Milestones	Measurement

Number of rural hospitals and primary care providers adopting integrated AI tools	Hospital and Provider contract deliverable reporting	By end of 2027, establish baseline utilization of AI by rural hospitals and primary care clinics and establish measurable target for increased utilization by end of the RHT Program, based on funding available for these projects.	Statewide
Number of primary care clinics adopting population health management analytic platforms	Provider contract deliverable reporting	By end of 2027, establish baseline utilization of population health management analytic platforms for primary care clinics and establish measurable target for increased utilization by end of RHTP, based on funding available for projects.	Statewide
Project ECHO Utilization	Contractor reporting	By end of 2026, establish baseline annual utilization of Project ECHO by rural providers and set measurable target for increasing annual utilization in every rural Washington county by end of 2028.	By county
Deployment of wearable technology	Contractor reporting	Measure the number of new consumer-facing wearables or other tools deployed to rural residents through RHT funding, by county by end of 2028.	By county
Increased telehealth access[55]	Medicaid claims data and contractor reporting	By end of 2027, establish a baseline of telehealth utilization amongst Medicaid clients in rural communities by service-type and establish measurable target for increasing utilization across at least three service types by end of 2029.	Statewide

Initiative 5: Develop Washington's rural workforce to support rural communities

Metrics	Data source	Milestones	Measurement
Expansion of the Rural Nursing Education Program	Contractor reporting	By end of the RHT Program, will graduate at least 60 Associate Degree Nurses to support rural communities through support of RNEP.	By county
Increase number of rural medical residencies	Contractor reporting	Will add at least 4 new clinical residencies in rural Washington by end of 2029.	Statewide

[55] This metric is used cross Initiatives 4 and Initiative 6. In Initiative 4, the metric will look at all service types and will set targets for three specific service types (one of which will be behavioral-health focused). Performance targets will account for this metric representing two initiatives.

Number of providers retained through workforce incentive programs	Contractor reporting	Will track the number of providers directly supported by retention bonuses as part of workforce incentive programs.	Statewide
Documented rural workforce challenges	Workforce Council Sentinel Network Reporting	Track documented rural workforce challenges through employer surveying and report on any changing or increasing challenges faced in rural communities.	By ACH region

Initiative 6: Expand and Sustain Washington's rural behavioral health system

Metrics	Data source	Milestones	Measurement
Increase mobile crisis units	Contractor reporting	Increase the number of mobile crisis units in rural Washington by end of 2027, scaled to level of funding.	By county
Increased telehealth access	Claims data and contractor reporting	By end of 2027, establish a baseline of telehealth utilization in rural communities by service-type and establish measurable target for increasing utilization across at least three service types by end of 2029.	Statewide
Increase clinic participation in CCBHC payment model	HCA Reporting	By end of 2028, support two new clinics participating in CCBHC payment model in rural communities.	Statewide
Follow-up after ED visit for mental health or SUD treatment	HEDIS FUA and FUM metrics	Track trends in behavioral health follow-up visits following ED visit for mental health or SUD treatment	Statewide and by region
Schools and school districts participating in Medicaid billing for behavioral health services	Medicaid Claims Data	Currently, 62 schools or school districts in rural counties are billing Medicaid. By end of 2026, set measurable target for increasing participation by end of the RHT Program based on available funding.	By Educational Service District and County

Sustainability plan

Health care systems will become sustainable in rural areas because people want to and can stay in rural areas, for their care and for their lifespan. Washington's RHT plan combines investments in modernizing the traditional health care delivery system, in broadening how and where rural residents can access care, and in increasing the capacity and reach of community supports. The combined power of these components will enable new opportunities for health and wellbeing in rural Washington.

First, the state's RHT plan will expand opportunities for individuals and families to stay in and move to rural Washington. Initiative 5 includes meaningful health care career pathways. Rural residents will be able to attain advanced degrees (often remotely) and then stay to practice in rural areas. Likewise, Washington's plan builds opportunities for people without a four-year degree to become employed in the community-based workforce, to care for people in their homes and in their towns. Further, the state's plan will embed technologies into consumer homes, community settings, and provider settings so that people do not have to move to other places to access the health care they need (Initiatives 1 and 4). As rural Washingtonians age, the RHT plan offers new and improved opportunities to age in place with support from community health workers (Initiative 2), more access to telehealth and personal health monitoring (Initiative 4), and additional long-term caregivers (Initiatives 2 and 5). Rural health systems strengthen and become more sustainable because rural communities strengthen and become more sustainable.

Second, Washington's RHT plan will support rural communities with the start-up costs that can set them up for sustainability through service reimbursement. Washington's investments under Initiatives 2, 3, 5, and 6 will cover costs for recruitment, training, and equipment. With that seed funding, providers will be able to establish a sustainable business model with private and public payer reimbursement for services. For example, community health workers (CHWs) are reimbursed for services rendered to Apple Health (Medicaid) clients, including assessments, care coordination and health system navigation, facilitating behavior change, and health education and promotion.[56] Washington will work with other state payers to expand coverage policies for CHW services, particularly in rural areas, to sustain those prevention and workforce investments. Likewise, start-up investments in mobile health and expanding EMS capacity will create pathways towards sustainable service reimbursement—particularly when paired with the strategic planning of The Rural Collaborative and payment model design efforts under Initiative 1.

Third, Washington's RHT Program initiatives also focus on building an infrastructure for long-term operational improvements and financial solvency (Initiatives 1 and 4). The technology fund will guide hospitals to adopt innovative technologies that improve the efficiency of clinical workflows and revenue cycle management—technologies that will enable financial returns to sustain the cost of the programs after the RHT Program. Expanding the capacity of a rural health network will create savings through shared services and peer learning. A new value-based payment model, co-designed by and for rural providers, will address the long-standing challenges of a low-volume delivery system, including high fixed costs to sustain essential services and misaligned incentives that fail to keep people out of the hospital. New payment models will account for the workforce and technologies needed to prevent chronic conditions from forming or advancing, ensure efficient operations, and improve quality of care. The transformation activities will create rural hospitals that have capacity and sustainable funding mechanisms that reflect the needs of their communities. As such, residents will be less likely to bypass their local hospital because it will provide the care they need when they need it.

Finally, the RHT Program will catalyze new forms of engagement across the state to build evidence about what works to sustainably transform rural health in Washington. Through the RHT Program's monitoring plan, governance structure, cooperative agreement with CMS, and ongoing community and stakeholder engagement, Washington will build shared learnings about what is most effective to improve health for rural residents. The

[56] **Washington State Health Care Authority. Community Health Workers (CHW)**. HCA. 2025.

Washington RHT advisory committee will make recommendations to the state legislature regarding changes to state statute, regulations, and investments that could align with the RHT Program and lessons learned from it.

Conclusion

The Washington RHT Program will build a healthier, more resilient, and financially sustainable rural health system. The state's initiatives will ignite innovation in rural hospitals, prevent disease and manage care in community settings, invest in the health of Native families, increase provider adoption of technology and data solutions, develop Washington's rural workforce, and expand and sustain Washington's rural behavioral health system.

Appendix: Other Supporting Materials

Table 1. Summary of Washington's rural facility and population score factors (A1–A7)

Table 1 summarizes the weighting factors (A1–A7) used in the rural facility and population score factors, following the Notice of Funding Opportunity (NOFO) requirements. Each factor was derived from statewide or national datasets and standardized methodology to ensure alignment with federal review criteria.

Factor (NOFO Reference)	Metric Description	Value / Estimate (Washington State)
A1. Absolute Size of Rural Population[57]	Total rural population (WA)	1,115,886
A2. Proportion of Rural Health Facilities[58]	Proportion of health facilities located in rural areas	0.40
A3. Uncompensated Care59	Total uncompensated care (in $ millions)	$2,385 million
A4. Percent of State Population in Rural Areas[60]	Share of population living in rural-designated census tracts	14.48%
A5. Metrics Defining Frontier Areas (Population)[61]	Percent of population residing in frontier Level 2 areas	2.1%
A5. Metrics Defining Frontier Areas (Land Area)[62]	Percent of total land area classified as frontier Level 2	26.8%
A6. Area of State in Total Square Miles[63]	Total geographic area of Washington State	66,456.59 sq. miles

[57] U.S. Census Bureau. (2021). *2020 Census population estimates by census tract.* Derived using the Federal Office of Rural Health Policy (FORHP) rural designation. Washington, DC: U.S. Department of Commerce.

[58] Washington State Department of Health. (2024). *Health Systems Quality Assurance (HSQA) Licensing Data.* Combined with Rural-Urban Commuting Area (RUCA) codes (version 3.1) to identify licensed facilities in RUCA 4–10 regions.

[59] Washington State Department of Health. (2023). *Washington State Hospital Financial Reports, 2022.* Olympia, WA: Office of Hospital and Patient Data Systems.

[60] U.S. Census Bureau. (2021). *2020 Decennial Census, population by census tract.* Weighted analysis based on Federal Office of Rural Health Policy (FORHP) rural designation.

[61] U.S. Census Bureau. (2021). *2020 Decennial Census population and land area by census tract.* Frontier Level 2 areas defined as <6 persons per square mile, computed using tract-level land area and population data.

[62] U.S. Census Bureau. (2021). *2020 Decennial Census population and land area by census tract.* Frontier Level 2 areas defined as <6 persons per square mile, computed using tract-level land area and population data.

[63] U.S. Census Bureau. (2020). *TIGER/Line shapefiles: Washington State (2020).* Land and inland water area calculations. Washington, DC: Geography Division.

A7. Percent of Hospitals Receiving Medicaid DSH Payments[64]	Hospitals receiving Medicaid Disproportionate Share Hospital (DSH) payments	0.43 (43%)

Table 2. Rural demographics in Washington[65]

Includes population, income, education, education, employment, and insurance comparisons between rural and urban areas in Washington.

Indicator	Rural areas in Washington	Urban areas in Washington
Total population size	1,115,886	6,589,395
% of total population	14.48%	85.52%
Total population size for males	564,174	3,279,598
% of total population for males	14.68%	85.32%
Total population size for females	551,712	3,309,797
% of total population for females	14.29%	85.71%
Total population size for 62 years and over	297,945	1,237,748
% of total population for 62 years and over	19.40%	80.60%
Total population size for 65 years and over	246,723	1,005,705
% of total population for 65 years and over	19.70%	80.30%
Land area (square miles)	56,511.50	9,943.50
% of Land area (square miles)	85.04%	14.96%
Simple average census tract density (average density across all census tracts)[66]	614.10	5,089.67
Population-weighted density (people per square mile)[67]	19.75	662.68
"Typical tract's" Median Income (each tract counts equally; Unweighted tract averages)	$74,837.64	$107,093.30
Population-weighted median income (average tract-level median household income, weighted by population)	$75,406.32	$108,505.61

[64] Washington State Health Care Authority. (2024). *Medicaid Disproportionate Share Hospital (DSH) payment reports, State Fiscal Year 2024.* Olympia, WA: HCA Division of Hospital Finance.

[65] U.S. Census Bureau. (2023). *2020 Decennial Census population and land-area data; 2022 American Community Survey (ACS) 1-Year Estimates,* analyzed by rural and urban designation using Federal Office of Rural Health Policy (FORHP) census-tract classifications. Washington, DC: U.S. Department of Commerce.

[66] This tells you something like "what is the typical tract density?", but it doesn't represent how the average resident experiences density.

[67] This tells you "How many people per square mile live in urban vs rural areas overall." It reflects the density as experienced by the population, not just the geography.

Number of unemployed (civilian labor force)	29,181	169,179
Number of employed (civilian labor force)	472,012	3,309,320
Unemployment rate	5.82%	4.86%
% High school degree or higher (25 years and over)	89.21%	92.72%
% Bachelor's degree or higher (25 years and over)	27.07%	40.78%
% uninsured (unweighted)	8.32%	6.04%
% uninsured (population-weighted mean)	8.48%	5.99%

Figure 1: Age 65+ population in Washington

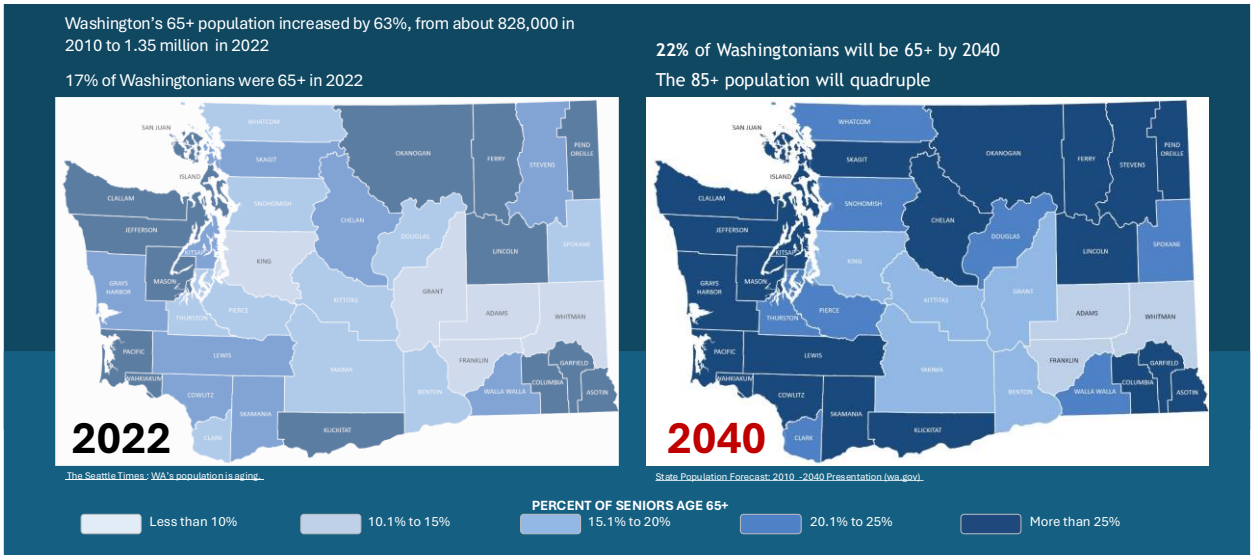

Table 3. Health outcomes by rurality in Washington[68,69,70,71,72,73,74,75,76]

Includes chronic condition, maternal child and child health, and substance use-related health outcomes.

Indicator	Notes on Indicator	Topic	WA State	WA Metro Counties	WA Non-Metro Counties	US Value
Arthritis	Percentage of adults who reported ever being told by a health professional that they had some form of arthritis	Chronic Conditions	24.4%	23.5%	31.9%	26.3%
Cancer	Percentage of adults who reported ever being told by a health professional that they had any form of cancer other than non-melanoma skin cancer	Chronic Conditions	8.2%	8.0%	10.4%	8.4%
Chronic Kidney Disease	Percentage of adults who reported ever being told by a health professional that they had kidney disease (excluding kidney stones, bladder infection and incontinence)	Chronic Conditions	3.3%	3.3%	3.9%	3.7%

[68] Centers for Disease Control and Prevention. (2023). *Behavioral Risk Factor Surveillance System (BRFSS), 2021–2023 data.* Atlanta, GA: U.S. Department of Health and Human Services.

[69] Centers for Disease Control and Prevention. (2023). *CDC WONDER Online Database, 2020–2022 data.* Atlanta, GA: U.S. Department of Health and Human Services. https://wonder.cdc.gov

[70] Health Resources and Services Administration, Maternal and Child Health Bureau. (2022). *Federally Available Data, 2018–2022.* Rockville, MD: U.S. Department of Health and Human Services.

[71] U.S. Census Bureau. (2023). *American Community Survey (ACS), 1-Year Estimates, 2022.* Washington, DC: U.S. Department of Commerce.

[72] Centers for Disease Control and Prevention. (2023). *National Immunization Survey–Child, 2020–2021 birth cohorts.* Atlanta, GA: U.S. Department of Health and Human Services.

[73] Health Resources and Services Administration, Maternal and Child Health Bureau. (2023). *National Survey of Children's Health, 2022–2023 data.* Rockville, MD: U.S. Department of Health and Human Services.

[74] Washington State Department of Health (2025). *Opioid and Drug Use Data.*

[75] Centers for Disease Control and Prevention (2025). *DOSE-DIS Dashboard: Nonfatal Overdose Emergency Department and Inpatient Hospitalization Discharge Data.*

[76] National Center for Health Statistics (2024). *Drug Overdose Deaths in the United State, 2003-2023.*

Indicator	Notes on Indicator	Topic	WA State	WA Metro Counties	WA Non-Metro Counties	US Value
Diabetes	Percentage of adults who reported ever being told by a health professional that they had diabetes (excluding prediabetes and gestational diabetes)	Chronic Conditions	9.6%	9.3%	12.1%	11.5%
High Cholesterol	Percentage of adults who reported having their cholesterol checked and being told by a health professional that it was high	Chronic Conditions	36.2%	N/A	39.8%	36.9%
Asthma	Percentage of adults who reported ever being told by a health professional that they have asthma	Chronic Conditions	10.7%	10.6%	11.5%	10.3%
Cardiovascular Disease	Percentage of adults who reported ever being told by a health professional that they had angina or coronary heart disease, a heart attack or myocardial infarction, or a stroke	Chronic Conditions	7.1%	6.7%	10.6%	8.5%
COPD	Percentage of adults who reported ever being told by a health professional that they had chronic obstructive pulmonary disease, emphysema or chronic bronchitis	Chronic Conditions	4.5%	4.3%	6.5%	6.4%
High Blood Pressure	Percentage of adults who reported being told by a health professional that they had high blood pressure	Chronic Conditions	30.6%	29.9%	37.0%	34.0%
Multiple Chronic Conditions	Percentage of adults who have three or more of the following chronic health conditions: arthritis, asthma, chronic kidney disease, chronic obstructive pulmonary disease, cardiovascular disease (heart disease, heart attack or stroke), cancer (excluding non-melanoma skin cancer), depression or diabetes	Chronic Conditions	9.6%	9.1%	14.2%	10.7%
Obesity	Percentage of adults who have a body mass index of 30.0 or higher based on reported height and weight	Chronic Conditions	30.6%	30.3%	33.6%	34.3%
Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births	Maternal and Child Health Outcomes	4.4	4.3	4.8	5.5

Indicator	Notes on Indicator	Topic	WA State	WA Metro Counties	WA Non-Metro Counties	US Value
Child Mortality	Number of deaths per 100,000 children ages 1-19	Maternal and Child Health Outcomes	25.4	N/A	N/A	29.0
Neonatal Mortality	Number of deaths during first 28 days of life (0-27 days) per 1,000 live births	Maternal and Child Health Outcomes	2.8	N/A	N/A	3.5
Maternal Mortality	Number of deaths related to or aggravated by pregnancy (excluding accidental or incidental causes) occurring within 42 days of the end of a pregnancy per 100,000 live births (5-year estimate)	Maternal and Child Health Outcomes	18.0	N/A	N/A	23.2
Children in Poverty	Percentage of children younger than 18 years who live in households below the poverty threshold	Maternal and Child Health Outcomes	11.4%	N/A	N/A	16.3%
Breastfeeding	Percentage of infants exclusively breastfed for six months	Maternal and Child Health Outcomes	31.9%	N/A	N/A	25.4%
Childhood Immunizations	Percentage of children who received by age 24 months all recommended doses of the combined seven-vaccine series: diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine; measles, mumps and rubella (MMR) vaccine; poliovirus vaccine; Haemophilus influenzae type b (Hib) vaccine; hepatitis B (HepB) vaccine; varicella vaccine; and pneumococcal conjugate vaccine (PCV)	Maternal and Child Health Outcomes	72.4%	N/A	N/A	66.9%
Well-Child Visits	Percentage of children ages 0-17 who received one or more preventive visits in the past 12 months (2-year estimate)	Maternal and Child Health Outcomes	79.2%	N/A	N/A	78.8%

Indicator	Notes on Indicator	Topic	WA State	WA Metro Counties	WA Non-Metro Counties	US Value
Well-Women Visits	Percentage of women ages 18-44 with a preventive medical visit in the past year	Maternal and Child Health Outcomes	66.2%	66.2%	66.6%	71.2%
Breast Cancer Screening	Percentage of women ages 40-74 who reported receiving a mammogram in the past two years	Maternal and Child Health Outcomes	68.1%	68.6%	64.3%	72.1%
Adverse Childhood Experiences	Percentage of children ages 0-17 who have ever experienced two or more of the following: parental divorce or separation; household with an alcohol or drug problem; neighborhood violence victim or witness; household with mental illness; domestic violence witness; parent served jail time; treated or judged unfairly due to race/ethnicity, sexual orientation, gender identity, or a health condition or disability; or death of a parent (2-year estimate)	Maternal and Child Health Outcomes	13.7%	N/A	N/A	14.5%
Asthma in Children	Percentage of children ages 0-17 who currently have asthma (2-year estimate)	Maternal and Child Health Outcomes	5.0%	N/A	N/A	6.6%
Teen Suicide	Number of deaths due to intentional self-harm per 100,000 adolescents ages 15-19	Maternal and Child Health Outcomes	13.7	N/A	N/A	10.5
Low Birth Weight	Percentage of infants weighing less than 2,500 grams (5 pounds, 8 ounces) at birth	Maternal and Child Health Outcomes	7.0%	N/A	N/A	8.6%
ED Visit for Non-Fatal Drug Overdose	Age-adjusted rate of non-fatal suspected drug overdose ED visits per 100,000 population (2023). Based on WA OFM Rural definition.	Substance use	347.43	344.42	357.24	125.1[77]

[77] Not age adjusted.

Indicator	Notes on Indicator	Topic	WA State	WA Metro Counties	WA Non-Metro Counties	US Value
Hospitalization for Drug Overdose	Age-adjusted rate of all drug and opioid overdose hospitalizations per 100,000 population (2023). Based on WA OFM Rural definition.	Substance use	69.55	77.26	58.01	49.477
Overdose deaths	Age-adjusted rate of any drug and overdose deaths per 100,000 population (2023). Based on WA OFM Rural definition.	Substance use	41.9	40.16	35.44	31.3

Table 4. Number of facilities in Washington by urban/rural distribution[78, 79, 80, 81, 82]

Hospitals	Rural	Urban	Total
Number of Critical Access Hospitals (CAHs)	33	6	39
Number of Sole Community Hospitals	3	1	4
Number of Medicare Dependent Hospitals	0	0	0
Number of Low Volume Hospitals	0	1	1
Number of Rural Emergency Hospitals	0	0	0
Number of other rural hospitals in FORHP			0
Number of other rural hospitals classified or reclassified			0
Total	**36**	**8**	**44**

Non-Hospitals	Rural	Urban	Total
Number of Rural Health Clinics (RHCs)	110	17	127
Number of Federal Qualified Health Centers	70	230	300
Number of Community Mental Health Centers	13	39	52
Number of Opioid Treatment Facilities	5	40	45
Number of Certified Community Behavioral Health Clinics	2	10	12
Total	**196**	**340**	**536**

[78] Washington State Department of Health. (2024). *WA Health hospital capacity and utilization data system.* Olympia, WA: Office of Hospital and Patient Data Systems.

[79] Washington State Department of Health, Office of the Assistant Secretary for Health Systems Quality Assurance. (2024). *Health Systems Quality Assurance (HSQA) data and licensing records.* Olympia, WA.

[80]Washington State Department of Health, Office of Community Health Systems. (2024). *Data provided by the Office of Community Health Systems.* Olympia, WA.

[81] Washington State Department of Health, State Office of Rural Health. (2024). *Program data provided by the State Office of Rural Health.* Olympia, WA.

[82] Centers for Medicare & Medicaid Services. (2024). *Provider of Service File – Hospital & Non-Hospital Facilities.* CMS Data, Washington, DC: U.S. Department of Health and Human Services.

Table 5. Factor A.2. Certified Community Behavioral Health Clinic (CCBHC) entities, site locations and addresses

Active Site of Care Name	Street Address	City	State	ZIP Code	Corresponding CCBHC Entity/ Institution Name	Demonstration	State-certified	SAMHSA	HRSA Rurality (Y/N)
Cascade Community Healthcare	2428 West Reynolds Ave.	Centralia	WA	98531				Y	Y
Columbia River Mental Health Services	6926 NE Fourth Plain Blvd.	Vancouver	WA	98661				Y	N
Columbia Wellness	921 14th Avenue	Longview	WA	98632				Y	N
Community Health Association of Spokane (CHAS)	5901 N. Lidgerwood St. Suite 223	Spokane	WA	99208				Y	N
CHAS Lewiston	1534 Idaho St.	Lewiston	ID	83501	CHAS			Y	N
Comprehensive Healthcare	402 S. 4th Ave.	Yakima	WA	98902				Y	N
Confederated Tribes and Bands of the Yakama Nation	401 Fort Road	Toppenish	WA	98948				Y	Y
CORE Health	1105 Broadway Street	Longview	WA	98632				Y	N
Excelsior Youth Center	3910 W Indian Trail Rd	Spokane	WA	99208				Y	N
Kitsap Mental Health Services	5455 Almira Drive NE	Bremerton	WA	98311				Y	N
Lake Whatcom Residential Treatment Center	3600 Meridian St.	Bellingham	WA	98225				Y	N

Sound Health (SH)	13555 Bel-Red Rd. Suite 228	Bellevue	WA	98005				Y	N
SH Auburn	4238 Auburn Way N.	Auburn	WA	98002	Sound Health			Y	N
SH Capitol Hill	1600 E. Olive St.	Seattle	WA	98122	Sound Health			Y	N
Volunteers of America Spokane	1440 N Haven St	Spokane	WA	99202				Y	N

Table 6. Factor A.7. Hospitals in Washington that received Disproportionate Share Hospital (DSH) payments (SFY2025 using FY2023 data)

Medicare Number	Hospital Name
Critical Access Hospitals	
501330	Astria Sunnyside
501334	Chelan County Public Hospital District No.2 D/B/A Lake Chelan Community Hospital
501308	Coulee Medical Center
501323	Jefferson Healthcare
501333	Kittitas Valley Healthcare
501336	Mason General Hospital and Family of Clinics
501314	Ocean Beach Hospital
501328	Okanogan County Public Hospital District No. 3 d/b/a Mid Valley Hospital
501318	Othello Community Hospital
501312	Prosser Public Hospital District dba PMH Medical Center
501326	Providence Mount Carmel Hospital
501331	Pullman Regional Hospital
501338	Snoqualmie Valley Hospital
501335	St. Elizabeth Hospital
501304	Summit Pacific Medical Center
501332	Tri-State Memorial Hospital
501327	Whitman Hospital and Medical Center
Non-Critical Access Hospital	
500139	Capital Medical Center
500124	Evergreen Health Kirkland
500039	Franciscan St. Michael Medical Center (FKA: Harrison)
500011	Franciscan St. Anne Medical Center (FKA: Highline)
500141	Franciscan St. Francis Hospital
500108	Franciscan St. Joseph Medical Center
500058	Kadlec Regional Medical Center
503301	Mary Bridge Children's Hospital
500015	MultiCare Auburn Medical Center
500044	MultiCare Deaconess
500079	MultiCare Good Samaritan Hospital
500129	MultiCare Tacoma General Hospital
500119	MultiCare Valley Hospital
500041	PeaceHealth St. John
500030	PeaceHealth St. Joseph
500050	PeaceHealth Southwest
500019	Providence Centralia Hospital
500077	Providence Holy Family Hospital

500014	Providence Regional Medical Center Everett
500054	Providence Sacred Heart Medical Center and Children's Hospital
500033	Samaritan Hospital
503300	Seattle Children's Hospital
503302	Shriners Hospitals for Children - Spokane
500026	Swedish Edmonds
500152	Swedish Issaquah
500027	Swedish Medical Center (First Hill)
Border City	
380007	Legacy Emanuel Hospital and Health Center

Table 7. List of Washington counties defined as "fully rural" or "not fully rural" using HRSA's Federal Office of Rural Health Policy (FORHP) County and Census Tract county eligibility data.[83]

County	FORHP County Eligibility
Adams County	Fully FORHP Rural
Asotin County	Not Fully FORHP Rural
Benton County	Not Fully FORHP Rural
Chelan County	Not Fully FORHP Rural
Clallam County	Fully FORHP Rural
Clark County	Not Fully FORHP Rural
Columbia County	Fully FORHP Rural
Cowlitz County	Not Fully FORHP Rural
Douglas County	Not Fully FORHP Rural
Ferry County	Fully FORHP Rural
Franklin County	Not Fully FORHP Rural
Garfield County	Fully FORHP Rural
Grant County	Fully FORHP Rural
Grays Harbor County	Fully FORHP Rural
Island County	Fully FORHP Rural
Jefferson County	Fully FORHP Rural
King County	Not Fully FORHP Rural
Kitsap County	Not Fully FORHP Rural

[83] Health Resources & Services Administration's Federal Office of Rural Health Policy County and Census Tract Excel File.

Kittitas County	Fully FORHP Rural
Klickitat County	Fully FORHP Rural
Lewis County	Fully FORHP Rural
Lincoln County	Fully FORHP Rural
Mason County	Fully FORHP Rural
Okanogan County	Fully FORHP Rural
Pacific County	Fully FORHP Rural
Pend Orielle County	Fully FORHP Rural
Pierce County	Not Fully FORHP Rural
San Juan County	Fully FORHP Rural
Skagit County	Not Fully FORHP Rural
Skamania County	Fully FORHP Rural
Snohomish County	Not Fully FORHP Rural
Spokane County	Not Fully FORHP Rural
Stevens County	Fully FORHP Rural
Thurston County	Not Fully FORHP Rural
Wahkiakum County	Fully FORHP Rural
Walla Walla County	Not Fully FORHP Rural
Whatcom County	Not Fully FORHP Rural
Whitman County	Fully FORHP Rural
Yakima County	Not Fully FORHP Rural

Table 8. RHT Program governance structure including primary roles and resolution pathways

Group	Primary roles	Resolution pathway
Executive Governance	• Receives quarterly briefings, otherwise brought in for oversight ad-hoc. • Participates on Advisory Committee directly, or through delegate. • Provide strategic direction and oversee any major decision making.	HCA Director may raise critical issues to Governor if necessary.
Coordinator	• Directly oversee development of procurements and contracts, as necessary. • Ensure deliverables with Centers for Medicare & Medicaid Services (CMS) and state Legislature are timely. • Escalate decisions to executive team as necessary via monthly meetings. • Organize staff teams and manage any RHTP program hires at HCA.	Raise unresolved issues with the Executive Governance group.
Consulted Leadership Team	• Support consultation. • Ensure success of Project Team. • Meet every other week.	Raise issues to Coordinator for resolution, as necessary.
Project Team	• Develop and score procurements. • Draft and execute contracts. • Produce reporting for federal and state officials. • Staff Advisory Committee. • Report to Leadership Team on progress.	Raise issues with Coordinator and Consulted Leadership Team at bimonthly check-ins.
Advisory Committee	• Staffed by DOH • Support recommendations on priorities for funding, within Washington's major initiatives outlined in its Rural Transformation Plan and RHTP application. • Review reporting from awardees of funds and suggest changes in prioritization of funding to Project Team throughout five-year duration of RHTP. • Make recommendations to the Legislature on statutory changes or state investments that could align state investments and policies with the Rural Transformation Plan.	Brings recommendations to Project Team and Coordinator.

Table 9. RHT Program project members including executive governance, acting staff, and advisory committee representatives

Group	Members			
Executive Governance	Ryan Moran, HCA Dir. (Lead organization)	Caitlin Safford, GOV	Angela Ramirez, DSHS Secretary	Dennis Worsham, DOH Secretary
Coordinator	TBD, Program Lead _____			
Consulted Leadership Team	Teesha Kirshbaum, HCA Catrina Lucero, HCA Mich'l Needham, HCA	Aren Spark, HCA Kahlie Dufresne, HCA (acting) Evan Klein, HCA (acting)	Rich Pannkuk, DSHS Bea Rector, DSHS Cynthia Holliman, OFM	Maria Courogen, DOH Lacy Fehrenbach, DOH
Project Team	Health Care Authority -Policy analysts -Data analysis and monitoring -Financial analysts	Department of Health, including the State Office of Rural Health -Program staff (for initiative implementation) -Advisory Committee support staff	Department of Social and Health Services -Program staff (for initiative implementation)	
Advisory Committee One representative from each group.	GOV, HCA, DOH, DSHS, OFM Tribes (2 reps) Rural hospitals Local public health	Federally Qualified Health Centers (FQHCs) Behavioral health providers Medical association Labor organizations	State Council on Aging *or* Area Agency on Aging Three community representatives from rural Washington • Two from eastern Washington, one from western Washington • Seeking experience in health care	