RURAL HEALTH NEEDS AND TARGET POPULATION

North Dakota stands as a hallmark of the American frontier—defined by its wide-open spaces, rugged Badlands, and deeply rooted rural communities. In North Dakota, we believe that rural communities are the heart of America—and they deserve a health care system that works as hard as they do. But today, that system is under immense pressure. North Dakota has made significant investments in rural care to address the needs of its large rural and frontier populations. However, the need for strategic and sustainable investment remains.

DEMOGRAPHICS

North Dakota is one of the least densely populated states in the nation. With only four urban centers, nearly half of North Dakotans (45.5%) live in rural communities, and nearly three in ten (29.1%) live in frontier areas, the third-highest share in the country. North Dakota's Rural Health Transformation Plan (RHTP) target population is centered on these rural and frontier communities.

The state's population reflects the heritage of the American heartland. American Indians make up 4.9 percent of North Dakota's population, well above the national average. North Dakota is home to five federally recognized tribes and one Indian community, including the Mandan, Hidatsa & Arikara Nation, the Spirit Lake Nation, the Standing Rock Sioux Tribe, the Turtle Mountain Band of Chippewa Indians, the Sisseton-Wahpeton Oyate Nation, and the Trenton Indian Service Area. Almost 60% of American Indians live in reservations that comprise some of the most rural areas of North Dakota. Tribal communities are vital to North Dakota's identity and are a priority population for addressing chronic disease and health access in North Dakota's RHTP.

Rural North Dakota is aging faster than its urban counterparts, with significantly higher shares of residents aged 45-64 (25.2% vs 21%), 65-84 (17.5% vs 12.4%), and 85+ (3.3% vs 1.9%) leading to an overall age gap of nearly five years. At the same time, the state is seeing growth in its youth population, creating a dual challenge: supporting older adults while preparing for the next generation. This demographic shift places pressure on the health care workforce and infrastructure, especially in rural areas where resources are already stretched thin.

While North Dakota's overall poverty rate is 11.2 percent, rural communities face deeper economic hardship, with rates in rural areas nearing 13 percent. Despite these differences, the state boasts one of the lowest unemployment rates in the nation at just 1.9 percent, a testament to the work ethic and resilience of North Dakotans. The economy is driven by key sectors like energy, agriculture, and health care—industries that fuel the nation and demand a healthy, supported workforce.

HEALTH OUTCOMES

Health outcomes in North Dakota tell a story of both strength and concern. North Dakota reports lower or comparable rates of most chronic diseases compared to national averages. However, the state's higher obesity rate raises questions about whether these lower chronic disease rates reflect true health advantages—or instead signal gaps in diagnosis and access to care, particularly in rural areas.

Condition[1]	North Dakota	National
Cardiovascular Disease	8.0%	8.5%
Chronic Kidney Disease	3.6%	3.7%
Chronic obstructive pulmonary disease (COPD)	5.2%	6.4%
Diabetes	9.5%	11.5%
High Blood Pressure	31.8%	34.0%
Obesity	35.6%	34.3%

[1] https://www.americashealthrankings.org/explore/measures

Rural North Dakotans face worse health outcomes than their urban counterparts, with higher rates of chronic conditions and mortality rates across every leading cause of death.[2] Cancer mortality is markedly higher in rural areas (81.6 vs. 65.3 per 100,000), as is diabetes prevalence (9.6% vs. 8.5%). The difference is stark: the most rural communities experience death rates more than 50% higher than urban areas.[3]

Chronic Condition or Mortality	Rural	Non-Rural
Diabetes[4]	12.2%	8.6%
Arthritis	30.5%	23.6%
COPD	6.1%	5.0%
Obesity	37.9%	33.8%
Cancer Mortality[5]	81.6 per 100,000	65.3 per 100,000

North Dakota's tribal communities face even greater challenges. On average, American Indians live 21 years less than their white counterparts in North Dakota, with significantly higher rates of chronic disease.

North Dakota Rates of Chronic Disease: American Indians vs. White				
	Diabetes	Depression	Asthma	Obesity
American Indians North Dakotans	20.2%	33.3%	19.6%	50.2%
White North Dakotans	10.1%	21.2%	13.5%	36.3%

ACCESS TO CARE AND WORKFORCE

Rural access to care remains a major barrier and is intrinsically tied to rural North Dakota's workforce challenges. Nearly 75 percent of rural counties in North Dakota are designated primary care shortage areas, and 45 percent lack adequate dental care—with 17 counties having no practicing dentist at all. Mental health care access is even more limited: 44 of the state's 51 counties are classified as mental health professional shortage areas.[6] While North Dakota's overall uninsured rate is lower than the national

[2] https://www.ruralhealthinfo.org/charts/46?state=ND
[3] https://med.und.edu/about/publications/biennial-report/index.html
[4] https://www.hhs.nd.gov/health/BRFSS/Data
[5] https://www.ruralhealthinfo.org/charts/38?state=ND
[6] https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard

average (7% vs. 10%), rural residents, especially children and working-age adults, are more likely to be uninsured than those in urban areas. Physician shortages are stark: rural areas have just 11.6 physicians per 10,000 residents compared to 40.1 in urban areas.[7] Although North Dakota slightly exceeds the national average in primary care physician availability overall, access is highly concentrated in urban centers (10.4 vs. 5.2 per 10,000[8]), and nine rural counties have no primary care physicians at all.[9] While North Dakota has had some success attracting young primary care physicians to rural areas, many relocate to urban practices by mid-career or after fulfilling incentive obligations. Only 12.3 percent of the state's primary care physicians serve rural areas, despite nearly half the population living there—and many of these providers are now nearing retirement, highlighting the need for workforce pipeline investments. Current staff is underutilized: Nearly 28 percent of the state's Registered Nurse workforce is working fewer than 20 hours per week, including 20 percent working less than 10 hours—representing a significant untapped labor pool. Meanwhile, many new graduates leave the state to begin their careers elsewhere, and a substantial percentage of employed nurses report plans to leave the profession or relocate. Specialty care is even more centralized, with just eight of the state's 252 general surgeons, psychiatrists, and OB-GYNs practicing in rural areas.[10] Nurse Practitioners (NPs) help fill gaps, with over 1,600 licensed statewide—76 percent certified in family practice—and a greater share working in rural areas than physicians.[11] Still, rural regions have fewer advanced

[7] https://www.ruralhealthinfo.org/charts/109?state=ND
[8] https://www.countyhealthrankings.org/health-data/north-dakota?year=2025&measure=Primary+Care+Physicians
[9] https://med.und.edu/about/publications/biennial-report/index.html
[10] https://med.und.edu/about/publications/biennial-report/index.html
[11] https://med.und.edu/about/publications/biennial-report/index.html

practice nurses overall (11.9 vs. 26.9 per 10,000).[12] Similarly, only 17.4 percent of the state's 571 Physician Assistants (PAs) work in rural areas.[13] Mental health workforce shortages are especially severe: only 15 counties have any licensed psychologists, 21 have no licensed counselors, and 25 have no licensed clinical social workers.[14] North Dakota ranks among the top states in excessive drinking, but half of counties have no licensed addiction counselor. Even in more resourced areas, provider-to-patient ratios remain high.

CRITICAL ACCESS HOSPITALS

Rural health care in North Dakota is largely anchored by critical access hospitals (CAHs), which make up 37 of the state's 48 acute care hospitals. Hospital infrastructure is supported by 58 rural health clinics and 28 community health center (CHC) locations. These facilities serve as lifelines for rural and frontier communities, often acting as the only local source of primary care and emergency services, but also as a referral and telehealth access point to regional and specialist care across the state. Many CAHs operate as comprehensive health centers, offering services that go far beyond hospital care. For example, Towner County Medical Center, an eight-bed CAH, also operates a rural health clinic, basic care and nursing facilities, and provides home care, independent living, therapy, chiropractic, lab and radiology, ambulance, and other services. This integrated model is common across North Dakota, where 35 of 37 CAHs own at least one additional health care business—with 92 percent owning a primary

[12] https://www.ruralhealthinfo.org/charts/112?state=ND
[13] https://med.und.edu/about/publications/biennial-report/index.html
[14] https://med.und.edu/about/publications/biennial-report/index.html

care clinic, 35 percent a nursing home, 22 percent an assisted living facility, and 14 percent a basic care facility.

BEHAVIORAL HEALTH

Core behavioral health services are delivered through a network of state-operated Behavioral Health Clinics, serving as a safety net across eight regional sites and four satellite locations. These Clinics align with the federal definition of Community Mental Health Centers, offering a full continuum of care that includes outpatient mental health and substance use disorder treatment, psychosocial rehabilitation, case management, peer support, intensive outpatient programs, State Hospital admission screenings, and 24/7 mobile and residential crisis services. Each regional Clinic supports either a state-operated or contracted crisis stabilization unit and recovery center.

Additionally, four regions operate transitional living facilities for individuals with serious mental illness, while three regions provide low-intensity residential substance use disorder treatment—with one region offering high-intensity residential services. North Dakota is actively advancing behavioral health integration and system transformation by transitioning four of its regional Clinics to the Certified Community Behavioral Health Clinic (CCBHC) model, with implementation anticipated by July 2026. This transformation will standardize service delivery statewide, expand access, stabilize funding, enhance crisis response, and improve quality and outcomes reporting.

LONG TERM CARE

North Dakota has invested in a strong network of 73 nursing facilities, 70 assisted living facilities, and 67 basic care facilities that play a vital role in supporting the

continuum of care for rural populations. However, long-term care is also at a tipping point. Since 2021, the state has lost 377 long-term care beds across 11 communities, including 285 nursing facility beds and 92 basic care beds, as facilities in towns like Bowman, Crosby, Mohall, and Mott have closed due to financial pressures and workforce shortages. These losses have forced residents to relocate far from home and made it harder for hospitals to discharge patients. Even health system–affiliated centers are shifting to swing-bed models in response to financial challenges and the regulatory burden on nursing facilities. North Dakota's long-term care system is viable, but vulnerable. Without intervention, these trends point toward further closures, deferred maintenance, and increased reliance on costly agency staffing, which only deepens financial instability.

EMERGENCY MEDICAL SERVICES

Rural emergency medical services (EMS) in North Dakota face growing strain on small, often volunteer-based agencies that must do more with fewer resources. Sparse populations, long transport distances, and severe weather conditions, including blizzard conditions that force widespread road closures, combine to create operational and logistical difficulties. Many rural EMS agencies rely heavily on volunteer personnel, but demographic shifts, particularly aging and youth outmigration, have greatly reduced the pool of available responders. Limited call volume in small towns further restricts fee-for-service revenue, leaving many services financially tenuous and dependent on local subsidies or fundraising to sustain operations. These pressures are compounded by the increasing demands of modern EMS practice, which require ongoing education, skill maintenance, technology, equipment, and coordination with other health care partners.

SUMMARY

North Dakota embodies the spirit of rural America—resilient, self-reliant, and deeply committed to community. But its rural health system needs support to sustainably meet today's challenges and prepare for tomorrow's demands. Strategic and innovative investment now will restore access, strengthen local care, and protect the health of rural Americans for generations to come. Strong families, secure communities, and a healthy nation begin with accessible, high-quality care close to home. Our strategy supports the values that built this country, self-reliance, community strength, local solutions, and American innovation, built on a foundation of sustainability.

RURAL HEALTH TRANSFORMATION PLAN: GOALS AND STRATEGIES

North Dakota is taking bold, practical steps to restore health, stability, and prosperity to America's heartland. North Dakota's RHTP focuses on creating new access points, modernizing care delivery, and empowering local providers to meet the needs of their communities through sustainable investments. In this section, we present North Dakota's vision, goals and strategies for transforming rural health and address each element required by statute. The goals described here form the basis for the proposed initiatives described in the *Proposed Initiatives and Use of Funds* tables:

Initiative 1: Strengthen and Stabilize Rural Health Workforce

Initiative 2: Make North Dakota Healthy Again | Preventive Care, Healthy Eating

Initiative 3: Bring High-Quality Health Care Closer to Home

Initiative 4: Connect Tech, Data and Providers for a Stronger North Dakota

CAUSE IDENTIFICATION

North Dakota's rural hospitals are the backbone of their communities, places where neighbors care for neighbors, emergencies are treated, and lives are saved. But

these vital institutions are under threat. Low patient volumes, high fixed costs, and volatile revenues are pushing many rural hospitals to the brink. Our RHTP is designed to reverse this trend by right-sizing rural hospital services, investing in modern infrastructure, combatting chronic disease, and transforming care delivery.

In 2024, North Dakota's 39 rural hospitals, including 37 CAHs and two Sole Community Hospitals, reported nearly $4.5 billion in gross revenue. Yet despite this, they posted a combined operating loss of $173 million, including $58 million in uncompensated care and facility write-offs. Their net income of just $58 million was only made possible by charitable donations, grants, and non-health care revenue, a sign that hospitals are surviving through community generosity, not sustainable business models.

North Dakota's CAHs have avoided closures for over a decade, yet their community-focused model is under pressure. Many CAHs lack the scale to participate effectively in value-based payment models or to generate sufficient covered lives for positive performance under alternative payment arrangements. These limitations are compounded by underdeveloped clinical and financial data systems, with many hospitals unable to afford the IT infrastructure necessary for success in modern care delivery and reporting. Persistent workforce shortages continue to present a barrier. Rural clinicians often work in isolation, without the peer support or training opportunities available in larger systems. While many rural providers operate independently, they often lack the administrative and strategic resources available in larger health systems. Despite decades of investment, financial pressures are mounting. Nearly 70 percent of rural hospitals operate service lines at a loss, 36 percent are at risk of closure, and 10 percent face immediate closure risk, underscoring the urgent need for transformational

approaches to rural health system sustainability.[15] Health Centers are also under strain, facing rising costs and declining revenues. Between 2023 and 2024, total costs per visit increased by 17 percent, and costs per patient rose by 11.3 percent, while total income declined by 6.2 percent. A growing number of uninsured patients has driven up uncompensated care, and although federal grants are intended to offset these costs, their inflation-adjusted value has declined by 27 percent over the past decade.

Utilization data from a North Dakota Hospital Association survey shows opportunities for CAHs to engage in more telehealth, outpatient, and surgical services. However, facilities may need to consider scope changes to fully utilize their capacity and close gaps in maternal, behavioral health, and pediatric care deserts in the state. North Dakota's first hospital has signaled a future transition to right size to the new Rural Emergency Hospital (REH) designation, but additional facilities may need to consider a change in licensure status to ensure a sturdy foundation for the future.

2024 Rural Hospital Utilization Snapshot | Averages Based on Responding CAHs	
Inpatient admissions	377
Swing bed admissions	67
Inpatient days	1,083
Swing bed days	1,242
ER visits	2,452
Clinic visits	13,130
Outpatient surgeries	685
Imaging visits	6,885
Telehealth visits	2,183

Meanwhile, North Dakota's long-term care system is also at risk. Since 2021, four nursing facilities have closed, leaving rural communities without local options for skilled or long-term care. While most long-term care facilities remain operational, they are financially fragile. Approximately two-thirds of rural and 40 percent of frontier

[15] https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

facilities operate at a loss, leaving little margin for emergencies and capital repairs, let alone innovation or adoption of new care models. Cash reserves are uneven, with some facilities holding less than 45 days of cash on hand, leaving them susceptible to even minor disruptions. Debt levels are manageable, but repayment is tight—one-third of facilities have debt-service coverage ratios below 1.2, and in rural areas, debt payments are 2.5 times higher than operating income, creating significant financial strain. Many facilities are one staffing shortage or equipment failure away from financial distress.

These numbers tell a clear story: rural health care in North Dakota is not in jeopardy due to lack of effort, it's at risk because the current model requires high-fixed costs, relies on outdated staffing and technology, and is reimbursed under care models built for large health systems. Our RHTP strategy and call to action: to invest in workforce and technology, reimagine service delivery, modernize care and reimbursement models, and make one-time capital improvements that will deliver sustainable results not only for hospitals, but for all rural and frontier providers.

IMPROVING ACCESS, WORKFORCE, AND FINANCIAL SOLVENCY

North Dakota's RHTP is built on a dual approach: strengthening rural health workforce and expanding access. These pillars are deeply interconnected—without a strong workforce, access suffers; without access, communities decline, and workforce retention becomes even harder. Our strategy aims to restore access, modernize care, and build a rural health system that is right-sized, financially viable, flexible in delivery, and connected across the continuum of care. This section describes the actions North Dakota will take to improve rural residents' access to primary, specialty, hospital and behavioral healthcare alongside other services and health care items.

To reverse workforce trends, we must work on new pathways for training. We know we can be successful, because we've done it before. When confronted with a dwindling population of American Indian physicians, North Dakota built the Indians Into Medicine program at the University of North Dakota that's supported the graduation of more than 250 American Indian physicians. Our workforce plan concentrates on new training pipelines for rural workforce needs:

- More Training, Closer to Home: We're expanding physician residency slots including tribal-specific rotations and programs to ensure providers are trained closer to home, and offering virtual, evening, and weekend education programs for current workers to advance without leaving their communities like the Trinity Health Radiologic Technology Program that trains new radiologic technicians in the hospital and clinic.
- Hands-On Rural Experience: Students will rotate through rural facilities, live in local housing, and learn from seasoned rural providers through the creation of a new Rural Health Preceptor Development Program.
- Public Health in Action: From water testing to environmental health, we're creating real-world training opportunities in rural public health—because prevention is just as important as treatment.
- Early Exposure, Lifelong Impact: We're bringing health care career education into middle and high schools and expanding simulator training to prepare the next generation of rural health heroes. We'll work with rural facilities and communities to bolster their local foundations to support continued programs to grow their workforce.

Training is only half the battle. We know there's no place like North Dakota; our message to health care workforce is that we'd love you to stay and build a big life in a small town. Our plan expands on already successful workforce programs and barriers like childcare that contribute to underutilized staffing models:

- Stronger Incentives: Providing recruitment and relocation grants for a variety of disciplines and making rural practice more financially sustainable for new practitioners.
- Support Where It Matters: Funding retention grants, technical assistance to communities and facilities to attract and retain needed workforce and grants to support creating or expanding on-site childcare—because supporting families supports the workforce.

Our workforce needs can't be met through training and recruitment alone, we also must change how we deliver care, using technology as an extender, and reducing the need for physical workforce for long-term viability.

- Smart Solutions: We're equipping rural facilities with remote monitoring tools and smart tech to reduce the burden on limited staff without compromising quality. We'll use telehealth to connect workforce to specialty clinicians, building on successful practices like equipping ND law enforcement with mobile crisis care technology.
- Innovation in Action: We will explore the use of robotics and AI to handle routine tasks like mopping floors, freeing up staff and clinicians to focus on what matters most, caring for people.

Some of the best workers are already here. We're not just building a new workforce, but upskilling and empowering the one we already have:

- Cross-Training for Impact: Silos are for grain, not health care. From behavioral health to chronic disease management, we're training non-specialists to meet the full spectrum of rural health needs, expanding the capacity of existing staff.
- Maternal Health Matters: We're investing in rural maternal care training, from EMS to lactation support, ensuring moms and babies get the care they deserve.
- Specialized Skills, Local Access: Programs like colonoscopy certification for primary care and vaccine administration training for pharmacists will bring more services closer to home and use our existing providers in new ways.
- Prepared for Anything: Emergency preparedness training will ensure our rural providers are ready to meet the evolving needs of their communities, while funding training for new EMS staff and recruitment costs to encourage service to their communities will ensure there is someone to respond.

Access to care in rural North Dakota is not only limited by workforce, but also by distance or the absence of services altogether. Our *Clinics Without Walls* strategy transforms how and where care is delivered. Telehealth dramatically reduces geographic and transportation barriers but requires access points with reliable technology and privacy. We will establish strategically located telehealth equipment and virtual medical rooms or pods in community locations such as schools, libraries, tribal centers, grocery stores, and jails– to bring virtual care closer to residents in underserved areas. We'll invest in a statewide telehealth network, to ensure that rural residents have freedom of choice and aren't restricted to small referral networks. We

will also focus on telehealth adoption, especially by older individuals who may be less familiar with technology. Successful practices like facilitated telehealth to deploy a Community Health Worker (CHW) or other resource to the patient's residence to provide training on telehealth equipment will help ensure that these investments are widely accepted and utilized.

Mobile clinics are another proven solution we will employ to deliver comprehensive, on-the-go care directly to hard-to-reach populations like primary care visits for oil and gas workers, or dental care to rural students. Mobile clinics can also support outreach services from larger hubs into urban areas where people need services like mammography, but don't have enough volume to support full-time staffing or equipment. Investments in remote patient monitoring (RPM) tools will further complement this strategy and set the stage for more hospital at home programs, extending the reach of urban and regional health care hubs. Tools such as blood pressure cuffs, glucometers, pulse oximeters, scales, and fetal non-stress tests allow robust surveillance of high-need patients at home without the need for frequent, burdensome in-office visits. Motion sensor technology to not just detect but prevent falls alongside other AI and smart technology can help keep more of our elders safely at home, reducing total cost of care. North Dakota will fund technical assistance to fully integrate devices into provider workflow and electronic health records, to ensure that the highest utility is captured from this investment and ensure sustainability.

North Dakota's health care systems face increasing demand for integrated, person-centered care – particularly for Medicaid members and other underserved populations with complex needs. Yet, siloed systems, fragmented communication, and

inconsistent care coordination practices continue to lead to inefficiencies, duplications, and avoidable health challenges. We seek to provide technical assistance to ND Medicaid, private payers, and providers to build effective care coordination programs, while also investing in the development of key technology solutions and community information exchange (CIE) to facilitate information sharing and referrals across organizations, building on our existing Programs for All Inclusive Care for the Elderly (PACE) and Dual-Special Needs Plans (D-SNPs) programs to connect payment with coordinated care. North Dakota will seek CIE solutions that additionally connect community organizations and volunteer networks—ensuring that no North Dakotan falls through the cracks. Investments in frontline workforce will help ensure this strategy is sustained and make rural America healthy again. ND Medicaid began reimbursing CHWs and Community Paramedics on October 1, 2025, but infrastructure is needed to ensure successful program launch to provide culturally appropriate outreach, care coordination, emergency response, and support for transitions of care. Start-up grants to support infrastructure, training and certification will assist in establishing local programs essential to building community trust, improving outcomes, and reducing avoidable hospital use while lowering overall health care costs.

To protect the rural safety net, we are funding technical assistance, training, and remodeling for providers filling critical service gaps—such as medical detox, crisis response, pediatric and ventilator beds, obstetric care, and home-based services. To support EMS delivery, we will modernize rural ambulance systems with updated equipment, including telehealth and EHR connectivity, support ambulance district consolidation, centralized dispatch and medical command, expansion of treat in place

implementation, and launch an enhanced first responder program to place trained responders in North Dakota's 1,800 townships.

Transportation is essential for timely access to care. Many North Dakota communities face gaps in both the availability of accessible vehicles and the administrative infrastructure to support a robust non-emergency medical transportation (NEMT) system. We will support two complementary initiatives: purchasing accessible vehicles for community-based NEMT providers, and a technology development grant to create a Medicaid mobile application for NEMT billing and trip tracking, aimed at improving efficiency, accuracy, and provider participation in the Medicaid program—expanding service capacity, reducing missed appointments, and ensuring a more efficient and user-friendly transportation system for Medicaid members and others.

None of these efforts will succeed without financial stability. Rural hospitals, clinics, and long-term care facilities face mounting financial pressures that threaten their survival. That's why our RHTP includes a robust financial solvency strategy focused on stabilizing rural providers and ensuring long-term sustainability. Value based payment models have historically left rural providers out, but ND Medicaid will advance new programs that build on the already successful Health System Value Based Purchasing Model and Nursing Facility Incentive Program. Work is already underway to add additional accountability to these models through the addition of a total cost of care measure in health systems and a withhold framework for shared risk for nursing facilities in the next biennium. Additionally, ND Medicaid is expanding value-based programs and alternative payment models to psychiatric residential treatment facilities, disrupting conventional reimbursement models and moving care focus to outcomes.

RHTP support will enable additional investments in North Dakota focused on lowering cost and improving outcomes:

- Create a Medicaid Value-Based Purchasing Program targeted at CAH providers to link a portion of payments to outcome and access metrics.
- Develop quality and data dashboard infrastructure to enable future transitions to value-based care and alternative payment models for additional residential and facility-based providers like Intermediate Care Facilities, SUD, and Basic Care providers.
- Explore alternative payment models (APMs) tailored to low-volume rural settings, offering predictable, prospective payments that stabilize revenue and reduce volatility.
- Align multipayer goals and objectives across Medicaid, Managed Care, and private insurers to reduce administrative burden and create the critical mass needed for sustained change.

In addition to payment model reform, our plan provides technical assistance grants to help rural hospitals right-size service delivery and remain viable. These supports include strategic, financial, and operational assessments; revenue cycle management; service line analysis; and conversion planning for scope or licensure changes like pursuing Rural Emergency Hospital (REH) status; diversifying revenue streams including robust supports to develop and enhance charitable activities to help fund future infrastructure needs or create evergreen funding for continued workforce scholarships and recruitment, strengthen business practices, and reduce reliance on

unstable reimbursement. This strategy will also allow for financial and leadership training for rural health care leaders and pooling resources to maximize impact.

Long-term care facilities face unique challenges and will receive targeted support to strengthen leadership and financial management, explore new revenue opportunities, and modernize infrastructure. Technical assistance will help struggling facilities right-size their business models, diversify services to include home- and community-based care, and comply with Medicaid HCBS settings requirements. These investments will reduce costs, improve quality, and ensure that rural elders can age with dignity in their communities.

Together, these strategies form a comprehensive, actionable plan to secure the future of rural health care in North Dakota. Our plan is predicated on continuous engagement with stakeholders to set priorities, identify vendors and address barriers to success. By investing in people, modernizing care delivery, and stabilizing finances, we are not just preserving rural health, but transforming it in a sustainable way.

MAKE NORTH DAKOTA HEALTHY AGAIN, FOCUSING ON OUTCOMES

In North Dakota, we know that health is more than just health care. We must go beyond treating illness, we must invest in the everyday habits that build lasting health, improve outcomes, and address chronic disease. That means recognizing that behavioral health, physical activity, and nutrition are not separate silos, but interconnected foundations of well-being. When people have access to mental health support, opportunities to move their bodies, and the knowledge and resources to eat well, they are more resilient, more productive, and more connected to their communities. Isolation, chronic disease, and food insecurity often go hand in hand; our integrated approach to fostering resiliency and connection, eating well, and moving

together is about more than improving outcomes, it's restoring hope, dignity, and strength to the communities that are the backbone of our nation. When prevention is embedded in clinical practice, it transforms health, leading to more cost-effective care, further adding to financial sustainability.

Our prairie communities are built on strong relationships, shared responsibility, and a deep commitment to caring for one another. But even in the most close-knit places, mental health challenges, substance use, and isolation can take a toll. That's why our RHTP includes a dedicated strategy to Build Connection and Resiliency, restoring the social fabric that keeps rural communities strong and healthy.

We will fund rural health care providers to implement evidence-based follow-up protocols after a suicide attempt—such as 48-hour post-discharge calls and Caring Contacts—to ensure that individuals are not left alone during their most dangerous moments. These simple, compassionate interventions have been shown to reduce repeat attempts and save lives, especially in rural areas where behavioral health services are limited.

We believe that local communities know best how to support their own people. That's why we will provide grant funding for rural towns and tribal communities to design and implement wellness strategies that reflect their unique needs and strengths and demonstrate improved outcomes. These may include traditional healing practices in tribal communities, mental health promotion campaigns, substance use prevention efforts, and community-building activities that foster belonging, reduce stigma, and promote hope.

Strong families are the foundation of our state. We will expand the Parents Lead initiative—a proven behavioral health promotion program—through a train-the-trainer model that equips local leaders to deliver sessions in workplaces, faith-based organizations, tribal communities, and schools. An annual parent survey will help track progress and tailor supports to meet the evolving needs of families, focused on gaining more participating parents and schools.

We are committed to supporting specialized populations in rural areas who face unique behavioral health challenges. This includes individuals reentering communities after incarceration, veterans, students, and families. Our plan includes:

- Behavioral health programming in schools, including a resilience-building curriculum to help youth develop coping skills and emotional strength.
- A school telehealth initiative to ensure students have access to mental health professionals, even in the most remote districts.

In today's digital world, screen time is a growing concern for parents, educators, and employers alike. We will provide training and support on healthy screen use for schools, families, and workplaces, helping communities strike a balance between technology and well-being. This initiative will promote digital wellness, reduce screen-related stress, and support healthier habits for all ages, building on North Dakota's Bell to Bell policy establishing phone-free K-12 public schools passed earlier this year.

Behavioral health doesn't exist in a vacuum. Nutrition and physical activity are powerful tools for mental wellness, helping to reduce anxiety, improve mood, and build emotional resilience. When people have access to healthy food and opportunities to

move their bodies, they are better equipped to manage stress, connect with others, and thrive. We know that strong communities begin with strong nutrition, but for too many rural residents, healthy food is out of reach due to barriers like distance, cost, or lack of knowledge. *Eat Well North Dakota* is about more than food, it's about freedom, dignity, and opportunity. We're investing in education, access, and innovation to ensure that the health of North Dakotans starts at the kitchen table.

Healthy choices start with knowledge. That's why we're embedding nutrition education into North Dakota's health care curriculum, ensuring that every provider—from doctors to nurses to community health workers—has the tools to teach patients how to eat well and reduce obesity rates. We'll also offer continuing education to keep providers up to date on the latest best practices, and we'll train them to use the Food is Medicine model—prescribing healthy food just like medication to prevent and manage chronic disease.

Education doesn't stop at the clinic door. A healthy start begins with moms and babies, but access to lactation support is uneven across the state. Two-thirds of North Dakota's International Board-Certified Lactation Counselors (IBCLCs) are located in just one metro area. To close this gap, we're partnering to train and deploy more IBCLCs in rural communities, ensuring that every mother has the support she needs to nourish her baby and improve breast feeding rates from 3-6 months. To further support growing families, we're developing new tools to help parents engage their children in healthy eating. We're connecting community partners—schools, churches, sports teams, and workplaces—with dietitians and nutrition experts to make healthy food the easy choice

in everyday life. In childcare settings, we'll introduce programming that exposes young children to nutritious foods early, building lifelong habits centered on nutrition.

North Dakota's farmland helps feed America, but it's not always easy to eat well in rural North Dakota. Many older adults and families face long drives, limited transportation, and high costs just to get groceries. That's why we're working with regional contractors to create centralized meal production and distribution hubs to preserve access to senior meals. These hubs will prepare nutritious meals using blast-freezing technology to preserve quality and safety—ensuring that even the most remote residents can receive healthy meals at home.

We're also expanding Farm-to-Table programs in schools, senior centers, and Tribal communities, connecting local producers with local consumers to strengthen both health and the rural economy. Where cost poses a barrier to accessing fresh or healthy food, we'll support cooperative purchasing for community partners like hospitals, schools, restaurants, and grocery stores to come together to access fresh foods, expanding on the investment made by the North Dakota Legislature through the Rural Grocery Store Sustainability Grant program. We'll partner with grocery stores and community partners to help families learn how to prepare nutritious meals with confidence.

For those who rely on food pantries, the challenges are even greater. Transportation, limited hours, and inconsistent food quality can make it hard to get the nutrition they need. We're tackling these issues head-on with community-driven solutions: expanding mobile pantry services, improving food variety and quality, extending hours, supporting local sourcing, and training staff to better serve their

communities. We'll also use community feedback to guide improvements—because the people closest to the problem often have the best solutions.

As we nourish our communities through better food access and education, we must also move our bodies. Nutrition, physical activity, and behavioral health are deeply connected, forming the foundation of a healthier, more resilient North Dakota. We'll focus on restoring energy, vitality, and connection through *North Dakota Moves Together*.

Chronic diseases linked to poor nutrition and physical inactivity remain one of the greatest threats to our nation's health, and North Dakota is no exception. In 2024, nearly two-thirds of North Dakotans did not get enough daily physical activity to reap the health benefits. As a result, 71 percent of adults are overweight or obese, nearly one-third are hypertensive, and over 10 percent are living with diabetes. These numbers are even more concerning in our rural communities, where access to safe spaces for activity and wellness resources is limited. To transform our rural health landscape, we will reignite the health of our rural population in body, mind, and spirit. Over the next five years, *North Dakota Moves Together* will restore a culture of movement, connection, and community pride across the state.

We know that knowledge is power, and many rural residents haven't been given the tools or encouragement to make physical activity a part of daily life. That's why our RHTP will launch a statewide public education campaign rooted in decades of evidence-based behavior-change research. From "Walk with a Doc" events to free park passes, health screenings, and friendly competitions, we'll make movement visible, accessible, and fun. Our message will reach every corner of the state through TV, radio,

newspapers, billboards, social media, and customized websites, ensuring that every North Dakotan knows that movement is medicine.

To build a healthier future, we must equip our people with the knowledge and skills to succeed. We will deploy evidence-based toolkits and high-quality training across rural communities through a partnership between ND Health and Human Services (NDHHS), UND's Center for Rural Health, the ND Department of Public Instruction and other partners. To build capacity and ensure long-term sustainability, clinical integration of physical activity will be infused into our medical school and health professional training curriculum; CME will be offered to existing physicians and health professionals. Local trainers, childcare providers, clergy, educators, coaches, and community partners, will be prepared to deliver this content, ensuring that the message of movement and wellness is sustained for generations.

Technology-driven peer support through a user-friendly digital platform that will share resources, track progress, promote local events, and celebrate success stories will help embed *North Dakota Moves Together* into the fabric of our communities. We'll partner with innovators to deploy wearables and biometric tools that connect patients with providers and front-line community health workers. And through a key partnership with North Dakota Parks and Recreation, we'll help families rediscover the joy of the outdoors through recreation.

True transformation happens when communities lead the way. We will engage schools, hospitals, workplaces, childcares, and civic groups to become champions of active living. Through contracts and strategic support, we'll expand access to safe, welcoming places to walk, bike, and play. We'll support cooking clubs, farmers markets,

and community events that bring people together. And we'll implement policy, system, and environmental (PSE) changes—like shared-use agreements for school gyms and enhanced physical education, enhanced playgrounds and parks—to ensure that movement becomes a way of life in every rural town.

DATA-DRIVEN SOLUTIONS TO CONNECT TECHNOLOGY AND PROVIDERS

Transforming rural care must do more than just expand access, it must connect systems, data, and technologies that power modern health care. North Dakota will build a smarter, more responsive, and more unified rural health system—one that breaks down silos, modernizes infrastructure, empowers providers, protects patients, and strengthens communities, all while aligning with CMS' Health Tech Ecosystem criteria.

In today's health care landscape, data is the backbone of quality care. Yet rural providers are often left out of the digital conversation and data is fragmented across systems, programs and providers. North Dakota will modernize its health care systems and data by modernizing electronic health records (EHRs) and outdated tech platforms, and use it to better connect programs that support seniors like PACE and D-SNPs. North Dakota's data environment will be transformed by unifying EHR, payer data, and pharmacy data into a secure, integrated, cloud-based platform. This will enable real-time insights that support population health, care coordination, and predictive analytics, to improve clinical decision-making and streamline care coordination and transitions. Multiple partners suggested specific platforms to accomplish these goals. To ensure a sound investment, North Dakota will engage with provider partners and other stakeholders to select a specific IT solution during the first budget year. Along the way, we'll also engage non-traditional partners, such as schools, housing agencies, and food

security organizations, and partner with them to use data to address health gaps and support preventive, community-based care.

We will implement the NDHHS Data Hub, a centralized home for data across Medicaid, SNAP, behavioral health and other Health and Human Services programs. This will give providers, case managers, and administrators a holistic view of patient and community needs, enabling earlier interventions, reducing crisis care, and improving outcomes. A modern licensure management system for hospitals, long-term care facilities, EMS personnel, and other providers will streamline credentialing, Medicaid enrollment, and accelerate workforce deployment. We will launch an All-Payer Claims Database and outcomes measurement tool to enhance transparency and accountability in pricing for consumers while helping North Dakota better evaluate cost, quality, and differences across systems.

To address the growing behavioral health crisis, we will implement a substance use monitoring program to track trends in near real-time and support local response efforts. We will also conduct a behavioral health workforce scan and mapping initiative to identify gaps across all four tiers of behavioral health professionals, ensuring that training and resources are targeted where they’re needed most.

Rural providers often face high costs, limited options, and predatory contracts when purchasing essential technology. North Dakota will support the creation and expansion of cooperative purchasing agreements for cybersecurity, EHRs, population health tools, and regulatory infrastructure, ensuring that rural providers can access the tools they need without breaking the bank. Additional funding will be directed to enhance and upgrade cooperative technology to ensure robust access to the best

technology available. We will also support shared regulatory, billing and finance infrastructure, helping small providers operate more efficiently and sustainably.

Building on these data platforms and investments, North Dakota's strategy will focus on rapid innovation through artificial intelligence (AI) and emerging technologies that expand rural capacity and improve care. We will use AI to detect early signs of chronic disease and behavioral health conditions, enabling earlier, more personalized interventions. AI will also support rural providers with decision support tools and diagnostics, helping bridge workforce gaps and improve quality of care.

We're also deploying drones to rapidly transport lab samples and medical supplies to and from remote areas, cutting delivery times and ensuring timely care. These strategies are not just innovative; they're practical, scalable solutions to real rural challenges.

We're investing in consumer-facing technologies that make health care more accessible and convenient. This includes expanding automated prescription pickup kiosks in community locations to reduce wait times, improve medication adherence, and head-off transportation barriers. We're also enhancing the state laboratory's capacity to process self-collected specimens, empowering individuals to manage their health privately and conveniently, while accelerating diagnosis and treatment and reducing disease transmission through better management.

Together, these initiatives represent a transformational investment in North Dakota's rural health system. By connecting technology, data, and providers, we are creating a health care ecosystem that is smarter, faster, and more responsive—one that

meets people where they are and ensures that every North Dakotan has access to the care they need, when they need it.

PARTNERSHIPS

The success of North Dakota's RHTP is grounded in the enduring values of the Great Plains and Upper Midwest—resilience in the face of adversity, pride in hard work, deep-rooted community ties, and a steadfast belief in looking out for one another. In a state where neighbors still check in on each other, where communities rally around shared challenges, and where people quietly do what needs to be done, we've built a coalition that reflects the very best of who we are. Our broad, committed coalition of health care providers, educators, tribal nations, public health leaders, local businesses, and community organizations reflects the belief that no challenge is too great when we work together, and that every North Dakotan deserves access to high-quality care, no matter how rural or frontier their home.

At the heart of this initiative are our health care providers. These partners are the boots on the ground—delivering care, coordinating services, and adapting to meet the evolving needs of their communities. These institutions are often the largest employers and most trusted resources in their communities. They are joined by ND Medicaid, local public health units, behavioral health providers, and NDHHS safety net programs, who bring essential insight into population health trends and help address the root causes of poor health.

We are proud to work alongside North Dakota's tribal nations, whose leadership and cultural knowledge are essential to delivering respectful, effective, and community-centered care. These partnerships ensure that tribal communities are not only included

but are leading efforts to improve health outcomes in ways that reflect their values, traditions, and sovereignty.

We believe in investing in the next generation. Our partnerships with K-12 schools, the North Dakota Department of Public Instruction, and higher education institutions like UND, NDSU, and the North Dakota Area Health Education Center (AHEC) are helping to build a strong rural health workforce pipeline. These partners also support chronic disease prevention and health education, starting early and reaching deep into communities.

We know that in rural North Dakota, health happens everywhere, not just in clinics. That's why we're partnering with community business like grocery stores and gas stations, churches, youth programs, and local coaches to serve as trusted access points for care, education, and outreach. These everyday spaces are where relationships are built and where health messages can truly take root.

In a state where winter storms and long distances can make travel difficult, reliable transportation is essential. Partnerships with transportation providers ensure individuals can reliably access care and services. This cross-sector approach is further enriched by collaboration with communities themselves, ensuring that local voices guide program implementation and sustainability.

North Dakota's rural health system is uniquely strengthened by a culture of collaboration over competition. Our rural health care providers have long understood that by working together, they can achieve more for their communities than they ever could alone. This spirit of cooperation has given rise to a robust network of rural provider partnerships that form the backbone of our RHTP.

At the center of this collaborative ecosystem is the North Dakota CAH Quality Network, operated by the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. For over 18 years, this network has served as a trusted platform for shared learning, quality improvement, and peer support among the state's CAHs. The Network helps hospitals meet Medicare Conditions of Participation, supports quality improvement initiatives, and fosters regional and statewide information sharing to reduce duplication and improve outcomes. It is a place where rural providers come together to share best practices, tools, and resources, ensuring that even the smallest hospitals can deliver high-quality care.

Complementing this is the North Dakota Rural Health Clinic (RHC) Network, established in 2021 to support the state's 57 Rural Health Clinics. This network provides technical assistance, education, and central coordination to help RHCs meet Conditions for Certification, improve performance, and collaborate more effectively. It also serves as a unified voice for RHCs, helping them identify needs, plan strategically, and work toward rural health priorities.

Another key partner is the Rough Rider High-Value Network (RRHVN), which connects 22 independent hospitals across the state. RRHVN supports shared clinical and operational activities, enabling hospitals to invest in diagnostic and treatment capabilities, control costs, and enhance patient experiences. Through its Clinical Integration Network, RRHVN ensures that patients receive continuous, coordinated care across the network—from surgery and ophthalmology to mental health and obstetrics. The RRHVN Clinical Integration Committee, composed of a practitioner from each member hospital, oversees all clinical and quality initiatives, ensuring that care

is locally informed and regionally aligned. The North Dakota Legislature supported Rough Rider's formation and continued operations with multi-million dollar appropriations in the 2023-2025 and 2025-2027 bienniums. These state investments have already started transforming care and will be a solid platform for expanding cooperative purchasing and shared infrastructure to more providers while reducing costs.

Beyond these formal networks, every one of North Dakota's 37 CAHs maintains strong referral relationships with tertiary hospitals located in the state's four largest cities: Fargo, Bismarck, Grand Forks, and Minot. These relationships form de facto regional care networks, allowing rural hospitals to stabilize patients locally and transfer them when higher levels of care are needed. CAHs collaboratively work within health networks to provide more and better access to essential health services. They use networks to gain greater efficiency and effectiveness, provide cost savings, share services or personnel, build capacity, and achieve higher organizational performance.

This deeply collaborative culture is one of North Dakota's greatest strengths. It reflects the values of the region: humility, mutual respect, and a commitment to doing what's right for the community. Through these networks, rural providers are not just surviving, they are innovating, adapting, and leading.

PROGRAM KEY PERFORMANCE OBJECTIVES AND OUTCOMES

NDHHS will evaluate progress toward the RHTP's four strategic initiatives through a structured, outcomes-driven framework that emphasizes measurable results, accountability, and transparency. North Dakota's key performance objectives, outcomes and metrics are grounded in the realities of rural care delivery and aligned with CMS

and state goals to improve health outcomes, expand access, strengthen rural provider sustainability, and modernize care delivery across all funded initiatives.

NDHHS, through a coordinated, department-wide effort involving data, public health, behavioral health, and information technology teams, will lead the development, collection, and analysis of performance data in collaboration with rural providers and community partners. NDHHS will coordinate across internal program areas and with external partners including provider organizations, tribes, health systems, universities and community stakeholders to ensure that data collection and reporting are accurate, consistent, and reliable.

Each initiative contains at least four measurable indicators, with at least one designed to be reported at a county or community level to reflect geographic variation in access and outcomes. We will continue to measure rural outcomes against non-rural outcomes to assess if gaps are being reduced. Metrics were selected based on their alignment with available or attainable data sources, their ability to demonstrate improvement within the five-year grant period, and their relevance to statewide rural health priorities. More detail about the metrics is available in the *Metrics and Evaluation Plan* section. Additional metrics and milestones tied to implementation progress can be found for key strategies and activities in the appendix.

Together, the initiatives form a unified evaluation framework that tracks both implementation milestones and health outcomes across interconnected domains:

Initiative 1: Strengthen and Stabilize Rural Health Workforce
• Increase Rural Provider Retention • Expand Remote Monitoring and AI-Assisted Care • Increase Recruitment of Rural Providers • Reduce Health Professional Shortages

Workforce shortages are one of the most pressing threats to rural health access. Measures such as provider retention and HPSA reduction directly measure whether North Dakota is making progress in stabilizing the rural health workforce. By tracking both recruitment and retention, the state can ensure that rural communities are not only attracting providers—but keeping them. Monitoring the adoption of AI-assisted care and remote monitoring also reflects how innovation is being used to extend workforce capacity and improve care delivery in hard-to-reach areas.

Initiative 2: Make North Dakota Healthy Again
• Increase Activity and Reduce Obesity • Increase Preventive Screenings • Increase Value Based Payment Models • Reduce Adverse Care Events • Reduce Chronic Disease Burden • Prevent Suicide

Our focus is on improving the health of North Dakotans—not just the systems that serve them. Measures like obesity rates, cancer screenings, and chronic disease burden provide insight into whether care is becoming more proactive, preventive, and effective. Improvements in suicide prevention outcomes reflect better coordination and behavioral health integration. These indicators are critical for understanding whether the RHTP is delivering on its promise to improve lives, not just services.

Initiative 3: Bring High-Quality Health Care Closer to Home
• Increase Telehealth and Remote Monitoring Use • Reduce Avoidable Emergency Department Use • Improve Care Coordination • Improve Timeliness of Care

Access to care is not just about availability, it’s about proximity, timeliness, and coordination. These metrics measure how well care is being delivered closer to where people live, especially in underserved rural areas. Increased telehealth use and reduced emergency department use signal that residents are receiving timely, preventive, and

coordinated care without needing to travel long distances. These are essential indicators of an innovative and responsive rural health system.

Initiative 4: Connect Tech, Data and Providers for a Stronger ND
• Increase Transparency • Modernize and Cross-Link Data • Create Savings from Cooperative Purchasing • Expand Remote Monitoring and AI-Assisted Care

A modern rural health system requires modern infrastructure. Metrics in this initiative reflect the state's commitment to building a connected, data-driven ecosystem that reduces administrative burden and improves care coordination. Tracking interoperability and cooperative purchasing not only shows progress in efficiency, it also demonstrates how shared investments can drive statewide impact. These metrics are foundational to enabling smarter decisions and sustaining transformation over time.

STRATEGIC GOALS ALIGNMENT

North Dakota's plan fully aligns with federal RHTP strategic goals, as demonstrated in the table below.

Strategic Goal	North Dakota Rural Health Transformation Plan Alignment
Make rural America healthy again	• Create new access points for health care services. • Address root causes of health care through a focus on behavioral health, nutrition, and physical activity. • Ensure sustainability of health gains through health payer payment policy. • Track and improve upon metrics relating to preventive care, chronic diseases and behavioral health.
Sustainable access	• Work with rural providers to create sustainability and revenue diversification plans to right-size for the future. • Invest in safety net service delivery through enhanced telehealth supports and closing gaps in our care continuum. • Incentivize group purchasing for a variety of rural provider needs.
Workforce development	• Develop additional rural health care training pipelines. • Expand scope of practice for pharmacists. • Incentivize a broader set of providers to serve rural areas including community health workers.
Innovative care	• Develop value-based purchasing programs and alternative payment models for rural providers. • Support innovations will increase efficiency and reduce reliance on in-person workforce.
Tech innovation	• Increase remote patient monitoring across the state.

	• Break down data silos by modernizing the state's health care data environment to unify EHR, payer and pharmacy data.

LEGISLATIVE OR REGULATORY ACTION

North Dakota is committed to transforming rural health through coordinated policy, regulatory action, and targeted investments. Our approach pairs immediate initiatives with durable legislative reforms to remove barriers, expand access, and ensure long-term sustainability for rural health systems across the state. The North Dakota Legislature convenes biennially each odd-numbered year. To accelerate rural health reform within the current biennium, the Legislative Council established a 34-member Interim Rural Health Transformation Committee to lead policy development, evaluate federal program provisions, and prepare the state for federal funding and implementation. The committee met October 14-15 and October 21, 2025, engaging in robust discussion about state policy levers, scoring opportunities under the federal RHTP, and legislative priorities. The committee's mandate includes reviewing federal program provisions, advising NDHHS on the state application, drafting necessary legislation, and advancing appropriation actions tied to the federal award. The Interim Committee advanced four legislative bill drafts to institutionalize successful RHTP strategies. Because the federal award timing falls inside the current biennium, North Dakota will convene a Special Session to appropriate RHTP funding once an award is confirmed. The Interim Committee intends to reconvene in December 2025 and early January 2026 to finalize legislation and prepare appropriations language for the Special Session. The committee will advance the four bill drafts adopted in October as priority agenda items for the Special Session to ensure statutory authority, as well as RHTP appropriations. Governor Armstrong directed NDHHS to pursue regulatory flexibilities

that complement legislative work. As part of that direction, NDHHS submitted a SNAP Food Restriction Waiver on October 24, 2025, to address root cause of chronic disease like obesity from high sugar beverages and candy in the SNAP population. NDHHS will pursue additional state plan amendments, waivers, and administrative rule changes as needed to operationalize RHTP initiatives, coordinate Medicaid supports, and remove regulatory friction points that slow adoption of innovative service delivery in rural settings.

OTHER REQUIRED INFORMATION

STATE POLICY ACTIONS

State Policy Action	North Dakota 2025 Policy
B.2 Presidential Fitness Test	The North Dakota Rural Health Transformation Interim Committee created a bill draft requiring participation in the presidential physical fitness test. The North Dakota Legislature intends to vote on this legislation during a special session in 2026.
B.3 SNAP Food Restriction Waiver	North Dakota submitted a SNAP waiver restricting soda, energy drinks and candy on October 24, 2025. North Dakota has been working closely with the USDA Food and Nutrition Service (FNS) to provide all necessary additional information. FNS indicated no concerns with North Dakota's materials and anticipates formal approval of North Dakota's waiver in the first week of November.
B.4 Nutrition Continuing Medical Education	The North Dakota Rural Health Transformation Interim Committee created a bill draft requiring the North Dakota Board of Medicine to require CME on nutrition and metabolic health each renewal cycle. The North Dakota Legislature intends to vote on this legislation during a special session in 2026.
C.3 Certificate of Need (CON)	North Dakota's Long Term Care Moratorium assists with several challenges facing rural facilities and helps prevent overcapacity and financial instability, helps stabilize workforce and care quality, promotes strategic use of resources and sustainability, and community choice and compliance with federal DOJ policy.
D.2 Licensure Compacts	Physician: North Dakota is an Interstate Medical Licensure Compact (IMLC) Member State serving as State of Principal License
	Nurse: North Dakota is a Nurse Licensure Compact State
	EMS: North Dakota is an EMS Compact State
	Psychology: North Dakota is a PSYPACT Participating State
	Physician Assistant: The North Dakota Rural Health Transformation Interim Committee created a bill draft joining the physician assistant licensure compact. The North Dakota Legislature intends to vote on this legislation during a special session in 2026.
D.3 Scope of Practice	Physician Assistant: North Dakota rated as optimal by American Academy of Physician Assistants.
	Nurse Practitioner: North Dakota designated as Full Scope of Practice by American Association of Nurse Practitioners
	Pharmacist: The North Dakota Rural Health Transformation Interim Committee created a bill draft expanding the scope of practice for pharmacists. The North Dakota Legislature intends to vote on this legislation during a special session in 2026.

State Policy Action	North Dakota 2025 Policy
	Dental Hygienists: The Oral Health Workforce Research Center (OHWRC) information appears to be outdated. Current policy in North Dakota: • Diagnosis: NDAC 20-04-01-01(6)(g) | RDHs cannot diagnose, but can provide oral hygiene treatment and planning under general supervision. • Prescriptive Authority: NDAC 20-04-01-01 | RDHs can orally transmit a prescription that has been authorized by the supervising dentist under general supervision. • Local Anesthesia: NDAC 20-04-01-03 | ND is currently changing Administrative Code to allow RDHs to administer local anesthesia under general supervision for adults and indirect supervision for minors • Supervision of Dental Assistants: RDH can take part in training/overseeing the work of dental staff as directed/supervised by a Dentist. • Dental Hygiene Treatment Planning: NDAC 20-04-01-01(6)(g) | RDHs can provide oral hygiene treatment planning under general supervision. • Provision of Sealants without Prior Examination: NDAC 20-04-01-01(6)(o) + 20-04-01-01(23) | RDHs can apply pit and fissure sealant without prior examination under general supervision. • Direct Access to Prophylaxis: NDAC 20-04-01-01(6)(a) | RDHs can provide complete prophylaxis under general supervision.
E.3 Short-Term, Limited-Duration Insurance (STLDI)	North Dakota Century Code Chapter (NDCC) 26.1-36.8 describes STLDI policies in North Dakota. In alignment with current federal guidance, ND STLDI plans may be a maximum of 12 months for the initial contract term and renewed for a 36 month maximum allowable total coverage period.
F.1 Remote Care Services	• ND Medicaid covers live video, store and forward, and remote patient monitoring services. ND Medicaid will review additional modalities added through the RHTP for coverage. • NDAC 50-02-15-03 allows exemptions to licensing requirements. • ND has taken a proactive approach to allow for telehealth practice. Instead of requiring a more burdensome license or registration, the ND Board of Medicine has implemented laws and rules to allow for telehealth services provided for continuation of care of established patient provider relationships; temporary care for those who are in North Dakota for business, work, education, or vacation; telehealth for preparation of an in-person care scheduled in another state; consultation; gratuitous services in case of an emergency; and practitioners traveling with sports teams. These options exist in lieu of a license or registration, while offering streamlined access.

Factor	North Dakota Status
Factor A. 2	North Dakota currently has no Certified Community Behavioral Health Clinics. North Dakota is moving forward with CCBHC implementation under a federal planning grant.
Factor A. 7	North Dakota had 5 hospitals qualify for Medicaid DSH payments in SFY 2025: Mercy Medical Center, Altru Health System, Trinity Hospital, Sanford Bismarck, and the North Dakota State Hospital

TECHNICAL SCORE FACTORS

North Dakota's RHTP meets and exceeds the criteria for the initiative-based technical score factors. The table below is provided as a reference for scoring these

factors. Please note this table does not include the State Policy Action technical factors that are described above. Additionally, in the *Proposed Initiatives and Use of Funds* tables below, we describe how each initiative meets the technical score factors.

Initiative-Based Factors	Application Information Supporting this Factor
B.1 Population health clinical infrastructure	ND's RHTP includes several complementary initiatives that support population health clinical infrastructure: • Enhancement of and/or creation of community-based care initiatives: *Make ND Healthy Again* (pgs. 19-25, 42-43, appendices) • How to strengthen the whole rural health care ecosystem at the community level through technological innovation, a focus on primary care, a focus on behavioral health, and expanded scope of practice for mid-level practitioners and pharmacists: *Coordinating and Connecting Care* (pgs. 15-17, 44, appendices); *Breaking Data Barriers* (pgs. 26-28, 44, appendices); *Building Connection and Resiliency* (pgs. 20-21, 43, appendices); pharmacist scope of practice (pgs. 14, 35, 37) • How to coordinate amongst existing rural community providers, community-based facilities, and other stakeholders to enhance access to preventative care, long-term care, behavior health, and other social health services: *Coordinating and Connecting Care* (pgs. 15-17, 44, appendices); *Breaking Data Barriers* (pgs. 26-28, 44, appendices) • Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as described in the application: *Sustainability Plan* (pgs. 58-60, appendices); *Metrics and Evaluation Plan* (pgs. 52-58)
B.2 Health and lifestyle	ND's RHTP includes several complementary prevention-focused initiatives: • Novel prevention-focused models emphasizing lifestyle changes, around physical activity and/or proper nutrition, that are evidence-based with potential for clear and measurable health outcome improvements: *Make ND Healthy Again* (pgs. 19-25, 42-43, appendices) • Engagement of a variety of stakeholders and community resources within the geographic area of the initiative to successfully execute vision: *Make ND Healthy Again* (pgs. 19-25, 42-43, appendices); *Partnerships* (pgs. 28-32, appendices); *Governance and Project Management Structure* (pgs. 47-48); *Stakeholder Engagement* (pgs. 49-52) • Clear, concise, and implementable goals focused on root causes of public health tailored to the needs of local rural communities: *Make ND Healthy Again* (pgs. 19-25, 42-43, appendices); *Metrics and Evaluation Plan* (pgs. 52-58) • Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as described in the application: *Sustainability Plan* (pgs. 58-60, appendices); *Metrics and Evaluation Plan* (pgs. 52-58)
C.1 Rural provider strategic partnerships	• Arrangements that include an exchange of best practices and coordination of care, partially facilitated through remote care services**:** *Coordinating and Connecting Care* (pgs. 15-17, 44, appendices); *Breaking Data Barriers* (pgs. 26-28, 44, appendices); *Clinics Without Walls* (pgs. 14-15, 43-44, appendices); *Technology as an Extender for Providers* (pgs. 13, 42); *Support Consumer Facing Applications and Devices that Improve Health* (pgs. 28, 34, 45) • Arrangements will expand access to specialty services in a financially sustainable manner: *Clinics Without Walls* (pg. 14-15, 43-44, appendices); *Sustaining Revenue* (pgs. 17-19, 43, appendices) *Right Sizing Rural Health Care Delivery Systems for the Future* (pgs. 15-19, 43, appendices)

Initiative-Based Factors	Application Information Supporting this Factor
	• Arrangements centralize and/or streamline back-office functions and resources to create cost savings for participants: *Eat Well North Dakota* (pgs. 21-23, 42, appendices) *Cooperative Purchasing for Technology and Other Health Care Infrastructure* (pgs. 23, 27, 31, 35, 42, 44-45, appendices), *Sustaining Revenue* (pgs. 17-19, 43, appendices) • Arrangements improve financial viability of rural providers, preserve independence of rural providers where appropriate, and strive to keep care local where appropriate:) *Right Sizing Rural Health Care Delivery Systems for the Future* (pgs. 15-19, 43, appendices); *Sustaining Revenue* (pgs. 17-19, 43, appendices) • Feasibility, long-term financial sustainability and robustness of suggested evaluation metrics as described in the application: *Sustainability Plan* (pgs. 58-60, appendices); *Metrics and Evaluation Plan* (pgs. 52-58)
C.2 EMS	• State policies and infrastructure that will support coordination between EMS and other provider types as well as EMS integration with other parts of the health care delivery systems. Examples include collaboration with primary care providers and standing up models like community paramedicine where appropriate: *Ensuring Safety Net Service Delivery* (pg. 16, 44, appendices) • Infrastructure that will support alternative site of care treatment (e.g. treat "in place" as part of an emergency call): *Ensuring Safety Net Service Delivery* (pg. 16, appendices) • Other investments to improve speed, access, and cost to deliver emergency medical services: *Ensuring Safety Net Service Delivery* (pg. 16, 44, appendices) • Feasibility, long-term financial self-sustainability and robustness of suggested evaluation metrics as described in the application: *Sustainability Plan* (pgs. 58-60, appendices); *Metrics and Evaluation Plan* (pgs. 52-58)
D.1 Talent recruitment	• Supporting health care career education infrastructure in rural communities, like health care career pathway programs in high schools: *Expanding Rural Health Care Training Pipelines* (pgs. 12-13, 29, 41, appendices) • Funding new residency training programs, fellowships or combined programs in rural communities, tied to at least 5 years of service spent in rural areas: *Expanding Rural Health Care Training Pipelines* (pgs. 12-13, 41, appendices) • Relocation grants for clinicians moving to rural communities for at least 5 years of service: *Improve Retention in Rural and Tribal Communities* (pgs. 13, 18, 33, 41-42, appendices) • Investment in health care talent recruitment related to Indian Health Services, as relevant for a state: *Improve Retention in Rural and Tribal Communities* (pgs. 13, 18, 33, 41-42, appendices) • A focus on supporting pathways for non-physician health care providers, non-hospital-based providers, and allied health professionals in rural areas: *Expanding Rural Health Care Training Pipelines* (pgs. 12-13, 15, 41-42, appendices), *Technical Assistance and Training for Existing Workforce* (pgs. 12-14, 16, 18, 27, 42, appendices) • Feasibility, long-term financial self-sustainability and robustness of suggested evaluation metrics as described in the application: *Sustainability Plan* (pgs. 58-60, appendices); *Metrics and Evaluation Plan* (pgs. 52-58)
E.1 Medicaid provider payment incentives	• Development and implementation of payment mechanisms incentivizing providers or ACOs to reduce health care costs, improve quality of care, and shift care to lower cost settings: *Investing in Value* (pgs. 17-18, 43, appendices) • Development and implementation of value-based programs that have a pathway to include two-sided risk and are supported by evidence to suggest programs will change patient and provider behavior: *Investing in Value* (pgs. 17-18, 43, appendices)

Initiative-Based Factors	Application Information Supporting this Factor
	• Feasibility, long-term financial self-sustainability and robustness of suggested evaluation metrics as described in the application: *Sustainability Plan* (pgs. 58-60, appendices); *Metrics and Evaluation Plan* (pgs. 52-58)
E.2 Individuals dually eligible for Medicare and Medicaid	• Ways that time-limited investments can support dual eligible enrollment in integrated plans, such as investments to promote data integration, technical assistance to support duals support and resources, and enrollment support: *Coordinating and Connecting Care* (pgs. 15-17, 44, appendices); *Breaking Data Barriers* (pgs. 26-28, 44, appendices) • Feasibility, long-term financial self-sustainability and robustness of suggested evaluation metrics as described in the application: *Sustainability Plan* (pgs. 58-60, appendices); *Metrics and Evaluation Plan* (pgs. 52-58)
F.1 Remote care services	• Enhancement of remote care services infrastructure within a State**:** *Clinics Without Walls* (pgs. 13-16, 21, 43-44); *Technology as an Extender for Providers* (pgs. 13, 42); *Support Consumer Facing Applications and Devices that Improve Health* (pgs. 13, 28, 42, 45, appendices) • Feasibility, long-term financial self-sustainability and robustness of suggested evaluation metrics as described in the application: *Sustainability Plan* (pgs. 58-60, appendices); *Metrics and Evaluation Plan* (pgs. 52-58)
F.2 Data infrastructure	• Enhancement of data infrastructure within a State, such as investments in EHR, clinical support, and operational software infrastructure upgrades that enable participation in data exchange and interoperability**:** *Breaking Data Barriers* (pgs. 26-28, 44, appendices) • For technology that has a cloud-based alternative compared to on-premises technology, preference for cloud-based, multi-tenant architecture when feasible: *Breaking Data Barriers* (pgs. 26-28, 44, appendices) • Feasibility, long-term financial self-sustainability and robustness of suggested evaluation metrics as described in the application: *Sustainability Plan* (pgs. 58-60, appendices); *Metrics and Evaluation Plan* (pgs. 52-58)
F.3 Consumer-facing technology	• Support the development, appropriate usage and/or deployment of various consumer-facing health technology tools for the prevention and management of chronic diseases: *Technology as an Extender for Providers* (pgs. 13, 42); *Support Consumer Focused Applications and Devices that Improve Health* (pgs. 13, 28, 42, 45, appendices) • Feasibility, long-term financial self-sustainability and robustness of suggested evaluation metrics as described in the application: *Sustainability Plan* (pgs. 58-60, appendices); *Metrics and Evaluation Plan* (pgs. 52-58)

PROPOSED INITIATIVES AND USE OF FUNDS

North Dakota's RHTP centers around four strategic initiatives built on a foundation of stakeholder feedback. The initiative, strategies and proposed activities are detailed in the tables below. Further information about key strategies and activities, including detailed implementation plans can be found in the appendix.

INITIATIVE 1: STRENGTHEN AND STABILIZE RURAL HEALTH WORKFORCE
1. *Expand Rural Health Care Training Pipelines* a. Create new physician residency training slots including tribal-specific residencies.

b. Create opportunities for existing workforce to train in place to obtain higher credentials through virtual, evening and weekend programs.
c. Expand rural rotations and housing for traditional students pursuing health care careers; embed students into rural health care facilities.
d. Create a Rural Health Preceptor Development Program to offer more training opportunities for students.
e. Create opportunities for rural public health training and hands-on public health experience.
f. Expand opportunities for health care career education in middle and high schools across North Dakota. Work with rural facilities to create opportunities for grow your own scholarship to employment.
g. Expand simulator training for the health care workforce.

2. *Improve Retention in Rural and Tribal Communities*
   a. Create recruitment/retention grants for rural providers.
   b. Provide technical assistance to support best practices for retaining clinicians.
   c. Embed on-site childcare in rural health care facilities.
3. *Technology as an Extender for Rural Providers*
   a. Equip health facilities with remote monitoring and smart technology to reduce reliance on physical workforce.
   b. Use robotics and artificial intelligence for tasks that do not require human intervention to reduce reliance on physical workforce.
4. *Technical Assistance and Training for Existing Workforce*
   a. Support technical assistance and training initiatives in the following areas: behavioral health for non-behavioral health professionals; chronic disease management and engagement; obstetric training for primary care, rural maternal health workforce training in EMS, prenatal/postpartum care, lactation and behavioral health support; colonoscopy training program to train and certify clinicians in performing colonoscopies; pharmacist vaccine administration; and emergency preparedness and EMS.

Main Strategic Goal: Workforce Development, Tech Innovation

Use of Funds: D, E, F, G, I, J, K

Technical Score Factors: C.1, D.1, F.1

Key Stakeholders: NDHHS, University of North Dakota (UND), North Dakota State University (NDSU), Higher Education Institutions, North Dakota Department of Public Instruction (DPI), K-12 Education, AHEC, Hospitals, Clinics, Medical Providers, Rural Communities, Tribes, Indian Health Service, CHAD, NDMA, NDLTCA, NDHA

Outcomes:	1.1, 1.2, 1.3, 1.4
Impacted Counties:	Statewide

Estimated Required Funding: $162,392,742. See budget narrative for details.

INITIATIVE 2: MAKE NORTH DAKOTA HEALTHY AGAIN | PREVENTIVE CARE, HEALTHY EATING

1. *Eat Well North Dakota*
   a. Enhance nutrition training for North Dakota providers by embedding nutrition into North Dakota's health care curriculum and developing continuing education opportunities for practitioners.
   b. Create trainings for health care providers to engage patients in making healthy food choices as a prescription.
   c. Develop education tools for parents about engaging children and families in healthy food choices to embed in Parents Lead, schools, and child care facilities.
   d. Develop programming for childcare facilities to expose children to healthy snack choices.
   e. Partner with grocery stores and others to teach North Dakotans about nutrition and preparing healthy foods.
   f. Engage community partners in sports, education, workplaces, and places of worship in encouraging healthy foods as part of their fellowship.
   g. Connect community partners to nutrition experts, dietitians, and curriculum for integrating nutrition into community programming.

h. Create opportunities for farm to table food distribution in schools, senior centers, tribes and communities across North Dakota.
i. Solve logistical barriers for nutritious meal and food distribution in rural communities in senior meal programs and grocery stores.
j. Support community partners in cooperative purchasing or other needs to support greater access to healthy food and with technology costs related to SNAP waiver implementation.
k. Increase rural access to International Board-Certified Lactation Counselors.

2. *North Dakota Moves Together*
   a. Create training for health care providers focused on the benefits of physical movement including the use of prescriptions to engage patients in physical movement.
   b. Foster physical movement in non-traditional partners including Youth Sport Coaches, Faith Leaders and Schools, and health care providers.
   c. Create community challenge grants for rural communities to log community miles to unlock infrastructure to support physical movement in their community.
   d. Provide grants to licensed childcare centers to support physical movement including strollers, outdoor play equipment, etc.
   e. Expand the use of existing infrastructure to support shared use agreements between schools, providers and communities to use gyms and weight rooms on nights and weekends, including funds to accommodate more community members and ensure safety.
   f. Training for workplaces, educators and childcare providers on incorporating physical activity into daily activities including lesson planning and activities.
   g. Training and technical assistance to enhance school physical education.
   h. Support for communities on engaging more youth in recreation sports.
   i. Partnership with state parks to engage families and communities in outdoor recreation opportunities.
3. *Building Connection and Resiliency*
   a. Fund rural providers to implement standardized follow-up protocols after a suicide attempt.
   b. Provide grant funds for rural communities to design and implement best practices that promote community wellness, mental health, strengthen resiliency and prevent substance use.
   c. Expand Parents Lead implementation to support the behavioral health of children through a train-the-trainer model; hosting Parents Lead sessions at workplaces, faith-based and tribal organizations; and implementation of an annual parent survey.
   d. Supporting behavioral health programming for specialized populations in rural areas.
      - School Curriculum for Building Youth Resilience
      - School Telehealth Initiative
   e. Healthy Screen Use – Training and support for schools, parents and workplaces.
4. *Investing in Value*
   a. Create a Medicaid Value Based Purchasing Program for CAHs.
   b. Explore alternative payment arrangements in Medicaid for CAHs and other low-volume settings
   c. Create a portal for quality reporting and data dashboards for residential facilities.
   d. Explore additional value-based purchasing programs and alternative payment arrangements for residential facilities and other providers.
   e. Create multi-payer alignment on outcomes and goals for value based and alternative payment arrangements.

Main Strategic Goal: Make Rural America Healthy Again; Innovative Care

Use of Funds: A, C, D, E, H, I, J, K

Technical Score Factors: B.1, B.2, B.4, C.1, E.1, F.3

Key Stakeholders: NDHHS, Communities, ND DPI, K-12 Education, Churches, Youth Sport Coaches, Jails, Higher Education, Medical Providers, CHAD, NDMA, Tribes, Indian Health Service

Outcomes:	2.1, 2.2, 2.3, 2.4, 2.5, 2.6
Impacted Counties:	Statewide

Estimated Required Funding: $85,868,031. See budget narrative for details.

INITIATIVE 3: BRING HIGH-QUALITY HEALTH CARE CLOSER TO HOME

1. *Rightsizing Rural Health Care Delivery Systems for the Future*
    a. Technical assistance for providers planning a licensure or scope change
    b. Right size remodeling and technology for providers choosing to right size existing facilities to fit current community needs.
    c. Modernization and technology for residential facilities to reduce need for in-person workforce or to meet licensure requirements for new billing pathways.
2. *Sustaining Revenue*
    a. Technical assistance for providers to explore and diversify their revenue streams.
    b. Technical assistance for small providers about business practices.
3. *Clinics Without Walls*
    a. Create telehealth infrastructure for local primary and specialty care in communities without a health care provider
    b. Create a telehealth network.
    c. Mobile clinic expansion for delivering primary care, behavioral health care, specialist care, and dental care.
    d. Purchase remote monitoring devices or apps and technical assistance and training to integrate into provider EHR and workflow.
    e. Transform primary care, dental, behavioral health and other outreach care to individuals at home or non-traditional care sites.
    f. CHW and community paramedic infrastructure, training, and certification start up grants.
4. *Ensuring Safety Net Service Delivery*
    a. Technical assistance, training, equipment and remodeling grants for providers filling a gap in the current service delivery system or expanding outreach and telehealth supports to underserved communities.
    b. Rural ambulance telehealth and EHR connectivity and equipment upgrades.
    c. Planning and technical assistance grants for consolidating rural ambulance districts and partnering with health care organizations; explore centralized medical command and dispatch.
    d. Enhanced first responder program to place a first responder in townships.
5. *Ensuring Transportation*
    a. Grants to existing organizations to purchase accessible vans or transportation vehicles for non-emergency medical transportation from rural areas to care delivery.
    b. Technology grant to develop a Medicaid NEMT billing app for Medicaid member and volunteer drivers for NEMT reimbursement.
6. *Coordinating and Connecting Care*
    a. Technical assistance for ND Medicaid, private payers, and providers to develop care coordination programs for patients with chronic disease or behavioral health conditions
    b. Develop a closed loop referral system and community information exchange to connect providers and existing community organizations and North Dakotans to volunteer opportunities.

Main Strategic Goal: Sustainable Access, Innovative Care, Tech Innovation

Use of Funds: C, D, F, G, H, I, J, K

Technical Score Factors: B.1, C.1, C.2, E.2, F.1, F.2, F.3

Key Stakeholders: NDHHS, Rural hospitals, long-term care facilities, basic care facilities, community-based services providers, community businesses (grocery store, gas station), schools, behavioral health providers, local public health units, transportation providers, Tribes, Indian Health Service

Outcomes:	3.1, 3.2, 3.3, 3.4, 3.5
Impacted Counties:	Statewide

Estimated Required Funding: $583,755,433. See budget narrative for details.

INITIATIVE 4: CONNECT TECH, DATA AND PROVIDERS FOR A STRONGER NORTH DAKOTA

1. *Breaking Data Barriers*
    a. Modernize North Dakota's health care data environment by unifying EHRs, payer data, and pharmacy data in a secure and integrated platform to improve clinical care, care coordination and increase access to population level data.
        - Expand access to a unified EHR for more rural and tribal providers.
        - Enhance existing EHRs with additional technology and AI add-ons.

b. Implement Data Hub platform to provide a centralized location for all HHS program data. c. Enhance transparency and data infrastructure through the creation of an all payer claims database and outcome measurement tool. d. Implement a substance use monitoring program to measure and track state progress. e. Automate measurement of immunization coverage rates for Medicaid members and use of data for quality improvement. f. Promote data interoperability for providers to create a more seamless patient experience when rural patients must interact with specialty providers or between payers and providers. g. Engage non-traditional partners in the use of health data to support population health. h. Adopt a modern, robust licensure management system for hospitals, long-term care facilities, EMS personnel, nurse aide registry and other medical providers. i. Develop and administer a behavioral health workforce scan, survey and point-in-time map. 2. *Cooperative Purchasing for Technology and Other Health Care Infrastructure* a. Support cooperative purchasing agreements for technology including cyber security, population health tools, and electronic medical records without predatory terms. b. Support cooperative purchasing of regulatory and financial infrastructure. c. Support cooperative purchasing or use of staff, bulk purchasing of supplies and equipment. 3. *Harnessing Artificial Intelligence (AI) and New Technology* a. Use AI to detect early signs of chronic disease and behavioral health conditions through predictive analytics. b. Expand capacity of rural providers through the use of AI. c. Expand the use of technology including drones to rapidly transport items such as laboratory samples and medical supplies. 4. *Support Consumer Focused Applications and Devices that Improve Health* a. Expand the use of automated prescription pickup kiosks. b. Enhance the capability of the state laboratory to process self-collected specimens.
Main Strategic Goal: Tech Innovation, Sustainable Access
Use of Funds: A, C, D, F, G, J, K
Technical Score Factors: B.1, C.1, E.2, F.1, F.2, F.3
Key Stakeholders: NDIT, NDHHS program administrators, health care providers, health care payers, Tribes, Indian Health Service

Outcomes:	4.1, 4.2, 4.3, 1.2
Impacted Counties:	Statewide
Estimated Required Funding: $167,983,794. See budget narrative for details.	

IMPLEMENTATION PLAN AND TIMELINE

Initiation

Dec. 31, 2025 to Apr. 1, 2026

Assign all RHTP projects to NDHHS teams.

Outline milestones and timelines for each project.

Structure formal plans for communication and stakeholder engagement.

Planning

Dec. 31, 2025 to Oct. 1, 2026

Develop detailed budgets and work plans for each project.

Develop grant application guidance for sub-awards.

Develop requests for proposal for projects that require procurement.

Execution

Feb. 1, 2026 to Sept. 30, 2030

Execute grant awards and contracts.

Monitor projects for adherence to timelines, deliverables, budgets and milestones.

Monitoring & Evaluation

Apr. 1, 2026 to Sept. 30, 2031

Track performance against goals and metrics.

Inform plans for future investments based on evaluation of RHTP initiatives.

This graphic represents a general timeline for the overall program. Initiative-specific plans and timelines are as follows. More detailed implementation plans are included in the appendices.

Strengthen and Stabilize Rural Health Workforce	
Stage 1: 12/31/25 to 9/30/26	- Issue subawards to partners for expanding training pipelines, TA & training and onsite childcare at facilities. - Develop and begin recruitment and retention grants. - Assess facilities' needs for technology as an extender.
Stage 2: 10/1/26 to 9/30/27	- Monitor and provide support to partners expanding training pipelines and TA/training. - Issue add'l subawards for TA/training and facility technology. - Issue add'l recruitment and retention subawards. - Collect data on all RHTP workforce programs.
Stage 3: 10/1/27 to 9/30/28	- Monitor and provide support to partners with workforce subawards. - Issue add'l subawards for TA/training, facility technology and recruitment and retention. - Continue data collection, linked to RHTP evaluation plan and metrics and adjust strategies as needed.
Stages 3/4: 10/1/28 to 9/30/29	- Issue add'l subawards for workforce initiatives. - Continue to monitor workforce subawards and track performance against evaluation and metrics.
Stages 4/5: 10/1/29 to 9/30/30	- Subawards end; ensure deliverables and reporting are complete. - Inform plans for future strategies based on evaluation of workforce initiatives.
Make North Dakota Healthy Again	
Stage 1: 12/31/25 to 9/30/26	- Create tools and programming for *Make ND Healthy Again* projects. - Engage a variety of partners statewide and issue subaward application guidance for *Eat Well ND*, *ND Moves Together* and *Building Connection and Resiliency*; issue subawards to partners. - Issue subawards to TA vendor(s) and design *Investing in Value* activities; engage providers and other payers.
Stage 2: 10/1/26 to 9/30/27	- Monitor and provide support to partners on *Make ND Healthy Again* projects. - Issue add'l subawards for *Eat Well ND*, *ND Moves Together* and *Building Connection and Resiliency*. - Pilot *Investing in Value* activities with select providers; collect data and refine strategy. - Collect data on all *Make ND Healthy Again* projects.
Stage 3: 10/1/27 to 9/30/28	- Monitor and provide support to partners for *Make ND Healthy Again* subawards. - Issue add'l subawards for *Eat Well ND*, *ND Moves Together* and *Building Connection and Resiliency*. - Expand *Investing in Value* activities to all eligible rural providers. - Continue data collection, linked to RHTP evaluation plan and metrics and adjust strategies as needed.
Stages 3/4: 10/1/28 to 9/30/29	- Issue add'l subawards for *Eat Well ND*, *ND Moves Together* and *Building Connection and Resiliency*. - Deepen accountability and refine payment models for *Investing in Value* activities. - Continue to monitor subawards and track performance against evaluation plan and metrics and adjust strategies as needed.
Stages 4/5: 10/1/29 to 9/30/30	- Subawards end; ensure deliverables and reporting are complete. - Inform plans for future strategies based on evaluation of *Make ND Healthy Again* initiatives.
Bring High-Quality Care Closer to Home	

Stage 1: 12/31/25 to 9/30/26	- Assess rural facilities and providers aiming to fill a gap in the current system needs for TA, training, technology and remodeling; issue facility subawards. - Provide application guidance and issue subawards for providers implementing *Clinics Without Walls* activities. - Issue subawards for rural ambulance system stabilization strategies. - Issue subawards for development of a Medicaid NEMT billing app and for accessible vehicle purchases. - Procure TA for ND Medicaid, other payers and providers to develop care coordination programs; procure closed loop referral system and community information exchange platform, in coordination with *Breaking Data Barriers* activities.
Stage 2: 10/1/26 to 9/30/27	- Monitor and provide support to partners working on *Bring High Quality Care Closer to Home* projects. - Issue add'l subawards for *Bring High Quality Care Closer to Home* projects. - Collect data on all *Bring High Quality Care Closer to Home* projects.
Stage 3: 10/1/27 to 9/30/28	- Monitor and provide support to partners with *Bring High Quality Care Closer to Home* subawards. - Issue add'l subawards for *Bring High Quality Care Closer to Home*. - Continue data collection, linked to RHTP evaluation plan and metrics and adjust strategies as needed.
Stages 3/4: 10/1/28 to 9/30/29	- Issue add'l subawards for *Bring High Quality Care Closer to Home*. - Continue to monitor subawards and track performance against evaluation and metrics.
Stages 4/5: 10/1/29 to 9/30/30	- Subawards end; ensure deliverables and reporting are complete. - Inform plans for future strategies based on evaluation of *Bring High Quality Care Closer to Home* initiatives.
Connect Tech, Data and Providers for a Stronger North Dakota	
Stage 1: 12/31/25 to 9/30/26	- Engage partners and finalize strategy for modernizing North Dakota's health care data environment. - Provide application guidance and issue subawards for providers implementing *Harnessing AI and New Technology* and *Support Consumer Focused Applications and Devices that Improve Health* activities. - Procure TA and IT vendors to implement *Breaking Data Barriers* activities. - Issue subawards for *Cooperative Purchasing for Technology and Other Health Care Infrastructure*.
Stage 2: 10/1/26 to 9/30/27	- Monitor and provide support to partners working on *Connect Tech, Data and Providers for a Stronger North Dakota* projects. - Issue add'l subawards for *Connect Tech, Data and Providers for a Stronger North Dakota* projects. - Collect data on all *Connect Tech, Data and Providers for a Stronger North Dakota* projects.
Stage 3: 10/1/27 to 9/30/28	- Monitor and provide support to partners with *Connect Tech, Data and Providers for a Stronger North Dakota* subawards. - Issue add'l subawards for *Connect Tech, Data and Providers for a Stronger North Dakota*. - Continue data collection, linked to RHTP evaluation plan and metrics and adjust strategies as needed.
Stages 3/4: 10/1/28 to 9/30/29	- Issue add'l subawards for *Connect Tech, Data and Providers for a Stronger North Dakota*. - Continue to monitor subawards and track performance against evaluation and metrics.
Stages 4/5: 10/1/29 to 9/30/30	- Subawards end; ensure deliverables and reporting are complete. - Inform plans for future strategies based on evaluation of *Connect Tech, Data and Providers for a Stronger North Dakota* initiatives.

GOVERNANCE AND PROJECT MANAGEMENT STRUCTURE

NDHHS will ensure strong oversight, accountability, and stakeholder engagement through a dedicated governance and project management structure. A RHTP Steering Committee, including a Procurement/Contract Officer, two Budget Specialists, a Compliance Lead, two Coordinators, and an Evaluator, will lead the effort, supported by other NDHHS staff as needed. The committee will meet monthly to guide strategy, oversee implementation, engage stakeholders, and evaluate progress. The committee will also ensure that no RHTP funds are used for expenditures attributable to intergovernmental transfers, certified public expenditures or any other expenditure to finance the non-federal share of expenditures for federal programs including Medicaid. The steering committee will collaborate with key stakeholders including the ND Indian Affairs Commission, the Center for Rural Health, providers, rural patients, and more.

Name	Role	NDHHS Division
Sarah Aker	Project Director	Medical Services
Krista Fremming	Project Contributor	Medical Services
Lonny Mertz	Grants Manager	Finance
Dirk Wilke	Project Contributor	Public Health
Kim Mertz	Project Contributor	Public Health
To be hired Dec. 2025	RHTP Procurement/Contract Officer	Finance
To be hired Dec. 2025	RHTP Account Budget Specialist III	Finance
To be hired Dec. 2025	RHTP Account Budget Specialist III	Finance
To be hired Dec. 2025	RHTP Compliance Lead	Finance
To be hired Dec. 2025	RHTP Coordinator	Medical Services
To be hired Dec. 2025	RHTP Coordinator	Medical Services
To be hired Dec. 2025	RHTP Evaluator	Public Health

The NDHHS Executive Leadership Team, in coordination with Governor Armstrong's office, will provide executive support and strategic alignment. Additionally, a state legislative Rural Health Transformation Committee will receive updates and offer input through public, livestreamed meetings. NDHHS will also host public listening

sessions and publish regular updates and outcomes on the RHTP webpage to ensure transparency and ongoing stakeholder involvement.

ANTICIPATED IMPLEMENTATION BARRIERS AND RISK MITIGATION STRATEGIES

North Dakota is committed to identifying and mitigating implementation risks that could impede progress toward improved access, quality, and sustainability of care in rural communities. This section outlines anticipated barriers and strategic interventions designed to ensure timely, effective, and common-sense execution.

Anticipated Challenge	Risk Mitigation Strategy
Lengthy procurement and technology implementation due to timelines	**Cutting Red Tape to Move Faster:** Outdated procurement rules slow down progress. That's why we're pursuing a legislative waiver to streamline the process, so we can get the right tools, technology, and partners in place without unnecessary delays. This means faster upgrades to rural health systems and quicker support where it's needed most.
Limited IT capacity and interoperability; Tech hesitancy	**Fixing the Tech Gap in Rural Care:** Many rural providers are ready to lead, but they need the right tools. We're investing in IT infrastructure and offering hands-on technical assistance to help providers modernize their systems, connect data, and deliver better care.
Provider Capacity	**Helping Providers Succeed:** Our plan heavily invests in technical assistance and support for rural providers, ensuring successful implementation and sustainable investments. Technical assistance will help providers explore new partnerships and services, navigate changes, and succeed in a transformed system. This is about partnership, not paperwork.
Showing Early Momentum or Visible Progress	**Starting Strong with Shovel-Ready Projects:** To accelerate impact, North Dakota will prioritize shovel-ready projects that can launch immediately upon award. We are actively engaging providers and their associations before funding is finalized to ensure alignment, build momentum, and hit the ground running. This early coordination will allow us to demonstrate quick wins and build trust across communities.
Complex projects requiring longer lead times	**Staggered Implementation to Mitigate Risk:** For larger or more complex initiatives, we will stagger milestones and funding across award years to manage risk and ensure capacity. Projects with longer lead times will be strategically phased into later years of the implementation timeline. This approach balances urgency with sustainability, ensuring that every dollar is deployed effectively and every project is set up for long-term success.
Stakeholder skepticism or lack of engagement	**Showing the Transformation in Action:** People need to see it to believe it. That's why we're launching a statewide communication strategy to spotlight success stories, showcase transformation through new Governor's Awards, share progress, and showcase best practices. We'll show how this plan is working, real stories, real results, real impact.

STAKEHOLDER ENGAGEMENT

In North Dakota, we don't just talk about rural health, we live it. As a proud rural and frontier state, engaging our rural and frontier communities isn't new; our state leveraged existing channels and opportunities for our RHTP. We launched a full-scale effort to hear directly from the people who power our rural health system: patients, hospitals, clinics, and provider networks, tribal leaders, and community champions. Our focus was building on existing knowledge to understand the needs of rural communities to improve care and support long-term sustainability and health.

We kicked off our engagement with a statewide survey, available digitally and on paper by request. We launched the survey with a new dedicated website for Rural Health Transformation, and sent the survey directly to Medicaid providers and Medicaid members. In addition, NDHHS promoted the survey on all social media platforms and through a press release, prompting radio, print, and television stories on the survey. NDHHS further engaged partners from provider associations, tribes, and others to share news about the surveys to their members. Open from August 12 to September 13, the survey asked North Dakotans to describe their rural health priorities, funding ideas, and vision for the future. We received 1,265 responses from individuals across the state. These voices shaped the foundation of our RHTP, guiding us towards the common-sense and practical initiatives rooted in real rural needs within our plan.

While strong themes emerged from the survey, we wanted to confirm results and gain deeper understanding of potential initiatives. We hosted three virtual listening sessions, giving participants multiple ways to share feedback in the way most comfortable to them, through Microsoft Whiteboards, Forms, live chat, or voice. Whiteboards and Forms were kept open after the listening sessions to capture further

input. Over 350 North Dakotans participated across the sessions and helped us sharpen our focus to confirm which priorities would be most effective and how North Dakota should prioritize investing the funds for maximum impact.

Tribal communities face unique health challenges, and we're committed to listening, learning, and acting. We held an in-person discussion alongside the quarterly Tribal Consultation meeting, bringing together nearly 60 participants from all five federally recognized tribes in North Dakota. Our conversation focused on barriers facing tribal members and strategies to overcome these challenges. The discussion allowed us to gauge the differences and similarities between what our tribal members face versus the broader rural community. We intend to keep tribal voices front and center throughout RHTP implementation.

We met individually with rural clinics, universities, hospitals, provider networks, community-based organizations, and more, including feedback from the state team that oversees PACE and D-SNPs. From federally qualified health centers to state agencies, we ensured that populations serving key demographics were included.

The North Dakota Legislature formed an interim Rural Health Transformation Committee, comprised of 34 dedicated legislators from both chambers and both parties, so ensure that our plan has the backing it needs to truly transform. This committee voted unanimously to advance our plan and will help advance the funding through the appropriations process. Many of these legislators have long been champions of rural health, funding many previous investments in rural care, and they renewed their commitment to make sure rural health gets the attention it deserves.

We've also launched a dedicated website and email address (rhtp@nd.gov) to keep the conversation going. Transparency isn't optional; it's essential. These important communication tools will be used to launch funding opportunities and report on funding and metrics, keeping us accountable for delivering transformation to rural communities.

NDHHS facilitates multiple committees that align with RHTP priorities including the State Health Council, Behavioral Health Planning Council, and two Medicaid-specific groups: the Medicaid Medical Advisory Committee and the Medicaid Member Engagement Committee. These committees meet regularly and will continue to provide critical feedback as we roll out funding opportunities for transformation and innovation.

METRICS AND EVALUATION PLAN

Metrics will be assessed through regular internal reviews and summarized in annual CMS progress reports, primarily using quantitative data from NDHHS administrative systems, Medicaid claims, and Behavior Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior System (YRBS), with supplemental new sources. Because statewide multisource payer data are unavailable, Medicaid claims and CAHPS will serve as proxies for statewide impact. Evaluation will track implementation (systems, participation) and outcomes (retention, adverse events, interoperability) and incorporate qualitative feedback from rural providers and stakeholders to contextualize results for emerging initiatives like cooperative purchasing, interoperability, and AI integration.

Initiative 1: Strengthen and Stabilize Rural Health Workforce	
1.1 Increase the rural provider retention rate at 3 and 5 years.	
Population	Statewide
Baseline	N/A
Baseline Year	CY2024
Baseline Description	Count of awards for recruitment/retention contracts
Target/Milestone	By year 3, increase the active recruitment/retention contracts by 60 By year 5, increase the active recruitment/retention contracts by 100

Data Source (Timing)	NDHHS (Annually)
Main Strategic Goal	Workforce Development, Sustainable access
County or Community	Yes
1.2 Expand remote monitoring and AI-assisted care to reduce staffing needs	
Population	Statewide
Baseline	N/A
Baseline Year	CY2025
Baseline Description	Percentage of rural facilities adopting each tool = Count of rural facilities utilizing RPM out of the total count of rural facilities in ND. Count of rural facilities AI-assist documentation tools out of the total count of rural facilities in ND.
Target/Milestone	50% increase of rural facilities adopting RPM/AI-assisted care by 2030
Data Source (Timing)	ND Health IT Adoption Survey (Annually), APCD (future)
Main Strategic Goal	Workforce Development, Tech Innovation, Innovative Care, Sustainable access
County or Community	Yes
1.3 Recruit new rural providers	
Population	Statewide
Baseline	Total number of rural providers with loan repayment: 48 • Dental Providers: 8 • Physicians: 9 • Midlevel Providers: 21 • Behavioral Health Providers: 10
Baseline Year	CY2024
Baseline Description	Number of rural providers with loan repayment.
Target/Milestone	By 2030, increase rural provider recruitment by 50%
Data Source (Timing)	NDHHS Primary Care Office (Annually)
Main Strategic Goal	Workforce Development, Sustainable access
County or Community	Yes
1.4 Reduce Health Professional Shortage Area (HPSA) counties	
Population	Statewide
Baseline	Health Professional Shortage Area Counties: • Primary Care: 38/51 Counties • Mental Health: 44/51 Counties • Dental Health: 23/51 Counties
Baseline Year	CY2024
Baseline Description	Number of counties classified as HPSA
Target/Milestone	By 2030, reduce designated HPSA by 15%
Data Source (Timing)	NDHHS Primary Care Office, Shortage Designation Management System Data. (Annually)
Main Strategic Goal	Workforce Development, Sustainable access
County or Community	Yes
Initiative 2: Make North Dakota Healthy Again	
2.1 Improve youth and adult activity and reduce obesity	
Population	Statewide
Baseline	Youth Activity: 54.5% | *95CI = 51.5 – 57.5* Youth Obesity: 16.3% | *95CI = 14.7 – 18.0* Adult Activity: 78.3% | *95CI = 77.0 - 79.7* Adult Obesity: 36.8% | *95CI = 35.2 – 38.5*
Baseline Year	CY2023 (ND YRBS), CY2024 (ND BRFSS)
Baseline Description	• Youth Activity: Percent of ND high school students that participated in 60 minutes of physical activity 5 or more days out of the last 7 days.

	• Youth Obesity: Percent of ND high school students that are obese, as calculated BMI by reported height and weight. • Adult Activity: Percent of ND adults reported physical activity or exercise during the past 30 days other than their regular job. • Adult Obesity: Percent of ND adults with diagnosis of obesity.
Target/Milestone	By 2030, increase physical activity rates by 10% relative improvement By 2030, reduce obesity rates by 10% relative improvement
Data Source (Timing)	ND YRBS (Every two years), ND BRFSS data sets (Annually); APCD (Future)
Main Strategic Goal	Make Rural America Healthy Again, Innovative Care
County or Community	Yes
2.2 Increase preventive screening rates	
Population	Statewide
Baseline	Breast Cancer Screening: 75.5% | *95CI = 72.8 – 78.2* Cervical Cancer Screening: 62.0% |*95CI = 58.5 – 65.5* Colorectal Cancer Screening: 69.6% | *95CI = 67.5 - 71.6*
Baseline Year	CY2024
Baseline Description	• Breast Cancer Screening: Percent of ND Women ages 40-74 who have had a mammogram in the past 2 years. (Every two years) • Cervical Cancer Screening: Percent of ND women aged 21-65 who have had a PAP test (cervical cancer screening) in the past 3 years. (Annually) • Colorectal Cancer Screening: Percent of North Dakota Adults aged 45+ that have ever had a colonoscopy or sigmoidoscopy. (Every two years)
Target/Milestone	By 2030, increase screening rates by 10% relative improvement
Data Source (Timing)	ND BRFSS data sets (Annually & Every two years); APCD (Future)
Main Strategic Goal	Make Rural America Healthy Again, Innovative Care
County or Community	No
2.3 Increase percentage of rural providers participating in ND Medicaid VBP/APMs	
Population	ND Medicaid
Baseline	34%
Baseline Year	CY2025
Baseline Description	Percentage = Count of rural providers in ND participating in ND Medicaid VBP/APMs out of the total rural providers in ND
Target/Milestone	By 2030, 60% participating in Medicaid VBP/APMs
Data Source (Timing)	ND CAH Quality Network website, Optumas, MMIS (Annually)
Main Strategic Goal	Make Rural America Healthy Again, Innovative Care
County or Community	Yes
2.4 Reduce adverse actionable events per care episode	
Population	ND Medicaid
Baseline	Diabetes AAE rate: 42% Hypertension AAE rate: 52%
Baseline Year	July 2023 to June 2025
Baseline Description	AAE% = AAE Dollars/Total Dollars The portion of total ND Medicaid health spending caused by preventable or avoidable complications per care episode (Diabetes, Hypertension). Lower AAE indicates fewer preventable complications relative to overall spending for the selected conditions across the state.
Target/Milestone	By 2030, reduce AAE% by 4% relative improvement for each episode type (Diabetes, Hypertension).
Data Source (Timing)	MMIS, Optumas
Main Strategic Goal	Make Rural America Healthy Again, Innovative Care
County or Community	Yes
2.5 Reduce Chronic Disease Burden and Risk	

Population	Statewide (18 and older)
Baseline	Cardiovascular Disease (stroke, heart attack, or CHD): 8.6% | *95CI = 7.8-9.4* Kidney Disease: 3.4% | *95CI = 3.0 – 3.9* COPD: 5.5% | *95CI = 4.8 – 6.1* Diabetes: 10.6% | *95CI = 9.7 – 11.5* High Blood Pressure: 31.8% | *95CI = 30.3 – 33.2* (Every two years)
Baseline Year	CY2023 (High Blood Pressure) / CY2024
Baseline Description	Percent of North Dakota adults with diagnosis of any cardiovascular disease, kidney disease, COPD, diabetes or high blood pressure.
Target/Milestone	By 2030, reduce overall chronic disease burden and risk by 10% relative improvement
Data Source (Timing)	ND BFRSS Data Sets (Annually); APCD (Future)
Main Strategic Goal	Make Rural America Healthy Again, Innovative Care
County or Community	Yes
2.6 Promote Mental Health and Prevent Suicide	
Population	Statewide (Highschool; 18 and older)
Baseline	High School: 7.4% | *95CI = 6.2 – 8.7* Adult: *Data not available until Fall 2026*
Baseline Year	CY2023 / CY2025
Baseline Description	• High School Respondent answers one or more to “during the past 12 months, how many times did you actually attempt suicide?” • Adult 18 and older Respondent answer to “In the past 12 months, have you attempted suicide?”
Target/Milestone	By 2030, reduce suicide attempt rates by 10% relative improvement
Data Source (Timing)	ND YRBS, ND BFRSS Data Sets (Annually)
Main Strategic Goal	Make Rural America Healthy Again, Innovative Care
County or Community	No
Initiative 3: Bring High-Quality Health Care Closer to Home	
3.1 Increase Telehealth / Remote Patient Monitoring (RPM) Encounters	
Population	ND Medicaid
Baseline	Rural Telehealth Encounters: 290 per 1,000 Medicaid members Rural RPM Encounters: 0.19 per 1,000 Medicaid members
Baseline Year	CY2024
Baseline Description	• Number of rural Telehealth Encounters standardized per 1,000 average monthly Medicaid members. • Number of rural RPM Service Encounters standardized per 1,000 average monthly Medicaid members
Target/Milestone	By 2030, increase rural Telehealth encounters by 20% / RPM encounters by 50%
Data Source (Timing)	MMIS (Annually), APCD (future)
Main Strategic Goal	Sustainable Access, Innovative Care, Tech Innovation
County or Community	Yes
3.2 Reduce avoidable ED visits	
Population	ND Medicaid
Baseline	32.15
Baseline Year	CY 2024
Baseline Description	Rate of ED visits per 1,000 member months among Medicaid members. Higher values (those toward the high end of the percentile distribution) may indicate overuse of the ED for Medicaid participants and may indicate that disparities in access to treatment exist for Medicaid members.
Target/Milestone	By 2030, 10% relative improvement
Data Source (Timing)	MMIS, Optumas (Quarterly/Annually); APCD (Future)
Main Strategic Goal	Sustainable Access, Innovative Care, Tech Innovation

County or Community	Yes
3.3 Improve Coordination of Care	
Population	ND Medicaid
Baseline	Adult: 85.2% Child: 84.7% Children with Chronic Conditions 75.4%:
Baseline Year	CY 2024
Baseline Description	Member responded Usually + Always
Target/Milestone	By 2030, 10% relative improvement
Data Source (Timing)	CAHPS Surveys (Annually)
Main Strategic Goal	Sustainable Access, Innovative Care, Tech Innovation
County or Community	No
3.4 Improve Getting Care Quickly	
Population	ND Medicaid
Baseline	Adult: 90.9% Child: 86.9% Children with Chronic Conditions: 88.5%
Baseline Year	CY 2024
Baseline Description	Member responded Usually + Always
Target/Milestone	By 2030, 10% relative improvement
Data Source (Timing)	CAHPS Surveys (Annually)
Main Strategic Goal	Sustainable Access, Innovative Care, Tech Innovation
County or Community	No
3.5 Improve Getting appointments with specialists as soon as needed	
Population	ND Medicaid
Baseline	Adult: 82.7% Child: 75% Children with Chronic Conditions: 80.6%
Baseline Year	CY 2024
Baseline Description	Member responded Usually + Always
Target/Milestone	By 2030, 10% relative improvement
Data Source (Timing)	CAHPS Surveys (Annually)
Main Strategic Goal	Sustainable Access, Innovative Care, Tech Innovation
County or Community	No
Initiative 4: Connect Tech, Data and Providers for a Stronger ND	
4.1 Implement all payer claims database (APCD)	
Population	Statewide
Baseline	N/A
Baseline Year	N/A
Baseline Description	New metric: N/A
Target/Milestone	By 2026: Design and Draft Legislation as Needed By 2028: Enactment By 2030: Publication of Outcome and Cost Dashboards Between Payers
Data Source (Timing)	ND HHS - Interagency and External Data Partners (Annual)
Main Strategic Goal	Sustainable Access, Tech Innovation
County or Community	Yes
4.2 Modernized NDHHS Data Hub live with cross-program linkages	
Population	NDHHS
Baseline	N/A
Baseline Year	N/A
Baseline Description	New metric: N/A
Target/Milestone	By 2030, 30% of HHS data assets and all key users from all HHS divisions onboarded to NDHHS Data Hub.
Data Source (Timing)	ND HHS - Interagency and External Data Partners (Annual)

Main Strategic Goal	Sustainable Access, Tech Innovation
County or Community	No
4.3 Annual tech cost savings via cooperative purchasing	
Population	Statewide
Baseline	N/A
Baseline Year	N/A
Baseline Description	New metric: N/A
Target/Milestone	By 2030, > $3M cumulative
Data Source (Timing)	Cooperative purchasing participant reporting (Annual)
Main Strategic Goal	Sustainable Access, Tech Innovation
County or Community	No
1.2 Expand remote monitoring and AI-assisted care to reduce staffing needs	
Population	Statewide
Baseline	N/A
Baseline Year	CY2025
Baseline Description	Percentage of rural facilities adopting each tool = Count of rural facilities utilizing RPM out of the total count of rural facilities in ND. Count of rural facilities AI-assist documentation tools out of the total count of rural facilities in ND.
Target/Milestone	50% increase of rural facilities adopting RPM/AI-assisted care by 2030
Data Source (Timing)	ND Health IT Adoption Survey (Annually), APCD (future)
Main Strategic Goal	Workforce Development, Tech Innovation, Innovative Care, Sustainable access
County or Community	Yes

Several metrics intentionally span multiple initiatives to reflect the interconnected nature of the transformation effort. For example, measure 1.2 is utilized across Initiative 1 and 4, because the actions in these areas directly support the adoption of remote monitoring and AI-assisted care as well as interoperability and connection of provider technology. This measure also ties into strategies and actions in Initiatives 2 and 3, as these devices will enable direct patient focus on managing chronic disease, meeting value-based care goals, and providing access closer to home, reducing costly travel. Measure 4.1 is critical to the future, transitioning from survey-reported data to statewide claims data, making data-driven decision making for population health and strategies directly impacting rural residents more viable for North Dakota in the future. These cross-initiative metrics reflect North Dakota's commitment to measuring transformation as a whole-system effort and enable broader evaluation of cumulative statewide impact.

DATA SOURCES AND GOVERNANCE

Metrics will rely on existing state systems and data sources and new reporting mechanisms established through RHTP investments. Primary data sources include:

Data Source	Anticipated Data
ND Medicaid claims and Optumas CIOT Dashboard	Quality and cost metrics such as Adverse Actionable Events (AAE) and emergency department utilization
Public Health BRFSS and YRBS	Statewide health and prevention outcomes
Licensure and HRSA Area Health Resource Files (AHRF)	Provider counts, retention, and HPSA classification
CAHPS surveys	Patient experience and care coordination metrics
NDHHS Procurement and NDIT	Cooperative purchasing, financial savings, and cybersecurity metrics
Behavioral Health Division	Workforce mapping and related data collection

Metrics will be managed under NDHHS's data governance framework. Results will be shared through internal dashboards and public-facing summaries to monitor progress, ensure transparency and stakeholder engagement.

EVALUATION TIMELINE AND REPORTING

Evaluation will span the five-year RHTP grant (2025–2029) with baselines set in Year 1 and annual milestone tracking thereafter. Metrics will be reviewed at least annually and quarterly when relevant to identify gaps and adjust implementation. Annual reports will document outcomes, financial accountability, and lessons learned for CMS, and findings will be shared with stakeholders via legislative summaries and public briefs to promote transparency and trust.

COOPERATION WITH CMS AND EXTERNAL EVALUATION

NDHHS will fully cooperate with CMS-led or third-party evaluations of the RHTP and will provide standardized datasets, documentation, and findings per CMS guidance. An independent internal evaluation team in Health Statistics & Performance will design and validate methods, conduct objective analyses, produce regular reports for CMS and the public, and may partner with academic or public health experts to strengthen rigor.

Evaluation results will guide data-driven improvements, enhance credibility and objectivity, and support sustained evaluation capacity beyond the grant period.

SUSTAINABILITY PLAN

North Dakota's RHTP is designed not only to catalyze immediate improvements in rural health access, quality, and system performance—but to lay the foundation for long-term, self-sustaining transformation. The state's approach to sustainability is rooted in strategic alignment with Medicaid value-based purchasing (VBP) models, cross-payer collaboration, legislative engagement, and the institutionalization of data-driven evaluation within NDHHS.

NDHHS will sustain and scale successful RHTP initiatives by embedding them into the state's Medicaid VBP framework and Managed Care Quality Strategy. As part of this strategy, RHTP performance metrics—such as care coordination, avoidable emergency department use, and preventive screening rates—will be incorporated into provider incentive structures and alternative payment models (APMs) and the state's Managed Care Contract. This alignment ensures that rural providers are financially rewarded for delivering high-quality, efficient, and patient-centered care, creating a durable incentive for continued transformation beyond the grant period.

North Dakota is committed to multi-payer alignment to ensure that rural health transformation is not siloed within Medicaid. NDHHS will work with commercial insurers, Medicare Advantage plans, including Dual Special Needs Plans and PACE, and self-insured employer groups to harmonize quality metrics, care coordination expectations, and data-sharing standards. This alignment will reduce administrative burden on rural providers and amplify the impact of RHTP investments. In addition, NDHHS is

committed to policy analysis and red tape reduction in ND Medicaid and other programs to eliminate institutional barriers to rural health access.

The North Dakota Legislature has demonstrated strong, bipartisan support for rural health innovation, workforce development, and behavioral health system reform. NDHHS will continue to engage with legislative leaders to codify successful RHTP strategies and align future policy efforts with the program's long-term goals. This includes potential legislative action to support cooperative purchasing models, telehealth infrastructure, and community-based behavioral health services.

NDHHS will sustain evaluation activities beyond the federal period by integrating ongoing performance tracking into its enterprise dashboards. These dashboards will enable real-time monitoring of health access, quality, workforce, and technology outcomes at both the state and county levels. RHTP metrics will be incorporated into NDHHS's Data & Quality infrastructure to ensure ongoing monitoring, transparency, and performance improvement across all program areas. Where applicable, findings and metrics will inform Medicaid VBP and other sustainability strategies.

To ensure that transformation is evidence-based and data-driven, NDHHS will deploy technical assistance and targeted interventions to underperforming regions, counties, or providers. Evaluation methods will be refined annually based on CMS feedback, stakeholder input, and emerging best practices. This approach ensures that lessons learned from the RHTP will continue to guide policy, funding, and innovation well beyond the federal grant period.