



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

FHC Critical Access Hospital (CAH) & Acute Care Hospital Appendices

This GO-NORTH Request for Applications is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$204 million with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

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 Rural Health Transformation (RHT) Federal 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) #	☐ 1	☒ 2	☐ 3	☐ 4	☐ 5
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Focus Area Descriptions

Focus Area 1: Access

Funding under this focus area supports the adoption or expansion of innovative care delivery models that improve health outcomes, enhance patient experience, increase access for rural populations, and strengthen the sustainability of critical access hospital services. Proposals should demonstrate how these models represent a significant change from current practice - not a continuation or modest expansion of existing operations.

Access	Example Activities
Telehealth Specialty Access	Expanding access to specialty services. Tele-stroke, tele-OB, tele-psychiatry, tele-ICU, tele-SANE, tele-cardiology, tele-nephrology; Expand access to specialty services that cannot be sustained on-site due to volume or workforce constraints; Integrate tele-specialty into ED, inpatient, and outpatient workflows.
Emergency Department Sustainable Transformation	Tele-ED backup coverage; Provider staffing models (APP-led with physician oversight, hybrid models); ED throughput and boarding reduction strategies; Integration with regional EMS/MIH programs; ED-based care coordination and discharge planning.
Obstetric Service Sustainability	Maintaining or restoring obstetric services in communities facing L&D closure or maternity care desert designation, through shared OB coverage models, tele-OB consultation, maternal safety bundles, and partnerships with tertiary perinatal centers.
Hospital-at-Home & Post-Acute Care Optimization	Piloting or expanding Hospital-at-Home models, developing swing bed programs, building skilled nursing partnerships, and coordinating home health discharge transitions.
Care Coordination & Closed-Loop Referral Integration	Redesigning discharge planning, implementing closed-loop referral systems, building care transition programs, and integrating with community paramedicine and CHW programs.
Outpatient Service Expansion	Expand outpatient service lines that reduce avoidable admissions and ED visits (infusion, wound care, cardiac rehab, outpatient procedures); Develop service lines that generate sustainable reimbursement to support hospital operations; Integrate outpatient services with primary care and specialty partners.
Example Metrics - Increased number of specialty services available on-site or via telehealth - Reduced transfer rates for conditions manageable locally - Reduced ED boarding times - Increased swing bed utilization or days	

- Improved ED throughput (door-to-provider, door-to-disposition)
- Increased OB delivery volume or maintained OB service availability
- Reduced avoidable readmissions
- Increased outpatient service volume and revenue
- Retention rates for clinical staff
- Patient satisfaction scores (HCAHPS)

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 critical access and acute care hospitals. 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.

One-time technology purchases with no clear connection to operational or financial improvement are not competitive under this RFA. Applicants must outline at least one technology investment area below that they plan to leverage in their application.

Technology	Example Activities
Cybersecurity Assessments & Remediation	Comprehensive cybersecurity risk assessments (HIPAA Security Rule, NIST CSF); vulnerability scanning and penetration testing; 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. Year 1 priority: baseline assessment and critical remediation.
Diagnostic Equipment Upgrades	Imaging, cardiac monitoring, laboratory equipment that expands on-site diagnostic capability and reduces outbound transfers
Health IT / EMR Modernization & Interoperability	EMR upgrades, optimization, or migration to modern platforms; implementation of interoperability standards HL7 Fast Healthcare Interoperability Resources (HL7 FHIR), United States Core Data for Interoperability (USCDI); bidirectional data exchange with HIEs, payer systems, and partner organizations; real-time admission/discharge/transfer (ADT) notifications; interface development for laboratory, imaging, and consulting report exchange; EMR optimization for clinical documentation, order set standardization, and care plan management.
AI & Clinical Decision Support Tools	Predictive risk modeling for readmission, sepsis, or deterioration; clinical decision support tools integrated into EMR workflows; evidence-based clinical reference tools; AI-assisted coding and revenue cycle automation; denials prediction and prevention.

Clinical Efficiency Technology	Ambient listening / AI Scribe documentation (converting to Subjective, Objective, Assessment, Plan, and Evaluation (SOAP) format, reducing after-hours documentation); Predictive risk modeling; Clinical decision support; Evidence-based reference tools; Real-time bed tracking and capacity management
Revenue Cycle Management	Real-time or near real-time claims management and denial tracking; Automated prior authorization; Coding optimization; Charge capture improvement for cost-based reimbursement
Shared Services Technology	Interoperable EHRs across partner organizations; E-Consults (secure messaging with specialists); Shared care plans; Centralized billing systems; Aggregated regional analytics dashboards
Population Health Infrastructure	Shared patient registries for chronic conditions; Dashboards for preventive care, quality measures, and care gaps across a shared patient base; Predictive analytics for proactive outreach
Interoperability	EMR interoperability between providers; Real-time admission/discharge/transfer notifications; Secure bidirectional exchange of screening results, care plans, medication lists, lab/imaging results; Integration with NH Care Connections
Telehealth Equipment & Community Access Points	Telehealth platforms and carts for ED, inpatient, and outpatient settings; tele-specialty equipment (tele-stroke, tele-ICU, tele-OB, tele-psychiatry, tele-cardiology); community access point kiosks or mobile units in remote locations without broadband; patient-facing telehealth applications; store-and-forward technology for remote specialty consultation; integrated scheduling and video platforms.
Cross-County Nursing Home / Hospital EMR Integration Pilot	EMR interoperability between acute care hospitals and regional skilled nursing facilities (SNFs) and 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; closed-loop referral management between hospital and SNF; pilot models for regional post-acute data integration.
Closed Loop Referral Interfacing	Integration with the NH Care Connections Closed Loop Referral System (CLRS); bidirectional referral exchange between clinical and community-based service providers; social determinants of health screening data transmission; 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: Financial Sustainability

Funding under this focus area supports projects that strengthen the financial and operational performance of CAHs and Acute Care Hospitals. 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 through care coordination and discharge planning improvements; Optimize bed utilization and swing bed management
Revenue Cycle Performance	Enhance claims management through real-time monitoring and denial tracking; Improve revenue capture for billable services including cost-based reimbursement optimization; Coding and documentation improvement
Shared Infrastructure	Share administrative functions, billing systems, supply chain, or clinical support services among rural providers to reduce per-facility fixed costs; Regional procurement cooperatives
Cost Reduction	Implement technology or process changes that reduce long-term operating costs; Reduce avoidable admissions and readmissions; Optimize staffing models and reduce reliance on locum or contract labor
Sustainable Service Lines	Develop or strengthen service lines that generate sustainable reimbursement (outpatient services, infusion, wound care, cardiac rehab, telehealth billable services); 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; Housing and community integration support for recruited staff
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.

These examples are for example only and do not create additional eligibility requirements or preferences.

Example 1: Project Development Stage - Telehealth and Care-Coordination Model

Organization: A rural hospital has identified gaps in timely follow-up care and limited access to specialty outpatient consultations but has not completed the operational, technology, partnership, or financial planning required for implementation.

Proposed Project: The hospital requests funding to assess its current state and develop an implementation-ready telehealth and care-coordination model. Initial activities would include:

- analyzing patient needs, referral patterns, transfer patterns, 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 rural hospitals, outpatient providers, emergency medical services, behavioral health providers, and potential regional specialty partners;
- 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-Transforming Care Delivery	Develops a coordinated telehealth model intended to improve specialty access, strengthen transitions of care, and reduce avoidable transfers or travel for rural patients.
2. Technology	Assesses telehealth, interoperability, care-coordination, privacy, and cybersecurity requirements before making a larger technology investment.

3. Financial Sustainability	Establishes the expected costs, reimbursement opportunities, operating responsibilities, potential efficiencies, and long-term funding model needed to sustain implementation.
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Expected Deliverables and Outcomes: Deliverables would include a documented current-state assessment, defined partnership and governance structure, recommended work flows, 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 Acute Care Hospital Strengthening Technology and Operational Readiness

Organization: A rural Acute Care Hospital 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 hospital 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. 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 hospital 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 - Rural Hospital Tele-Specialty Model

Organization: Participating rural hospitals have documented specialty-access gaps and intend to partner with a health care organization qualified to, provide the specialty services via telehealth, operate through one coordinated specialty access telehealth model rather than developing separate programs.

Application Structure: One eligible organization must serve as the lead applicant and fiscal agent. The lead applicant may be a participating rural hospital or a partnering healthcare organization providing specialty services through telehealth, provided it meets the eligibility requirements in Section 2.1 of the RFA. The application must identify participating hospitals and other organizations, their roles, and their responsibilities. For organizations receiving a portion of the award as subrecipients, the application must define their scopes of work, deliverables, budgets, and performance expectations. The lead applicant remains responsible for oversight, performance monitoring, financial management, reporting, and compliance with applicable award requirements.

Note: Organizations may participate as partners or subrecipients in other applications when activities are distinct and funding is not duplicated. Participation as a lead applicant remains subject to Section 2.4 of the RFA. Project Development applications are not limited in number. For Preparatory Investments and Program Ready, an eligible applicant is limited to one application as the lead applicant.

Proposed Project: The applicant requests funding to implement a coordinated tele-specialty 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;
- implementing a sustainability strategy based on appropriate reimbursement, shared infrastructure, operational efficiencies, retained patient volume, and other identified revenue or cost-saving opportunities;
- identifying appropriate service lines and originating sites;
- developing the long-term sustainability plan to operate the coordinated specialty telehealth model beyond the term of the RHT grant; and
- subject to the limitations on using RHT funds to pay for services, provide the specialty telehealth services.

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 specialty access and care coordination across rural communities.
2. Technology	Uses shared telehealth, interoperability, cybersecurity, and reporting infrastructure to support reliable delivery across organizations.
3. 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 number of participating rural sites, service lines, the estimated and actual number of unduplicated rural patients served, specialty encounters completed, changes in appointment availability and wait times, avoided patient travel, referral completion, transfers avoided when clinically appropriate, technology adoption, patient and provider experience, financial performance, 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.