Rural Health Transformation Grant Guide — Oregon

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AUDIENCE: State health agencies, Medicaid, rural providers, collaboratives

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary Oregon can use the CMS Rural Health Transformation (RHT) cooperative agreement to stabilize rural access, strengthen workforce, modernize technology and data, and advance value-focused care delivery over FY26–FY30. The program provides five years of funding to states (only the 50 states are eligible) with distribution split between an equal base share and a workload-based share; applications are due November 5, 2025, with awards expected by December 31, 2025. (cms.gov)

Oregon's rural profile shows substantial opportunity: in 2024 an estimated 33% of residents lived in rural areas and 2% in frontier areas, across 10 officially designated frontier counties (Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Wallowa, Wheeler). (ohsu.edu) At the same time, Oregon's rural system is strained by facility and service line reductions (e.g., recent and potential obstetrics closures), rising overdose mortality, and EMS coverage challenges in frontier communities. (opb.org)

The Rural Health Transformation Collaborative (the Collaborative) can support Oregon's plan through: statewide virtual specialty support (critical care, ED, behavioral health), remote monitoring for chronic and post-acute care, consumer screening/engagement tools, program management and analytics, interoperable data exchange (including TEFCA-designated QHIN connectivity), and cybersecurity uplift for rural hospitals. These capabilities map to the RHT pillars and allowable uses (technology, workforce, prevention/chronic, innovative care), with documented deployments among member organizations. (sequoiaproject.org)

The guide below outlines: (a) how Oregon's needs align with the RHT NOFO; (b) three to four modular program options calibrated to Oregon's CCO-based Medicaid model and 1115 demonstration authorities; (c) governance and payment mechanics; (d) a 24-month activation plan emphasizing fast-start, high-impact deliverables that remain conditional on state policy, procurement, and contracting.

Printable one-page summary (for distribution)

- Oregon need snapshot (2024–2025):
    - 33% rural; 2% frontier; 10 frontier counties. (ohsu.edu)
    - 25 CAHs; ~98 RHCs; ~90 FQHC organizations/sites outside large urban. (ruralhealthinfo.org)
    - OB service reductions in Seaside and Baker City; overdose deaths up 33% in 2023. (opb.org)
    - ~16 CCOs administer most OHP; ~1.4M Oregonians enrolled (2024–2025). (oregon.gov)
- RHT fit (program timeline and structure):
    - Eligible applicant: State of Oregon; deadline Nov 5, 2025; awards Dec 31, 2025; 50/50 base vs. workload. (cms.gov)
- Collaborative contributions (illustrative):
    - Tele-ICU/ED/behavioral (Avel eCare), rural provider networks (Cibolo), RPM for chronic/post-acute (BioIntelliSense), consumer screening and multilingual digital triage (Humetrix), AI decision support (Viz.ai), interoperability via TEFCA QHIN (eClinicalWorks PRISMANet), cybersecurity lift (Microsoft), program integration and analytics (Accenture/KPMG/PwC/AVIA). (sequoiaproject.org) (blogs.microsoft.com)
- Primary options for Oregon:
    1. Rural Chronic Care at Home (RPM + tele-specialty) across frontier counties;
    2. Maternal and Behavioral Health Integration (tele-OB, perinatal RPM, tele-psychiatry, 988 integration);
    3. Community Paramedicine & Tele-EMS (frontier EMS support, EDIE-linked);
    4. Rural Cyber/Data Modernization (QHIN exchange, hospital cyber uplift). (See Sections 5 and 9 for details.)

2. Eligibility and RFP Fit 2.1 Program intent and timeline (public sources)

- Purpose: State-led, five-year cooperative agreement to transform rural healthcare delivery with investments spanning prevention, workforce, innovative care, technology and data. (cms.gov)
- Eligibility: Only the 50 U.S. states (no territories or DC). One application per state. (cms.gov)
- Timeline: NOFO posted mid-September 2025; applications due Nov 5, 2025; awards Dec 31, 2025; earliest start Q1 FY26. (simpler.grants.gov)
- Funding structure: 50% equal base across approved states; 50% workload-based using CMS-specified factors. (cms.gov)

Assumptions note (citations pending): Detailed page limits, attachment lists, caps (e.g., administrative or category caps), technical scoring weights, and conditional point recovery timelines are referenced in internal applicant briefing materials but not publicly available on CMS.gov at time of writing; this guide treats those details as assumptions requiring confirmation against the final NOFO PDF. See "Assumptions and Open Questions."

2.2 Requirement–Capability–Evidence mapping (selected examples)

- RHT use: Technology innovation (remote care, cyber, data).
    - Collaborative capability: Virtual hospital/tele-specialty (Avel eCare); RPM (BioIntelliSense); AI triage/detection (Humetrix, Viz.ai); statewide analytics and PMO support (Accenture/KPMG/PwC/AVIA).
    - Evidence: Virtual ICU/ED and behavioral crisis programs for rural sites; FDA-cleared wearable platform with clinical intelligence; ED/ICU stroke workflow impact literature; consulting program management toolkits.
- RHT use: Workforce development/recruitment.
    - Collaborative capability: Tele-mentoring for rural ED/ICU; pharmacy workforce pipelines; ambient documentation to reduce burnout; coordinated upskilling across providers.
    - Evidence: Described capabilities and training constructs in collaborative materials.
- RHT use: Interoperability and care coordination.
    - Collaborative capability: eClinicalWorks PRISMANet TEFCA QHIN, patient-facing health record apps.
    - Evidence: eClinicalWorks designated as QHIN (Jan 16, 2025), enabling nationwide exchange under TEFCA. (sequoiaproject.org)
- RHT use: Cybersecurity uplift in rural facilities.
    - Collaborative capability: Microsoft rural hospital cybersecurity program; discounted security suites; assessments and training.
    - Evidence: 550+ rural hospitals participating as of March 2025; reports of 700+ by July 2025 (industry and AHA reporting). (blogs.microsoft.com)
- RHT use: Behavioral health and SUD services.
    - Collaborative capability: Tele-behavioral (Avel eCare, Teladoc), multilingual consumer tools (Humetrix), 988 implementation support (consulting partners).
    - Evidence: Collaborative descriptions of virtual crisis care and BH network.

3. Oregon Context Snapshot 3.1 Population and geography (2024–2025)

- Rural/frontier shares: 33% rural (1.40M people), 2% frontier (97.7k); frontier counties: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Wallowa, Wheeler (ORH definitions). (ohsu.edu)
- Broadband: $148.96M ARPA CPF grants executed in May 2025 to bring fiber to 13,438 locations (90% previously unserved) across 17 counties—conditions favor tech-enabled care if providers are equipped. (oregon.gov)

Collaborative alignment: consumer screening and telehealth at retail/community sites; RPM for chronic and post-acute; tele-specialty for frontier hospitals; cyber hardening to reduce downtime risk.

3.2 Rural facility mix and EMS

- Facilities: 25 CAHs; ~98 RHCs; ~90 FQHC locations outside large urban areas; 9 short-term PPS hospitals outside major urban areas (RHIhub profiles, July 2025). (ruralhealthinfo.org)
- EMS: Many rural ambulance areas rely on volunteers; reports of suspended ground coverage in some frontier communities; approximately 70% of Oregon's ground ambulance service areas are rural—underscoring need for tele-EMS, community paramedicine, and cross-coverage models. (klcc.org)

Collaborative alignment: tele-EMS consults; community paramedicine protocols; EDIE-driven alerts and information exchange; program management for cross-agency governance.

3.3 Workforce and HPSA indicators

- Oregon participates in CCO-based managed care; rural counties frequently face primary care, dental, and mental health HPSA designations (HRSA). Statewide counts vary by quarter; HRSA dashboards confirm ongoing HPSA designations as of Oct 2025. (data.hrsa.gov)

Collaborative alignment: tele-specialty coverage; pharmacist-driven chronic care; ambient documentation tools; clinical upskilling; recruitment support through improved working conditions and consult backup.

3.4 Medicaid and policy environment

- Delivery model: 16 CCOs serve the majority of ~1.4M OHP members (2024–2025); capitation and quality incentives are well-established. (oregon.gov)
- 1115 demonstration: Approved Sept 28, 2022 (effective through 9/30/2027), including continuous coverage up to age 6

and HRSN supports; STCs updated 2024–2025. (cms.gov)

- Quality incentives: Annual CCO incentive program with published measures/benchmarks (e.g., SDOH screening, perinatal, SUD initiation/engagement). (oregon.gov)
- HIE landscape: Oregon hospitals widely use EDIE; PointClickCare enables cross-setting alerts; prior statewide HIE onboarding concluded in 2021; HITOC strategic plan (2024–2028) prioritizes stronger exchange (including behavioral/oral health, social services) and consumer privacy. (oregon.gov)

Collaborative alignment: QHIN-enabled exchange, population health analytics, multi-payer dashboards, and consent-aware consumer applications. (sequoiaproject.org)

3.5 Maternal, behavioral health, and SUD

- Maternal care: OB unit closures or contemplated reductions (Seaside; Baker City 2023) increase travel times and risk; maternal deaths were 6 in 2023 (15.5 per 100,000 live births). (opb.org)
- Overdose: 1,833 overdose deaths in 2023 (+~33% YoY), with fentanyl driving spikes in Multnomah County; OHA maintains overdose dashboards for statewide and county trend monitoring. (opb.org)

Collaborative alignment: tele-OB "hub-and-spoke", remote perinatal monitoring; 24/7 tele-BH; multilingual triage; analytics to target risk; pharmacy-based outreach and adherence programs.

3.6 Telehealth and broadband policy

- OHP covers video, audio-only, and online telehealth modalities; state rules specify telehealth POS and modifiers, with OAR updates in 2025. (oregon.gov)
- Oregon Broadband Office completed ARPA CPF awards for un/underserved areas; additional local BEAD/CPF projects continue. (oregon.gov)

3.7 Oregon policies intersecting RHT technical factors (illustrative status)

- Licensure compacts: Oregon has not joined IMLC (physician) and is not a PSYPACT member (psychology) as of Oct 2025. (oregon.gov)
- Certificate of Need: Oregon maintains a CON program for specified projects (e.g., new hospitals, SNF/ICF beds); related legislative activity continues. (oregon.gov)

3.8 Oregon metrics to capability linkage (examples)

- Frontier counties with sparse hospital coverage → tele-hospitalist/tele-ICU, tele-OB, tele-BH; EMS tele-consults.
- High SUD mortality trend → multilingual triage, tele-BH, pharmacy-based adherence, targeted analytics.
- HIE gaps (BH/oral/social) → TEFCA QHIN exchange + EDIE/Collective signals. (sequoiaproject.org)
- Cyber threats to small hospitals → Microsoft rural program assessments/training/discounts. (blogs.microsoft.com)

4. Strategy Aligned to RFP Oregon can articulate a statewide rural transformation anchored in:

- Connected rural networks: A Cibolo-enabled, member-owned High Value Network (HVN) for independent rural hospitals/clinics to share clinical services, procurement, analytics, and governance—complementing existing health system affiliates and CCO infrastructures.
- Virtual specialty and EMS backup: Avel eCare virtual hospital services for ICU/ED/hospitalist/behavioral coverage; tele-EMS for frontier response.
- Home-centered chronic care: BioIntelliSense continuous monitoring with exception-based workflows integrated to local clinicians and CCO care management.
- Consumer engagement & navigation: Humetrix multilingual triage/intake and patient-facing PHR integrated to claims/EHR; retail health touchpoints (CVS/Walgreens/Walmart) for screening/vaccination/adherence.
- Data and cyber foundations: eClinicalWorks PRISMANet QHIN for TEFCA exchange; Microsoft rural cybersecurity program for security uplift and compliance. (sequoiaproject.org)
- Program integration and economic modeling: Accenture/KPMG/PwC for PMO, benefit-cost tracking, SPA/contracting support.

Equity for rural and Tribal communities: leverage HITOC's strategic directions for HIE, ensure culturally appropriate consent and data use, include Tribal clinics in data-exchange/onboarding and tele-specialty access, and deploy multilingual patient tools. (oregon.gov)

Privacy and security: TEFCA participation (QHIN connectivity), HITRUST/ISO-aligned platforms, and state OAR telehealth documentation—combined with Microsoft assessments/training—to reduce breach risk and downtime. (sequoiaproject.org)

5. Program Design Options (modular; can be combined) 5.1 Option A: Rural Chronic Care at Home (Frontier-first)

- Target: Adults with CHF/COPD/diabetes in frontier and high-risk rural counties (e.g., Harney, Lake, Malheur, Sherman, Wallowa). (ohsu.edu)
- Problem: Hospital readmissions, long travel for specialist follow-up, limited local workforce.
- Solution components:
    - Continuous physiologic monitoring and exception management (BioIntelliSense).
    - Tele-cardiology/pulmonology consults (Avel eCare + system partners).
    - Pharmacy outreach and adherence support (CVS/Walgreens).
    - CCO-integrated analytics to prioritize outreach.
- Payment logic: Blend of RHT funds for technology/training and Oregon CCO incentives (e.g., diabetes oral evaluation, SDOH screening); potential Medicaid directed payments to reinforce outcomes. (oregon.gov)
- Enabling policy: OHP telehealth coverage (incl. audio-only), pharmacist scope; maintain POS/modifier compliance. (oregon.gov)
- Risks: Device acceptance, alert fatigue, broadband gaps. Mitigation: onboarding protocols, exception thresholds, device connectivity kits.
- Indicative scale: 2,000–5,000 enrollees over 24 months; scalable statewide.

5.2 Option B: Maternal and Behavioral Health Integration

- Target: Pregnant/post-partum patients in counties affected by OB service reductions; rural adults with SUD/BH needs. (opb.org)
- Solution: Tele-OB "hub-and-spoke," perinatal RPM (BP/glucose), 24/7 tele-psychiatry/crisis; multilingual intake; referral integration with 988.
- Payment logic: RHT start-up + CCO incentive alignment (post-partum care rate; SUD initiation/engagement). (oregon.gov)
- Risks: Workforce adoption, continuity to in-person services. Mitigation: local nurse navigators, clear transfer protocols.

5.3 Option C: Community Paramedicine & Tele-EMS (Frontier EMS)

- Target: Frontier EMS agencies with volunteer staffing and long transport times. (opb.org)
- Solution: Avel eCare tele-EMS consults; community paramedicine visits for high-risk patients; EDIE/Collective alerts to route follow-up. (oregon.gov)
- Payment logic: RHT funds for equipment/training; explore Medicaid coverage for community paramedicine and avoidable ED reduction incentives (through CCO contracts).
- Risks: Scope of practice boundaries; Mitigation: protocols vetted with OHA/EMS authorities.

5.4 Option D: Rural Cyber and Data Modernization

- Target: CAHs, small rural hospitals, RHCs, behavioral health clinics.
- Solution: Microsoft assessments/training and discounted security suites; QHIN-enabled exchange via eClinicalWorks; statewide dashboards for CCO and RHT metrics. (blogs.microsoft.com)
- Payment logic: RHT tech funds; CCO quality and reporting synergies.
- Risks: Staff capacity; Mitigation: managed service bundles, hands-on training.

6. Governance and Collaborative Roles 6.1 Structure (text diagram)

- State (Lead Agency; e.g., OHA): sets RHT plan/targets; oversees funds, reporting; aligns CCOs and state policy levers.
- Medicaid/CCOs: contract alignment, quality incentives, data feeds.
- Provider consortia (HVN via Cibolo): rural governance vehicle, shared services, spend transparency.
- Collaborative members:
    - Clinical services: Avel eCare (virtual ICU/ED/BH/EMS).
    - RPM: BioIntelliSense.
    - Consumer/triage/PHR: Humetrix.
    - Interoperability/EHR: eClinicalWorks PRISMANet (QHIN). (sequoiaproject.org)
    - Cyber/cloud/AI platform: Microsoft.
    - Retail health: CVS/Walgreens/Walmart.
    - Program integration/economics: Accenture/KPMG/PwC/AVIA.

6.2 RACI (selected)

- Plan development: State (R), Medicaid/CCOs (C), HVN (C), Collaborative PMO (A for drafting support).
- Clinical activation: Providers/HVN (R), Avel/RPM vendor (A/R), CCOs (C), State (I).
- Data/cyber stack: Microsoft/eClinicalWorks (A/R), providers (R), State HITOC/OHITAI (C), CCOs (C). (sequoiaproject.org)
- Evaluation/reporting: PMO (A/R), State (A), CCOs (C), provider sites (R).

7. Payment and Funding

- Funding pathways consistent with RHT: technology and workforce investments, virtual care services, data/cyber modernization, and targeted provider payments that align with quality and access goals. (cms.gov)
- Medicaid alignment:
    - Use CCO quality incentives and potential directed payments to sustain high-value activities (e.g., maternal follow-up, SUD engagement, SDOH screening). (oregon.gov)
    - 1115 authorities (continuous coverage/HRSN) can complement RHT investments (e.g., housing/nutrition supports tied to chronic care). (cms.gov)

Illustrative cost categories and timing (ROM; actuals subject to procurement)

- Clinical services (tele-ICU/ED/BH/OB), RPM devices/services, analytics/reporting, cyber tooling/training, HIE/QHIN connectivity, retail health activations, program management and evaluation. (Evidence of each component's feasibility in collaborative materials.)

8. Data, Measurement, and Evaluation

- Core measures (aligned with OHA/CCO and RHT): SDOH screening and referral; diabetes control and oral evaluation; postpartum care; SUD initiation/engagement; BH access; avoidable ED visits; readmissions; tele-specialty response times; hospital financial stability indicators (days cash on hand, operating margin). (oregon.gov)
- Data sources: CCO claims; EDIE/Collective alerts; EHR (eClinicalWorks and others) via TEFCA; EMS run data; OHA registries; consumer app telemetry (opt-in). (oregon.gov)
- Privacy/security: TEFCA trust framework; state OAR telehealth coding/claims; Microsoft hospital cyber program. (secure.sos.state.or.us)
- Evaluation: PMO creates a learning system with quarterly dashboards; methods include difference-in-differences at county level and site-matched comparisons where feasible.

9. Implementation Plan (first 12–24 months; dates indicative) Gantt-style summary

- Workstream; Start; End; Primary owner; Outputs
    - Statewide HVN formation and site cohorting; 2026-01-15; 2026-06-30; HVN/State; charter, participation agreements.
    - Tele-ICU/ED/BH activation in 8–12 rural hospitals; 2026-02-01; 2026-12-31; Avel + sites; service-level KPIs and escalation playbooks.
    - RPM cohort (1,500–2,500 patients) in 5–7 counties; 2026-03-01; 2027-03-31; BioIntelliSense + clinics; enrollment >80% target group; exception-based workflows.
    - Maternal/BH integration pilots (tele-OB/perinatal RPM + tele-BH); 2026-04-01; 2027-03-31; Providers + Avel/Humetrix; postpartum care rate improvement plan; BH access metrics.
    - EMS tele-consult + paramedicine (3 frontier agencies); 2026-02-15; 2027-03-31; Avel + EMS partners; protocolized tele-EMS, post-discharge home checks.
    - Cyber modernization (10–15 hospitals); 2026-02-01; 2026-12-01; Microsoft + sites; completed assessments/training; MFA and identity hardening. (blogs.microsoft.com)
    - QHIN/HIE enablement, dashboards; 2026-03-01; 2026-10-31; eClinicalWorks + State; TEFCA exchange live; RHT/CCO dashboards. (sequoiaproject.org)
    - Evaluation & sustainability modeling; 2026-01-15; recurring; PMO; quarterly dashboards and value tracking; SPA/contract options.

Gating decisions: site readiness; legal/contracting; data-sharing agreements; cybersecurity remediation plans; Medicaid alignment for sustainability.

Procurement/legal notes: All partner involvement is subject to RFP/contracting under state rules; flow-down of HHS GPS and 2 CFR Part 200 requirements applies to subrecipients and contractors. (hhs.gov)

10. Risk Register (selected; owner; mitigation)

- Rural workforce acceptance; HVN clinical leads; staged onboarding, incentives, tele-mentoring.
- Broadband gaps; State/OBO; device kits, offline data buffering, prioritize fiber-served sites. (oregon.gov)
- Cyber incident during rollout; Sites/Microsoft; pre-go-live assessments, MFA, incident playbooks. (blogs.microsoft.com)
- Data-sharing barriers; State/HITOC; TEFCA participation, consent tools, legal templates. (sequoiaproject.org)
- OB service availability; Provider/HVN; tele-OB coverage; transfer protocols. (opb.org)
- Patient engagement with RPM; Providers; navigator training; culturally appropriate materials (multilingual).
- EMS volunteer capacity; Local EMS; tele-supervision, stipends/training grants. (opb.org)
- Interoperability across EHRs; PMO/eClinicalWorks; FHIR-based exchange via QHIN bridging. (sequoiaproject.org)
- Financial sustainability post-RHT; State/CCOs; directed payments/quality incentives; ROI tracking. (oregon.gov)
- Policy changes (SNAP/telehealth rules); State; continuous policy monitoring; scenario planning. (oregon.gov)

11. Draft RFP Response Language (boilerplate—adapt in Oregon's voice) Program purpose and scope (excerpt) "Oregon proposes a rural transformation model that combines statewide virtual specialty coverage, home-centered chronic care, and data/cyber modernization, enabled by a member-owned rural High Value Network and aligned with Coordinated Care Organizations (CCOs). This model supports RHT pillars—prevention/chronic disease, sustainable access, workforce, innovative care, and technology—and leverages TEFCA-enabled exchange for care coordination. Implementation is phased, contingent on site readiness, contracting, and alignment with Oregon policy and Medicaid authorities." (cms.gov)

Technology and data (excerpt) "Oregon will deploy interoperable tools that support direct patient care and statewide analytics, including continuous monitoring for high-risk populations, tele-hospitalist/ICU/behavioral consults, multilingual triage and patient-facing records, TEFCA QHIN connectivity for claims/EHR exchange, and rural hospital cybersecurity assessments/training. Data will be shared under applicable consent and privacy frameworks." (sequoiaproject.org)

Workforce and EMS (excerpt) "RHT funds will support rural workforce retention via 24/7 specialist backup, reduced documentation burden, structured training, and pharmacy-aligned chronic disease management. In frontier counties, tele-EMS and community paramedicine will extend clinical reach."

Evaluation (excerpt) "Oregon will report quarterly on access, quality, utilization, and financial stability, aligning with established CCO incentive measures (e.g., SDOH screening, postpartum care, SUD engagement) and RHT goals. Dashboards will integrate TEFCA exchange data, EDIE alerts, claims, and RPM signals." (oregon.gov)

12. Assumptions and Open Questions

- NOFO details requiring confirmation: page limits, attachment lists, administrative and category-specific caps, initiative scoring rubric, and conditional policy points/recovery timelines. Please confirm against the posted NOFO PDF on Grants.gov (CMS-RHT-26-001) before finalizing application language. (simpler.grants.gov)
- Medicaid financing approach: confirm feasibility of directed payments and/or SPA adjustments to sustain community paramedicine and tele-specialty after RHT start-up.
- Site selection: finalize cohort of rural/frontier hospitals, RHCs, FQHCs, EMS agencies, and retail locations with willing partners and adequate connectivity.
- Data-sharing governance: confirm statewide approach to TEFCA participation and consent management for BH and social data streams.

13. References

1. Rural Health Transformation (RHT) Program overview, CMS. https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview (accessed 2025-10-14). (cms.gov)
2. CMS press release: "CMS Launches Landmark $50 Billion Rural Health Transformation Program" (2025-09-15). https://www.cms.gov/newsroom/press-releases/cms-launches-landmark-50-billion-rural-health-transformation-program (accessed 2025-10-14). (cms.gov)
3. CMS Current Funding Opportunities (listing CMS-RHT-26-001). https://www.cms.gov/about-cms/grants-cooperative-agreements/currentnts-funding-opportunities (accessed 2025-10-14). (cms.gov)
4. Simpler Grants (CMS-RHT-26-001 opportunity listing). https://simpler.grants.gov/opportunity/782f996f-78f8-4742-8b68-d2bf50c87f99 (accessed 2025-10-14). (simpler.grants.gov)
5. Oregon Office of Rural Health (ORH): Rural/Frontier definitions, 2024 Claritas data and frontier county list. https://www.ohsu.edu/oregon-office-of-rural-health/about-rural-and-frontier-data (accessed 2025-10-14). (ohsu.edu)
6. Rural Health Information Hub – Oregon state profile (facilities, July 2025). https://www.ruralhealthinfo.org/states/oregon

(accessed 2025-10-14). (ruralhealthinfo.org)

7. OHA: Coordinated Care Organizations (general info and news releases). https://www.oregon.gov/oha/OHP/Pages/CCOs.aspx; https://content.govdelivery.com/accounts/ORHA/bulletins/3e70d56 (accessed 2025-10-14). (oregon.gov)
8. OHA: CCO Quality Incentive Program resources and measures. https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx (accessed 2025-10-14). (oregon.gov)
9. OHA: Telehealth coverage (OHP) and OAR telehealth coding. https://www.oregon.gov/oha/hsd/ohp/pages/telehealth.aspx; OAR update excerpt (DMAP 39-2025). (accessed 2025-10-14). (oregon.gov)
10. OHA: Oregon Vital Statistics 2023 fast stats (maternal deaths). https://www.oregon.gov/oha/PH/BirthDeathCertificates/VitalStatistics/AnnualReports/Pages/index.aspx (accessed 2025-10-14). (oregon.gov)
11. OB service reductions in rural Oregon: OPB (Seaside), Salem Reporter (Baker City). https://www.opb.org/article/2025/08/19/providence-seaside-hospital-closes-maternity-unit/; https://www.salemreporter.com/2025/09/18/what-happened-after-a-rural-oregon-town-lost-its-maternity-ward/ (accessed 2025-10-14). (opb.org)
12. Overdose trends: OPB report (2024 data), OHA overdose dashboard. https://www.opb.org/article/2024/12/13/deaths-from-drug-overdoses-surged-nearly-33-in-oregon-last-year/; https://www.oregon.gov/oha/ph/preventionwellness/substanceuse/opioids/pages/index.aspx (accessed 2025-10-14). (opb.org)
13. EMS coverage challenges: OPB/KLCC features on rural EMS. https://www.opb.org/article/2025/06/25/emergency-medical-care-rural-oregon/; https://www.klcc.org/health-medicine/2025-07-01/volunteers-fill-gaps-in-rural-oregon-emergency-medical-care (accessed 2025-10-14). (opb.org)
14. Oregon Broadband Office – CPF awards (May 2025). https://www.oregon.gov/biz/programs/Oregon_Broadband_Office/Pages/default.aspx (accessed 2025-10-14). (oregon.gov)
15. HITOC/HIE and EDIE/Collective platform in Oregon. https://www.oregon.gov/oha/HPA/OHIT/Pages/Programs.aspx; https://www.oregon.gov/oha/hpa/ohit-hitoc/pages/hieworkgroup.aspx (accessed 2025-10-14). (oregon.gov)
16. CMS/HHS: Oregon 1115 demonstration approvals and STCs; Medicaid.gov OHP waiver page. https://www.cms.gov/newsroom/press-releases/hhs-approves-groundbreaking-medicaid-initiatives-massachusetts-and-oregon; https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82956 (accessed 2025-10-14). (cms.gov)
17. eClinicalWorks QHIN designation (Jan 2025). https://sequoiaproject.org/astp-and-the-sequoia-project-designate-eclinicalworks-as-qhin/ (accessed 2025-10-14). (sequoiaproject.org)
18. Microsoft Cybersecurity for Rural Hospitals—participation metrics (AHA news, Microsoft blog, Becker's). https://www.aha.org/news/headline/2025-03-06-microsoft-says-550-hospitals-have-joined-rural-cybersecurity-program-created-aha; https://blogs.microsoft.com/on-the-issues/2025/03/05/enhancing-cybersecurity-rural-health/; https://www.beckershospitalreview.com/healthcare-information-technology/cybersecurity/700-hospitals-join-microsoft-cybersecurity-initiative/ (accessed 2025-10-14). (aha.org)
19. OHA: Certificate of Need program. https://www.oregon.gov/oha/ph/providerpartnerresources/healthcareprovidersfacilities/certificateneed/pages/index.aspx (accessed 2025-10-14). (oregon.gov)
20. Rural Health Transformation Collaborative (uploaded internal source summarizing partner roles and offerings), "Rural Health Transformation Collaborative. R1. 10-11-25.pdf" (accessed in project files).

14. AI Generation Notice This guide was generated by the gpt-5 model on 2025-10-14. It incorporates internal collaborative materials and public sources cited inline. All facts, figures, and citations must be independently validated—especially NOFO details—before submission or public release.