Foundation for Healthy Communities (FHC) Request for Application (RFA)

FHC Home Health and Community Care Appendix

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The Governor's Office of New Opportunities and Rural Transformational Health (GO-NORTH), was established by Executive Order under Governor Kelly Ayotte, and is funded by the federal Rural Health Transformation (RHT) program. GO-NORTH advances five strategic initiatives to improve the health and sustainability of rural New Hampshire.

Initiative 1: Population Health

Increase prevention, chronic disease management, and improved behavioral and maternal health.

Initiative 2: Access

Ensure sustainable access to care by strengthening rural hospitals, health centers, EMS, and telehealth services

Initiative 3: Workforce

Build and retain a skilled rural health workforce through education, training, and career pathways.

Initiative 4: Technology

Modernize care delivery by expanding technology, interoperability, and data security.

Initiative 5: Financial Sustainability

Promote financial sustainability with innovative payment models and value-based care.

GO NORTH delivers this work through five Hubs, each supported by a GO NORTH lead who provides coordination, guidance, and oversight to ensure alignment with statewide priorities. The 5 Hubs represent rural health experience and knowledge that will support our work together. [Program Overview | GO-NORTH]



INITIATIVE(S) #	Access Technology Financial Sustainability
RFA ISSUED	Mid-November 2026
FHC POINT OF CONTACT	GO-NORTH-FHC@healthynh.org
CONTRACT TYPE	Grant Subaward Agreement
APPLICATION DUE DATE	January 7, 2027

Focus Area Descriptions

Focus Area 1: Access

Funding under this focus area supports new or expanded care delivery models that improve health outcomes, enhance patient experience, and strengthen access to care for rural New Hampshire communities. Applicants proposing to expand an existing service should explain how the investment will contribute to sustainable transformation at their current stage of readiness.

Access	Example Activities
Community Nursing	Nursing visits or assessments; post-discharge follow-up; medication reconciliation; chronic disease monitoring; fall risk assessments; coordination with primary care; remote patient monitoring. **Example Project:** A community nurse or visiting nurse association proposes to serve several rural towns and partner with community-based organizations, town offices, senior centers, and the area primary care practice to run a scheduled nursing clinic. Nurses complete post-discharge follow-up, medication reconciliation, fall-risk assessments, and chronic disease checks, remote patient monitoring, and send findings to the patient's primary care provider through a defined referral workflow. Funds support partnership development, site planning, approved clinic equipment, technology adoption, remote patient monitoring equipment, and the referral and documentation workflows; visits are billed through existing home health and primary care reimbursement.
Mobile Health Clinics	**Example Project:** In partnership with rural health care providers, establish a mobile community health clinic with scheduled visits at accessible community locations including town halls, senior housing, libraries, food pantries and worksites. The mobile clinic offers walk-in and scheduled primary care, preventive screenings, vaccinations, chronic disease checks and telehealth links to specialists. Visit notes and results go back to each patient's primary care provider through defined referral workflows, and if the patient does not have a primary care practice mobile clinic care coordinators support referrals to a primary care provider. Applicants may also propose to partner with the University System of New Hampshire to utilize mobile simulation clinics – built out to clinic level standards – as mobile clinics in rural areas. Funds support partnership development, route and site planning, an equipped mobile clinic unit (or utilization of the USNH mobile clinical simulation van in partnership with USNH), scheduling and records systems, development of referral pathways and technology. Visits are

	billed through existing primary care and preventive service reimbursement pathways. Note, vehicles require FHC prior approval, see Section 3.5.
Home-based Primary Care Models	Routine primary care visits for home-based adults including acute illness evaluation and treatment, preventive care, preventive screening, chronic disease management, remote patient monitoring, telehealth visits; medication management and reconciliation; and care coordination with specialists. **Example Project:** Rural health care organizations, such as a home health agency and a rural primary care practice, partner to design a home-based primary care program for homebound older adults who routinely miss office appointments. The team pairs in-home and telehealth visits for acute illness, preventive care, and chronic disease management with remote patient monitoring, health-related social needs screening, shared care plans, and specialist coordination. Funds support model design, telehealth and monitoring equipment, and care-coordination infrastructure; the practice bills visits under existing coverage and reimbursement pathways.
Community-Based Maternal Health	Community-based maternal health services, such as home visits, remote monitoring, or tele-obstetric consultation coordinated with rural providers and perinatal partners. **Example project:** Rural health care organization, such as a home health agency and an obstetric team at the nearest delivery hospital, partner to offer postpartum home visits and remote blood pressure monitoring for patients who live long distances from the hospital. The partners build tele-obstetric consultation and escalation protocols, a referral pathway to perinatal health, and shared documentation. Funds support protocol development, monitoring equipment, technology, and data exchange; the application identifies which visits are reimbursable and how unreimbursed components will be sustained.
Post Hospital Discharge Community Nursing	Home nursing visits, remote monitoring, in-home specimen collection, mobile diagnostic services, pharmacy support, and physical therapy coordinated with hospital and community partners. **Example project:** A home health agency partners with a rural hospital to deliver the home-based components of a post-discharge program: in-home nursing, specimen collection, mobile diagnostics, pharmacy delivery, and physical therapy, with local emergency medical services for escalation. Funds support clinical protocols, escalation and transfer agreements, remote monitoring technology, and staff training. The sustainability plan

	identifies the reimbursement pathway the program will rely on after the award period and the agency's contracted role in it.
Community Health Worker Programs	Health coaching and chronic disease support; care coordination; Health related social needs (HRSN) screening; connecting individuals to community resources; care coordination home visits and follow-up after hospitalization. **Example Project:** A visiting nurse association embeds community health workers (CHWs) in its home health team to follow patients after hospital discharge. CHWs screen for health-related social needs, connect patients to community assistance, transportation, and food resources, provide health coaching, and flag clinical concerns to the nurse. Funds support CHW training and certification, referral technology, and workflow integration.
Medication Access and Support	Help rural patients obtain prescribed medications, store them safely, and manage their medication regimens. **Example Projects:** Coordinating with pharmacies, arranging delivery, and providing education on storage and use. Rural health care organization partners with pharmacists to support patients managing complex medication regimens after discharge. Home health or VNA nurses reconcile medications at the first home visit using a shared medication list, the pharmacy arranges delivery and packaging, and a pharmacist provides telehealth consults for high-risk regimens. Funds support workflow design, electronic exchange of medication lists among the agency, pharmacy, and primary care, and patient education on safe storage and use.
Mobile Diagnostic Imaging	Bring diagnostic imaging to county-operated nursing homes, with additional service to rural healthcare providers. **Example Projects:** Coordinating mobile visits, scheduling patients, and sharing results with referring providers. County-operated nursing homes partner to procure a mobile imaging unit including mobile X-ray and ultrasound for its residents and extends the service to nearby rural providers and communities reducing transports to the hospital for routine imaging. Funds support scheduling and order workflows, transmission of results into the nursing home's and referring providers' records, and any equipment. Imaging services are billed under existing reimbursement. Note, vehicles and equipment require FHC prior approval, See Section 3.5.

Dementia Care: GUIDE Program Expansion	**Example Project:** Expanding partnerships with an organization currently participating in the CMS Guiding an Improved Dementia Experience (GUIDE) Model to extend its dementia care program into additional rural communities, working with rural adult day centers and home care agencies as CMS-approved partner organizations. Funds support start-up costs that GUIDE payments do not cover: training rural care navigators, building in-home and adult day respite capacity, telehealth for remote dementia assessments, caregiver training at community sites, and data exchange with rural primary care. Ongoing care management and respite are paid through GUIDE's monthly payments and respite benefit, not grant funds.
Aging in Place	**Example Project:** Health care organizations and community-based organizations partner to support rural older adults at risk of losing independence at home, including partnerships to bring occupational therapy, a registered nurse, and a handy worker who visit the home over to support the older adults in adopting assistive devices and making changes to support at home independent living. Funds support training, partnership development, referral pathways from hospitals, primary care, and ServiceLink, and outcome tracking.

Example Metrics

- Number of community health workers embedded in community or home health care
- Number of patients on remote monitoring
- Number of community nurse visits
- Increased preventive care utilization
- Increased telehealth utilization
- Increased number of rural patients served
- Reduced missed appointments
- Decreased emergency department (ED) utilization
- Decreased re-admissions

Focus Area 2: Technology

Funding under this focus area supports technology investments that produce a demonstrable return on investment by modernizing care delivery and strengthening the operational and financial sustainability of home health care organizations or projects. Competitive projects will demonstrate how technology investments will improve patient care while reducing administrative burden, lowering costs, increasing clinical productivity, and enhancing revenue cycle performance.

Applicants proposing a technology investment should describe how it will strengthen home health or community care delivery in rural New Hampshire and demonstrate its anticipated return on investment. To be competitive, proposals for one-time technology purchases should explain how the investment will lead to measurable operational or financial improvements.

Technology	Example Activities
Health IT Investments	• Comprehensive cybersecurity risk assessments (HIPAA Security Rule, NIST CSF) and remediation of identified vulnerabilities - patch management, access controls, encryption, network segmentation; security awareness training for staff; implementation of multi-factor authentication, endpoint detection and response (EDR), and backup/disaster recovery solutions. • Interoperability with electronic health records systems, technology investments to support integrated clinical workflows between rural health care providers and home health • Implementation of interoperability standards HL7 Fast Healthcare Interoperability Resources (HL7 FHIR), United States Core Data for Interoperability (USCDI); bidirectional data exchange with payer systems, and partner organizations • Real-time admission/discharge/transfer (ADT) notifications
Home Health Equipment Upgrades and Remote Patient Monitoring	• Equipment that expands home health capacity to serve patients in the community or home. • Remote patient monitoring
Clinical Decision Support Tools	• Evidence-based clinical reference tools • Technology to deploy predictive modeling that flags home health patients at risk of hospitalization or emergency department utilization based on home health or Outcome and Assessment Information Set (OASIS) assessments and visit documentation • Ambient listening and AI-scribe documentation
Shared Services Technology	• Interoperable electronic health records across partner organizations • E-Consults (secure messaging with specialists) • Shared care plans and discharge planning

Cross-County Nursing Home / Hospital Electronic Health Records Integration	• Electronic health records interoperability between acute care hospitals and regional skilled nursing facilities (SNFs) and county nursing homes • Shared discharge planning and medication reconciliation workflows; • Real-time bed availability and transfer tracking • Shared care plan documentation across acute and post-acute settings • Care coordination technology and management between hospital and nursing home • Pilot models for regional post-acute data integration.
Referral Interfacing	• Use of enhanced care coordination tools • Bi-directional referral exchange between clinical and community-based service providers • Health related social needs screening and referrals • Referral status tracking and feedback loops • Community resource directory integration • Referral outcome measurement and reporting

Example Metrics

- Reduced provider documentation time
- Reduced prior authorization turnaround times
- Reduced no-show rates
- Increased patient portal utilization
- Increased telehealth completion rates
- Reduced staff time spent on administrative tasks
- Increased automation of administrative workflows
- Reduced cybersecurity incident response time
- Reduced outbound transfers due to expanded on-site diagnostic or tele-specialty capability
- Reduced 30-day readmissions through RPM and post-acute coordination
- Increased clean claims rate; reduced claims denial rate
- Reduced days in A/R
- Increased revenue from newly captured billable services
- Cost savings from shared infrastructure or consolidated platforms

Focus Area 3: Value Based Care

Funding under this focus area supports projects that support efforts to participate in, ready for, and transition to value based care (VBC). RHT funds can be used to support that transition (e.g. population health data analytics, risk identification, tracking and interventions, chronic disease management / remote patient monitoring, etc.)

Value Based Care	Example Activities
Projects that build the operational, financial and clinical infrastructure aimed at improving readiness for Value Based Payment (VBP), Advanced Payment Models (APMs) and/or Accountable Care Organization (ACO)	VBP Readiness Assessment and Strategy Development – Evaluate organizational readiness for participation in value-based payment arrangements and develop a roadmap for implementation. Population Health Analytics Infrastructure – Develop data analytics capabilities to identify high-risk populations, measure performance, track cost and utilization trends, and support value-based contracting. Quality Measure Alignment, Risk Stratification and Reporting Systems – Establish systems, dashboards, and workflows to collect, monitor, and report quality, utilization, and cost metrics required under VBP, APM, or ACO arrangements. Care Pathway Standardization and Clinical Integration – Develop evidence-based care pathways, clinical protocols, and cross-provider workflows designed to improve outcomes and reduce unnecessary variation in care delivery. VBP Contracting and Financial Modeling – Build organizational capacity to evaluate risk arrangements, model financial performance, develop shared-savings methodologies, and negotiate value-based contracts. Cross-Organizational Data Sharing and Care Coordination Infrastructure – Establish agreements, governance structures, interoperability solutions, and shared reporting processes among participating providers. Provider and Staff Training for Value-Based Care – Train clinical and administrative staff on quality measures, population health management, care management workflows, and performance improvement methodologies.

	Value-Based Performance Dashboard Development – Create dashboards that integrate quality, utilization, financial, and patient outcome measures to support continuous performance management.

Example Metrics

- Number of strategic partners engaged in VBP/ACO planning or implementation
- Completion of a shared VBP/ACO strategy or implementation plan
- Technology /data infrastructure implemented
- Number of cross-organizational workflows or care pathways developed
- Shared-savings methodology/dashboard developed
- Contracting/participation milestones achieved
- Number of shared quality, utilization and cost measures established across participating organizations
- Increased participation in VBP arrangements
- Increased percentage of revenue tied to alternative payment models
- Increased attributed patient populations under value-based arrangements

Focus Area 4: Financial Sustainability

Funding under this focus area supports projects that strengthen the financial and operational performance of health care organizations. Proposed activities should reduce administrative burden, improve operational efficiency, strengthen long-term financial sustainability, and demonstrate a clear return on investment.

Financial Sustainability	Example Activities
Operational Efficiency	• Streamline prior authorization, referrals, scheduling, and administrative workflows • Reduce length of stay or hospital discharge barriers through care coordination and discharge planning improvements; • Optimize county bed utilization
Revenue Cycle Performance	• Enhance claims management through real-time monitoring and denial tracking • Improve billing and coding for billable services • Documentation improvement
Shared Infrastructure	• Share administrative functions, billing systems, supply chain, or clinical support services among rural providers to reduce per-organization fixed costs • Regional procurement cooperatives
Cost Reduction	• Implement technology or process changes that reduce long-term operating costs • Optimize staffing models and reduce reliance on locum or contract labor

Sustainable Service Lines	• Develop or strengthen service lines that generate sustainable reimbursement • Phase out unsustainable service lines with transition plans
Workforce Retention	• Investments that reduce turnover and agency dependency - training pipelines, residency programs, cross-training, leadership development
Innovative Shared Savings Model	• Adoption of shared savings models and innovative care models that incentivize prevention of avoidable hospital admissions, readmissions, emergency department utilization, and institutionalization, and where savings are reinvested into the models and interventions that led to the savings.

Example Metrics

Administrative Burden:
- Average time to complete prior authorizations or referrals
- Provider time spent on documentation after clinic hours
- Reduction in administrative costs.

Operational Efficiency:
- Time from referral to completed appointment
- Number of patients seen per provider or care team

Revenue Cycle Management:
- Clean claims rate
- Claims denial rate
- Days in accounts receivable (A/R)
- Average reimbursement per visit

Financial Sustainability:
- Cost per patient visit
- Revenue generated from preventive services or care coordination
- Annual operating cost savings
- Return on investment (ROI) for technology or process improvements
- Percentage increase in billable services captured

Shared Infrastructure:
- Cost savings from shared infrastructure
- Reduction in duplicated services
- Number of shared staffing or administrative functions implemented

Example Projects by Readiness Stage

The following examples illustrate how projects may be structured at different stages of organizational readiness. They are illustrative only and do not limit the types of projects that may be proposed. Applicants should develop projects that respond to documented rural needs, reflect their current capacity, and align with the Focus Areas in Section 3.4.

See RFA Sections 2.4 and 3.4 for focus area requirements and Section 5.2 for scoring criteria. Applicants must address at least one focus area and should identify their primary focus area and explain how any additional focus areas support the proposed outcomes.

Example 1: Project Development Stage – Home-Based Primary Care Model

Organization: An adult day center located in a rural county currently offers health monitoring and medication management but has identified that there are gaps in primary care services for its attendees. They have not completed the operational, technology, partnership, or financial planning required for implementation.

Proposed Project: The day center requests funding to assess its current state and develop an implementation-ready home-based primary care model. Initial activities would include:

- analyzing patient needs, service gaps, and the estimated number of rural patients who could benefit;
- assessing organizational infrastructure, staffing, workflow, credentialing, technology, interoperability, privacy, and cybersecurity readiness;
- convening primary care providers;
- defining the roles, governance, data-sharing responsibilities, and financial responsibilities of participating organizations;
- evaluating telehealth and care-coordination technology options and documenting anticipated costs and return on investment;
- developing an implementation plan with milestones, a detailed budget, performance measures, risk-mitigation strategies, and a sustainability plan; and
- conducting a limited pilot only if the applicant demonstrates sufficient readiness and receives all required approvals.

Alignment with Section 3.4

Focus Area	How This Proposal Addresses It
1. Access	Develops a coordinated home-based primary care model intended to improve and strengthen access and reduce access barriers for rural patients.
2. Technology	Assesses telehealth, interoperability, care-coordination, privacy, and cybersecurity requirements before making a larger technology investment.

3. Value Based Care	Assesses organizational readiness for participation in value-based payment arrangements by evaluating quality measurement capabilities, population health management strategies, data-sharing requirements, performance reporting needs, and potential payer and partner alignment opportunities.
4. Financial Sustainability	Establishes expected costs, reimbursement opportunities, operating responsibilities, potential efficiencies, and long-term funding needed to sustain implementation.

Expected Deliverables and Outcomes: Deliverables would include a documented current-state assessment, defined partnership and governance structure, recommended workflows, project and implementation plan, technology requirements, baseline measures, outcome targets, and a defensible estimate of rural patients expected to be served. If a pilot is approved, the applicant would also report pilot utilization, patient access, workflow performance, and lessons incorporated into the implementation plan.

Why this fits Project Development: The organization has identified a credible rural need but must strengthen its infrastructure and readiness before committing to full implementation. The project produces actionable deliverables and may advance into Preparatory Investments when defined readiness milestones are met.

Example 2: Preparatory Investments Stage - A Rural Home-Health Agency Strengthening Technology and Operational Readiness

Organization: A rural home-health agency has a functioning electronic medical record but has documented cybersecurity vulnerabilities, limited interoperability, inconsistent telehealth adoption, and revenue-cycle performance challenges. Leadership has completed initial planning and is prepared to implement a bounded set of infrastructure improvements.

Proposed Project: The agency requests funding for targeted technology and operational investments that address documented barriers to care transformation. Activities may include:

- completing a cybersecurity assessment and implementing prioritized remediation;
- improving electronic medical record functionality and interoperability with rural providers, referral partners, and post-acute organizations;
- implementing care-coordination and closed-loop referral tools;
- purchasing and deploying approved telehealth technology and establishing standardized clinical and administrative workflows;
- implementing revenue-cycle tools and workflow improvements tied to documented baseline performance;
- training staff and monitoring technology adoption, workflow performance, and patient use; and
- developing an implementation plan for the next stage of care-delivery transformation.

Alignment with Section 3.4

Focus Area	How This Proposal Addresses It
1. Access-Transforming Care Delivery	Establishes the workflows and care-coordination infrastructure needed to expand access, improve referrals, and support more coordinated rural care.
2. Technology	Implements cybersecurity, interoperability, telehealth, and operational technology tied to documented needs, adoption measures, and anticipated return on investment.
3. Value Based Care	Builds the foundational infrastructure needed for value-based care participation through improved interoperability, quality reporting, care coordination, population health analytics, and performance measurement capabilities that support future VBP contracting and accountability for outcomes.
4. Financial Sustainability	Targets measurable operational improvements, such as reduced denials, lower avoidable administrative costs, improved staff productivity, or retained patient volume.

Expected Deliverables and Outcomes: The applicant would establish project-specific baselines and targets, such as technology implementation and adoption rates, telehealth utilization, the estimated number of rural patients served, referral completion rates, denial rates, staff time saved, and documented cost reductions or revenue improvements. Targets must be supported by the applicant's own data and assumptions rather than generic industry estimates.

Why this fits Preparatory Investments: The agency has completed foundational planning and is ready to make defined, one-time investments that remove barriers to broader transformation. The proposal may progress to Program Ready activities when implementation, adoption, and performance milestones are met.

Example 3: Program Ready Stage – Hospital Discharge Community Nursing Partnership

Organization: A home health organization partners with a hospital to reduce hospital readmissions, primary care providers and emergency medical service providers qualified to enhance post-discharge care and coordination to reduce avoidable readmissions.

Application Structure: One organization that meets the lead applicant eligibility requirements in RFA Section 2.1 must serve as the lead applicant and fiscal agent. The application should identify each proposed subrecipient and define its scope of work, budget, responsibilities, and performance expectations. See RFA Sections 2.2, 2.4, and 3.2 for funding restrictions, application limits, and award structure.

Proposed Project: The applicant requests funding to implement a hospital discharge community nursing model. Activities may include:

- deploying a shared telehealth platform and supporting equipment across participating rural sites;

- establishing unified clinical protocols, care-coordination workflows, credentialing and privileging processes, scheduling procedures, and escalation pathways;
- integrating relevant clinical information and referral data across participating organizations;
- implementing supporting cybersecurity, interoperability, data-sharing, and performance-reporting infrastructure;
- training clinical and administrative staff and monitoring adoption across participating sites;
- establishing governance, accountability, and financial arrangements for all participating organizations; and
- implementing a sustainability strategy based on appropriate reimbursement, shared infrastructure, operational efficiencies, retained patient volume, and other identified revenue or cost-saving opportunities;
- defining the rural service area, patient eligibility, and admission and discharge workflows;
- planning for ongoing home visits, monitoring, diagnostics, and pharmacy coordination after the award period; and
- identifying any proposed direct healthcare service costs and explaining how they meet the restrictions in RFA Section 3.5.

Alignment with Section 3.4

Focus Area	How This Proposal Addresses It
1. Access-Transforming Care Delivery	Replaces fragmented, facility-specific approaches with a coordinated model that expands access and care coordination across rural communities.
2. Technology	Uses shared telehealth, interoperability, cybersecurity, and reporting infrastructure to support reliable delivery across organizations.
3. Value Based Care	Implements a coordinated care model designed to support value-based payment participation through shared quality measures, cross-organizational care pathways, performance monitoring, data sharing, and governance structures that improve outcomes while managing total cost of care.
4. Financial Sustainability	Reduces unnecessary duplication, shares infrastructure and operating costs, and establishes a credible plan to sustain services after the funding period.

Expected Deliverables and Outcomes: The applicant would report the estimated and actual number of unduplicated rural patients served, home visits completed, transfers to non-hospital facility-based care, emergency department visits and readmissions, patient and caregiver experience, cost

per patient, and progress toward sustainability. Measures would include baselines, targets, data sources, and reporting methods aligned with applicable GO-NORTH performance indicators and CMS requirements.

Why this fits Program Ready: The participating organizations have completed the foundational planning needed to begin implementation. The application includes committed participants, defined governance, an executable work plan and budget, identified technology and clinical workflows, measurable outcomes, and a credible sustainability strategy.

GO-NORTH Performance Indicators

GO-NORTH performance indicators are the measures used to determine whether funded projects are achieving their intended outputs and outcomes and advancing New Hampshire's Rural Health Transformation Plan and applicable CMS requirements. Depending on the project, indicators may address rural patients served, access to care, service availability, health outcomes, care coordination, technology adoption, operational efficiency, financial performance, patient or provider experience, and sustainability. Applicants should propose relevant project-level baselines and targets. Final required indicators, definitions, reporting frequency, and targets will be confirmed during the award and contracting process.

Transformation Technical Assistance Center (T-TAC)

Award recipients may be connected with qualified T-TAC resources to support project planning, implementation, performance improvement, and sustainability based on identified needs and subject to FHC approval and resource availability.