

TRANSFORMATION OF RURAL HEALTH (TORCH) CARE HUB¹ APPLICATION²

The Rural Health Transformation Program information provided by the Missouri Department of Social Services 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 \$216,276,817.66, 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.

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² See ToRCH Care overview webinars here - <https://mydss.mo.gov/mhd/rural-health>

- for details on Hub operations (e.g., program details, staffing details, context, etc.)

1. HUB ANCHOR APPLICATION

ToRCH Care – Hub Anchor Application

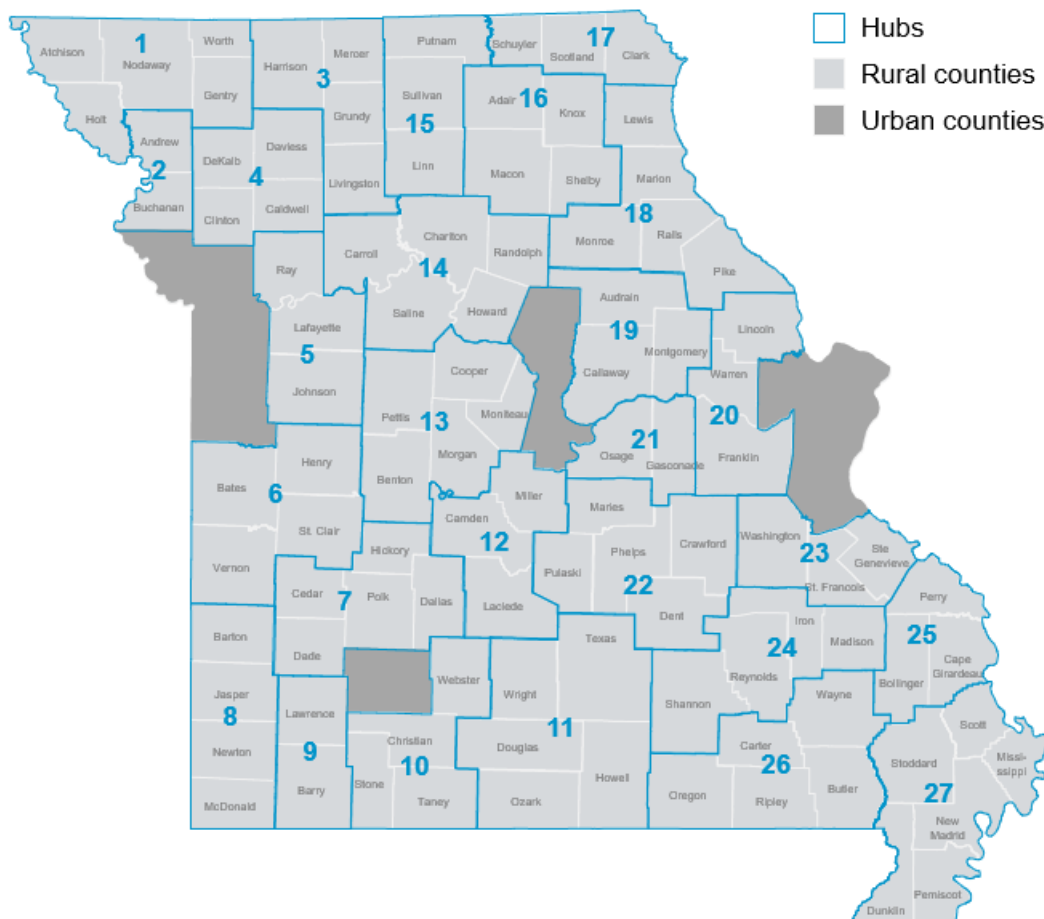
Maximum allowable application response length: 30 pages (not including letters of support attachments or appendices / exhibits). Applicants should use standard fonts at least size 11 pt and follow the section structure within this document within 1.1.1 through 1.7.1.

The application should be submitted as a single PDF containing the organization's application narrative and all appendices to DSS.RHTP@dss.mo.gov with subject line "Hub Anchor Application [insert your Hub number] - [Organization Name]".

Hub Anchor applicant webinar: May 19, 2026 at 11am CT. Registration link is [here](#)

Application Deadline: June 18, 2026

Hub Represented (see map below): _____



SECTION 1 — Proposed Hub Eligibility*

**See following “2. Hub & Hub Anchor Details Overview” for Hub roles and responsibilities details*

1.1.1 Hub Anchor Organization

Identify the organization proposing to serve as the Hub Anchor and demonstrate community alignment with its application.

Applicants should include:

- Organization name
- Organization type (e.g., hospital, FQHC, RHC, LPHA, CCBHC, pharmacy, CBO, other)
- Services currently provided to rural citizens
- Executive sponsor name and title (i.e., senior leader who will be accountable for the Hub within the organization, like a CFO)
- Description of prior convening or coordinating roles
- Attestation of Hub Anchor application specific webinar attendance or review of posted recording

Applicants may include information from (non-exhaustive, optional):

- Organizational mission statements
- Prior coalition leadership examples

1.1.2 Community Alignment & Partner Intent

Applicants must demonstrate meaningful community engagement prior to applying. Describe how partners were engaged in developing this application and their level of interest in participating.

Applicants must attach:

- Letters of support (where possible) from at least:
 - One clinical provider (hospital, FQHC, RHC, or CCBHC)
 - One pharmacy
 - One EMS / MIH-CP provider
 - One Local Public Health Agency (LPHA)
 - One Community-Based Organization (CBO)

Please also provide additional letters of support if received. These can include letters from organization types not listed and/or from multiple organizations of the same type.

- Unique letters of support should describe:
 - Anticipated role in the Hub
 - Willingness to participate in Leadership Board, data sharing, and workflows
 - The individual organization's perspective, role, and commitment to the Hub collaboration; **note that templated responses will not be accepted**

Applicants should also describe:

- Description of how partners were engaged in shaping this application
- How conversations were convened (meetings, calls, working groups)
- (Optional) Key themes or feedback that shaped the application

SECTION 2 — Governance & Community Leadership (25 points)

1.2.1 Reasoning for application

Applicants should include:

Provide a narrative describing your organization's motivation and rationale for serving as the Hub Anchor within your community. Include specific reasons why your organization is best suited to lead this effort on behalf of your community.

1.2.2 Proposed Hub Leadership Board Structure

Describe the proposed Leadership Board in detail including its proposed members, what sectors of healthcare they are associated with, and planned governance approach.

Applicants should include:

- List of **proposed members by role/sector** (names preferred but not required)
- For named individuals:
 - Brief bio (1–2 paragraphs)
 - Organizational role and decision authority
 - Confirmation of interest (email or letter)
- Record keeping processes (e.g., agendas, meeting minutes, bylaws, etc.) – *note copies of meeting agendas and minutes will be required to be shared with RCNs and RHTO*
- Sectors to be represented within the Leadership Board (e.g., clinical provider, LPHAs, CBOs, physicians, community leaders, data experts)

- Proposed decision-making and voting approach, including how data / fact-based analysis will be used to support decision-making
- Proposed Hub leadership board voting members (e.g., to determine priority needs and associated programs, placement of RHTP Navigator roles) and reasoning. There can be no more than 10 voting members, and there must be at least:
 - One clinical provider (hospital, FQHC, RHC, or CCBHC) voting member
 - One pharmacy voting member
 - One EMS / MIH-CP provider voting member
 - One Local Public Health Agency (LPHA) voting member
 - One Community-Based Organization (CBO) voting member
- Planned leadership board meeting cadence during onboarding and initial needs assessment (weekly minimum)
- Planned long term leadership board meeting cadence (monthly minimum)
- How both clinical and non-clinical partners will be meaningfully included
- (Optional) If an active Medicaid participant will be included on the leadership board, and if so, if included as a voting member

Applicants may source information from (non-exhaustive):

- Existing coalitions
- Advisory boards
- Executive referrals from partner organizations

SECTION 3 — Community Partnerships & Engagement Depth (25 points)

1.3.1 Partner Ecosystem

List existing and anticipated Hub partners by category with reasoning for expected partnership to demonstrate the strength and breadth of the potential partner ecosystem.

For every expected Hub partner, applicants should include:

The organization name, its counties served, provider type, services currently provided to rural citizens, and past partnership or reason for anticipated partnership in the future (e.g., current relationship status new, emerging, or active). Include expected Hub partners within each of the following sectors:

- Hospitals

- FQHCs
- Behavioral health centers
- Pharmacies
- Non-clinical provider
- EMS / MIH-CP
- CBOs (food, housing, transportation, etc.)
- LPHAs
- Other social entity (e.g., school, faith-based organization, fire department)

Expected partners to include may come from (non-exhaustive):

- Existing referral lists
- Community Health Needs Assessment partners
- Public health coalitions
- EMS service rosters

1.3.2 Community Engagement Approach

Applicants should include:

- Planned engagement mechanisms (forums, board meetings, working groups)
- How feedback will be collected and acted upon
- How data and technology will help ensure informed decision making
- How new partners addressing local needs will be onboarded at launch
- How the Hub will continue engaging partners and community voices beyond application submission

1.3.3 Strength of Existing Relationships

Applicants should provide:

Brief examples of prior multi-partner collaboration across healthcare, public health, EMS, and CBO partners, and the leadership role played if applicable.

1.3.4 Community support and partnership intent

Total number and diversity of letters of support will be factored into this section.

SECTION 4 — Operational & Staffing Readiness (25 points)

Report on ability to quickly recruit, select, staff and onboard new staffing (i.e., Program Coordinator and RHTP Navigators as applicable) after selection and demonstrate staffing model planning. Applicants and Hub partners should work together to plan where RHTP Navigators sit according to local needs.³

1.4.1 Hub Staffing Model

Applicants should include:

- Anticipated hiring timelines
- Expected placement of RHTP Navigators and reasoning⁴
- Whether positions are new or redeployed
- Existing staff who may transition
- Supervision structure
- Gaps requiring support (e.g., limited HR recruitment infrastructure, known care navigator pipeline shortage, training needs)

Applicants may source from (non-exhaustive):

- HR planning documents
- Prior care coordination programs

1.4.2 Ability to Activate Quickly

Applicants should include:

- Earliest possible start dates
- Known gaps requiring RCN or RHTO support
- Risks to timely onboarding
- Overarching description of readiness to begin onboarding immediately if selected (Stage Gates 1–2 as defined in Section 2.5.1)

SECTION 5 — Digital & Data Readiness (10 points)

Provide experience with data sharing and/or use of performance reviews in transparent and accountable measures to iterate organizational planning, demonstrating an ability to support coordinated workflows and reporting.

³ See section 2.4.6 for further details

⁴ See appendix A and Section 2.3.5 for further details

1.5.1 Data Sharing Commitment

Applicants should include:

- Prior experience with shared platforms (e.g., care coordination systems, community-based platforms, EHRs, MCO systems, HIE participation)
- Known barriers to data sharing
- Identification of a technical/data point of contact
- Statement of commitment to secure data sharing for care coordination and reporting purposes to meet ToRCH Care goals across Hub partners (clinical and non-clinical), including participation in a shared referral platform
- Narrative describing approach to cybersecurity controls, consent, privacy, and data governance for cross partner coordination (e.g., responsibility for consent workflows, documentation of information-sharing decisions)

Attachments encouraged:

- Draft or signed Data Sharing Agreements
(final reporting requirements and data elements are subject to change and may be defined at the State level after selection)

1.5.2 Prior Experience

Describe any experience, and to what degree, with:

- Regional or statewide health information exchanges (HIEs/HINs - e.g., SHINE, SPHERE)
- Community Information Exchange platforms aligned with modern interoperability standards (e.g., HL7 FHIR, USCDI, Gravity Project terminologies, LOINC-coded HRSN screenings, OAuth 2.0)
- Shared dashboards
- Population health analytics
- Data collection today, and data collection planned in the future
- Use of data to make informed clinical or programmatic decisions (provide examples)

1.5.3 Reporting & Performance

Applicants should include:

- Prior examples of performance reviews (e.g., tracking population health analytics to inform decision making)
- How the Hub Leadership Board will use dashboards
- Comfort with transparency and accountability

- Description of how metrics will be reviewed and used to inform decision making within your organization and the Hub

SECTION 6 — Initial Community Priorities and ToRCH Care Alignment (15 points)

Describe planned strategic focus with local needs program funding and understanding of the ToRCH Care program goals, demonstrating alignment between the two. Planned strategic focus and programs should be thought of collaboratively with prospective Hub partners and will be reviewed and finalized in later leadership board meetings.

1.6.1 Narrative of Proposed Hub Operations

Provide a short narrative describing how your organization intends to operate aligned with the RHTP mission and the ToRCH Care program.

Narrative should include:

- Planned collaboration with assigned RCN and the RHTO
- Plan to convene, identify, and work with Hub partners
- Description of how your organization's workflows, data, and partners will interact according to the outlined ToRCH Care activities (e.g., Hub based coordination workflows, technology usage, expected role in the partner ecosystem)
- Narrative of anticipated progression through the Stage Gates as defined in the Hub desktop procedures
- Narrative of intentional alignment of operations with the RHTP mission to bring high-quality care closer to home and improve healthcare access and outcomes in a systemic, long-term way.

1.6.2 Priority Focus Areas (Year 1)

Applicants should include:

- Identification of 1–3 priority focus areas for the first year (e.g., maternal health, behavioral health access, chronic disease, transportation).
- Data or other evidence (e.g., community health needs assessment) supporting each priority's relevance to regional population
- Why these are feasible early wins (e.g., ability to have near-term impact on local community needs)
- Which populations will be targeted

1.6.3 Proposed Localized Programs Alignment with the broader ToRCH Care mission (See Section 2.6 for further details)

Applicants should include:

- Identification of proposed localized programs to address community needs and associated reasoning / details (e.g., specific analysis / data supporting decision making)
- Specific program (e.g., home visiting, MIH-CP, NEMT) options to be prioritized
- Ranking of proposed programs by priority
- Which partners would lead implementation
- How programs align with ToRCH Care outcome/access goals
- How the Hub would coordinate activities
- Description of launch readiness for each localized program option selected

1.6.4 Connection to Hub Metrics

Applicants should include:

- Description of how success will be measured at the Hub level aligned to the proposed metrics in the ToRCH Care program
- How data will be collected⁵
- How results will be reviewed and adjusted

1.6.5 Learning & Adaptation

Applicants should include:

- Description of how the Hub will use data, feedback, and partner input to adjust strategies over time
- Use of feedback loops
- Openness to changing strategies
- Participation in regional learning forums
- Narrative of how the Hub model will be sustained over the five-year program period (e.g., operational, workforce, and other sustainability considerations)

⁵ *Certain data collection methodologies, definitions, and reporting elements will be specified at the State level and shared across Hubs to ensure consistency.*

SECTION 7 — Readiness Attestation & Commitment

1.7.1 Attestation

The applicant attests that:

- ☐ Community leadership understands the expectations of participation
- ☐ Community engagement has occurred in good faith
- ☐ The Hub is prepared to be held accountable to shared outcomes along with and across all Hub partners
- ☐ Participation will be neutral and collaborative

Authorized Signature: _____

Name / Title: _____

Date: _____

2. HUB & HUB ANCHOR DETAILS⁶

SECTION 1 – RHTP OVERVIEW

2.1.1 RHTP Vision And Objectives

[The Rural Health Transformation Program \(RHTP\)](#) offers Missouri an unprecedented opportunity to confront the longstanding challenges for the ~2.5 million Missourians in rural areas facing widening health disparities across three interconnected dimensions:

Access to care

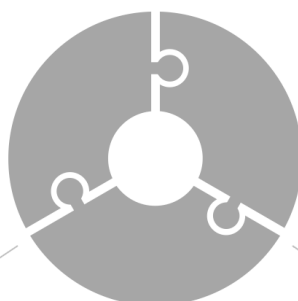
Rural residents often travel farther and wait longer for essential services.

Provider shortages and lack of affordable care contribute to unmet needs, especially in behavioral health, obstetrics, and chronic disease management.

Health outcomes

Chronic conditions, maternal health challenges, and behavioral health concerns are more prevalent in rural communities.

Delayed or deferred care leads to poorer outcomes that ripple through families and local economies alike.



Provider sustainability

Rural health systems – hospitals, clinics, FQHCs, and public health agencies – work tirelessly to serve our communities, but they operate under growing financial and operational strain. Many providers face workforce shortages, reimbursement pressures, and outdated infrastructure that make it difficult to sustain critical services.

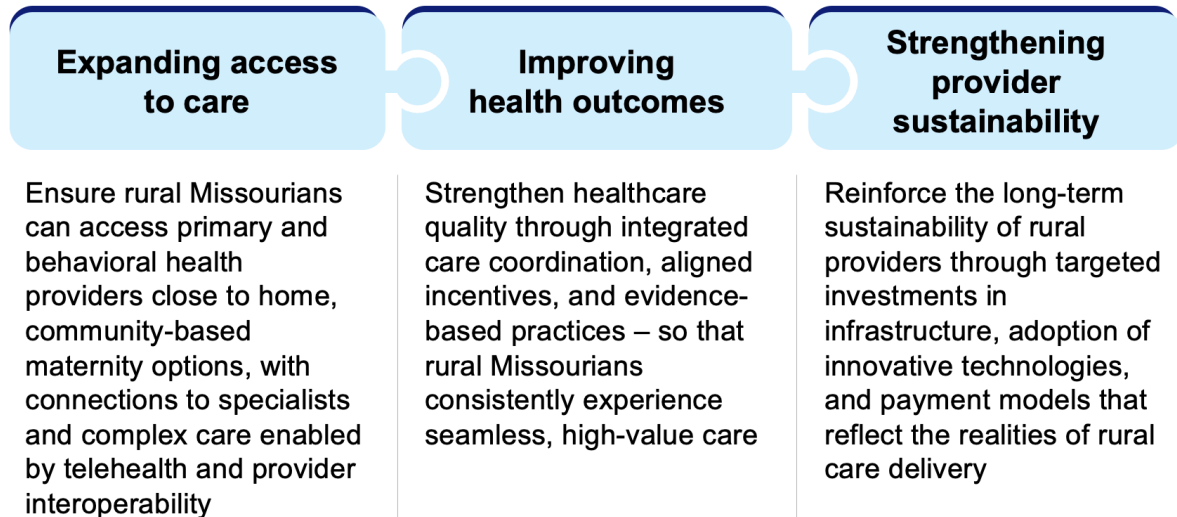
The program intends to pursue a bold and comprehensive vision that will fundamentally shift the healthcare experience for rural residents:

⁶ Note – Hub operations are subject to change

Our vision

Every rural Missourian has access to the high-quality care they need through a delivery system that is well aligned, community anchored, and built to last.

Our objectives



2.1.2 Transformation of Rural Community Health Care (ToRCH Care) Strategy

To bring the RHTP to life, Missouri is transforming how rural healthcare works through the Transformation of Rural Community Health Care (ToRCH Care) program. The program consists of a statewide network of healthcare Hubs designed to bring care closer to home, make clinical and non-clinical services more seamless, and ensure that no rural resident is left behind. ToRCH Care builds on Missouri's successful Transformation of Rural Community Health [\(ToRCH\) pilot](#), which proved that locally governed, data-driven collaboration can improve both outcomes and financial stability. Participating hospitals and clinics achieved measurable results, including a 19.6% increase in controlled blood pressure and an 18% increase in behavioral-health follow-up after ED visits.

2.1.3. ToRCH Care Key Performance Objectives

Through the ToRCH Care program, there are three key areas and eleven key success metrics Missouri hopes to achieve meaningful and measurable improvements on including:

- Access to care measures focusing on ensuring the entire rural population of Missouri has access to care, targeting a higher number of care touchpoints

- Healthcare outcome measures focusing on improving rural outcomes with meaningful gaps in care compared to urban areas including chronic diseases, maternal health, and behavioral health
- Sustainability measures focusing on ensuring the upkeep of planned initiatives and shared savings to enable long-term improvements to the healthcare ecosystem, long after RHTP funding comes to an end in five years

The following metrics were identified as priorities within Missouri's RHTP application:

Impact areas	Key performance objective ([C] = county-level metric)	Baseline	5-year Target
Access to Care	% of rural population with access to care and coordination through Hub partners [C]	N/A	100%
	Number of behavioral, maternal, and chronic care touchpoints supported through Hub partners [C]	N/A	≥ 60,000
	Rate of hospitalizations and ED visits BH diagnosis, improved by preventative behavioral health access [C]	4.2%	3.8% (≥10% reduction)
	Increase in rural primary care visits at touchpoints per rural resident	Baseline in Y1	≥10% increase
Healthcare Outcomes	ED visits per 1000 rural residents [C]	456	410 (≥10% reduction)
	% of adults with uncontrolled hypertension (>130/80) [C]	56.7%	51% (≥10% reduction)
	% of diabetic patients with controlled diabetes (A1C < 9%) [C]	63.6%	57–60% (≥5–10% increase)
	% of births with low birth weight (<2500g) [C]	8.4%	7.6% (≥5% reduction)
	Use of pharmacotherapy for opioid use disorder (OUD) among patients covered through Hub partners [C]	Baseline in Y1	≥5–10% increase
Sustainability	Service access restored or preserved	Baseline in Y1	≥80% approved projects operational
	Total earnings from APM participation [C]	N/A	To determine in Y1

2.1.4 Hub Overview

A **Hub** is the local **center for care coordination** in a rural community.

It is **not a new building or a single clinic**. Instead, it is a **formal partnership**, led by a Hub Anchor, among:

- Hospitals
- Federally Qualified Health Center (FQHCs)
- Behavioral health providers
- Emergency Medical Services / Mobile Integrated Healthcare
- Pharmacies
- Local Public Health Agencies (LPHAs)
- Rural Health Clinics
- Other primary care clinics
- Non-clinical providers such as community health workers, home visitors, doulas, peer support specialists, and other “bridge” providers

- Community-based organizations (CBOs) including but not limited to food banks, housing organizations, transportation providers, childcare, and other social support organizations
- Other social entities such as faith, fire, schools, and community groups

The Hub's job is to make sure that **when someone in the community needs help - medical, behavioral, or social - that person does not fall through the cracks.**

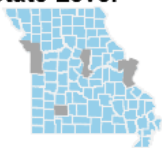
The Hub helps partners:

- See the **whole picture** of what a person needs across the entire health ecosystem (from clinical to non-clinical to CBOs to social)
- Know **who is doing what**
- Share information (with permission) so care is **coordinated instead of fragmented**
- Use data to **target the most pressing healthcare needs** in a local community and track improvement progress

2.1.5 RCN & RHTO Overview

To build the central foundation of ToRCH Care, seven Regional Coordinating Networks (RCNs) will connect and provide technical assistance and oversight to groupings of Hubs across the state. Both the RCNs and Hubs will be overseen by the statewide Rural Health Transformation Office (RHTO). Together, the RCNs and Hubs will form an integrated operating model that enables coordinated and improved care across providers with the ability to track outcomes and impact, ensuring that every rural Missourian can reach the right care without barriers.

State Level



The **Rural Health Transformation Office (RHTO)** will act as a central helper to RCNs and Hubs working in close partnership to ensure development is consistent with best practices, while maintaining flexibility for local adaptation

Regional Level



The **7 Regional Coordinating Networks (RCNs)** provide the **scale and power** to make local action sustainable through technical assistance and connection of regionally aligned Hubs

Three Missouri healthcare associations (MHA, MPCA, and MBHC²) will jointly anchor the RCN infrastructure

Local level



The **~30 Hubs** are the **front line** of engaged community partners¹ coordinating care at the **county-by-county level** and grounding decisions in a local context



1. Including but not limited to: Hospitals, behavioral health providers, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Local Public Health Agencies (LPHAs), EMS, pharmacies, and community organizations

2. Missouri Hospital Association, Missouri Primary Care Association, Missouri Behavioral Health Council

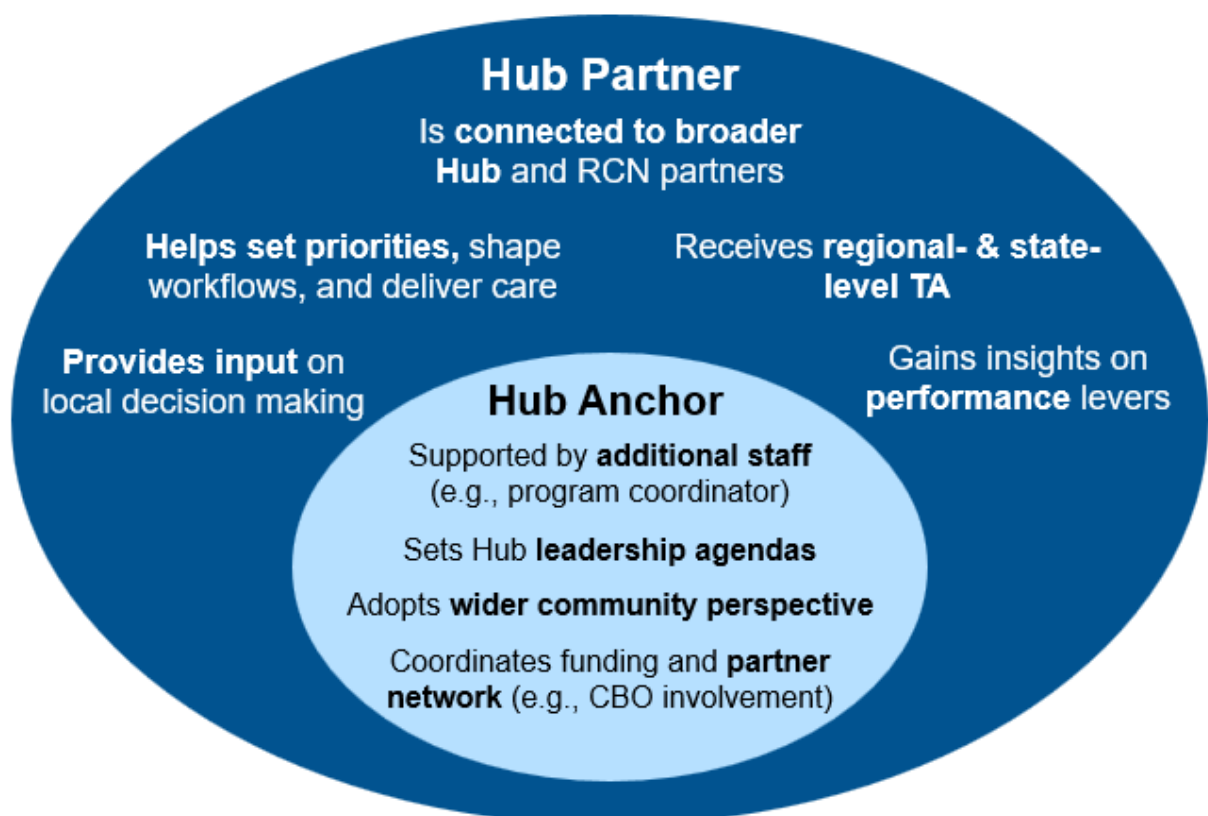
SECTION 2 HUB APPLICATION PROCESS

Missouri strongly encourages rural providers and prospective Hub partners to convene and collaboratively determine the most appropriate Anchor organization—or shared responsibility partner consortium structure - based on local capacity, trust, and operational readiness. The intent of the Hub application process is not to create competition among local providers, but to foster alignment and shared ownership of rural health transformation. Prospective Hub partners should work together to determine whether responsibilities (e.g., fiscal management, convening, staffing, data oversight) are best housed within a single lead entity or distributed across a consortium model with clearly defined roles.

SECTION 3 – HUB ANCHOR OVERVIEW*

**See Section 4 for additional information*

2.3.1 Hub Anchor Summary



Benefits of Serving as a Hub Anchor

Key benefits for Hub Anchors include:

- Additional staffing to support Hub workflows, review, and other responsibilities
- Establishment of leadership board agendas and operating procedures

- Gain a wider perspective of the local community's needs and current services
- Ability to coordinate funding and the Hub partner network
- Financial savings and improvement of front-end of operations (e.g., providing health care, not sick care) deriving from alternative payment models

2.3.2 Why the Hub Anchor Matters

Hub Anchors play a central role in strengthening collaboration, guiding shared community health priorities, and providing visible, neutral leadership in organizing partners – healthcare providers, public health, behavioral health, EMS, pharmacies, and community-based organizations - toward improved outcomes.

2.3.3 The Anchor's Role

The Hub Anchor is responsible for convening partners across its respective region and leading its community in creating change in the local healthcare system. The Hub Anchor hosts infrastructure, staff, governance, and coordination, and ensures partners can work together effectively. This includes convening a local Leadership Board, supporting shared decision-making, and managing the day-to-day operations that keep coordination moving.

The Hub Anchor will lead the selection of programs addressing local needs based on local community needs assessments, support coordination of select workforce training programs, and have opportunities to provide input on RHTO priorities (e.g., APM design) alongside other providers.

2.3.4 The Leadership Board as the Decision Forum

The Hub Leadership Board is where community priorities are set and resources are directed. Through this forum:

- Board members review data on local needs and outcomes
- The Board agrees on which issues to prioritize (e.g., maternal health, behavioral health access, chronic disease)
- Programmatic funding is directed to technical assistance options and partner-led initiatives that best address those needs
- The Anchor facilitates this process and ensures decisions are implemented, but decisions are made collectively

2.3.5 Hub Anchor Operations

- The Anchor employs, recruits, selects, and oversees the Program Coordinator. The Anchor will coordinate the location of the RHTP Navigators in

collaboration with Hub Leadership Boards and partners. Especially where there is more than one Navigator available, Hubs are encouraged to explore placing RHTP Navigators⁷ across multiple facilities within the Hub to align with ToRCH Care priorities and local needs. Navigators placed outside the Anchor will be recruited and managed by the host organization

- The Leadership Board—made up of local providers, EMS, LPHAs, pharmacies, non-clinical providers, and CBOs—sets priorities and approves how Hub resources are used
- The Anchor facilitates meetings, tracks progress, and communicates with the Regional Coordinating Network (RCN)
- Decisions are made collectively; the Anchor executes the group’s decisions

SECTION FOUR - ADDITIONAL DETAIL ON THE HUB ANCHOR ROLE

2.4.1 Hub Anchor Definition

A Hub Anchor is the **lead organization** responsible for convening and coordinating the **Local Community Hub** in its service area, directing services in the interest of patients and the community. Rather than “owning” all services, the Anchor utilizes their existing services and organizes hospitals, clinics, EMS, pharmacies, LPHAs, behavioral health providers, and community-based organizations (CBOs) into a **cohesive local network** that can plan together, share information, and act on community health priorities.

2.4.2 Hub Operational Role

The Hub operates as the local coordination engine for ToRCH Care. Its core functions include:

- Convening **clinical and non-clinical partners** on a regular basis.
- Coordinating **referrals, follow-up, and shared programs** across participating organizations.
 - Hub partners not actively using CIE systems will eventually have licenses revoked
- Using **data and dashboards** to understand local health needs and track progress.

⁷ See appendix A for Hub RHTP Navigator allocation details

- Implementing a defined set of **Hub Access programs** (e.g., MIH-CP, specialty consultation lines) and discretionary **localized programs according to local needs** (e.g., school-based care, non-emergency medical transportation enhancements, nutrition programs).
- Reporting performance and sharing learnings with the **Regional Coordinating Network (RCN)** and the **Rural Health Transformation Office (RHTO)**.

2.4.3 Hub Anchor Roles and Responsibilities

Introduction to Hub Anchor roles and responsibilities


Hub Anchors serve as the neutral coordinator of the Hub, driving the collective efforts of all Hub partners to improve local patient outcomes

- 
Governance of local Hub partners:
 - Host and support a Hub Leadership Board with key local partners
 - Set agendas, steer meetings, and ensure decisions are made and documented
- 
Coordination & workflow management:
 - Help partners agree on referral pathways (e.g., who gets NEMT, home visiting, BH referral)
 - Ensure staff (CHWs, EMS, CBOs) know when and how to connect patients
- 
Staffing & operational oversight:
 - Organize the hosting of Hub Program Coordinators and RHTP Navigators (with State-provided funds)
 - Select and help implement Hub Access and localized programs to address community needs
 - Ensure partner roles and responsibilities within each program are clearly defined
- 
Data & reporting:
 - Use dashboards and reports to understand local healthcare gaps and track Hub progress
 - Report performance and share learnings with RCNs and RHTO

2.4.3.1 Operational Leadership Responsibilities

The Hub Anchor is responsible for:

- Providing **day-to-day management** and staffing for the Hub (e.g., Hub Program Coordinator and RHTP Navigators).
- Hosting and supporting the **Hub Leadership Board** composed of key local partners, both clinical and non-clinical.
- Ensuring that **referrals, care coordination processes, and social support linkages** are organized and functioning effectively.
- Overseeing the Hub's **local workplan**, budget utilization, and performance tracking.
- Serving as the primary point of contact with the **RCN and RHTO**.

The Anchor is not expected to perform all services independently; rather, it is expected to **organize and lead the collective effort of participating partners**.

2.4.3.2 *Hub Anchor Responsibilities*

The Anchor role can be categorized into five primary domains:

A. Convening and Governance

- › Host and support a **Hub Leadership Board** with key local partners.
- › Set agendas, facilitate meetings (minimum monthly), and ensure decisions are made and documented.
- › Effectively communicate information passed down from the RCN or RHTO to Hub partners (e.g., directives, strategies, successes, and failures)

B. Coordination and Workflows

- › Facilitate agreement among partners regarding **referral pathways** (e.g., who gets NEMT, home visiting, behavioral health referrals).
- › Ensure that partner staff (CHWs, EMS, CBOs) understand when and how to connect patients.
- › Continuously assess the local landscape of clinical and social care services to ensure all are working in unison to support ToRCH Care success

C. Staffing and Operations

- › Host a **Hub Program Coordinator and RHTP Navigators (depending on local needs⁸)** supported by state funding.
- › Support daily operational coordination, program implementation, and follow-up tracking.

D. Data and Reporting

- › Utilize reports and dashboards provided by RCNs and the RHTO to identify local gaps and track progress.
- › Submit required reporting to the **RCN and RHTO**.

E. Program Implementation

- › With the Hub leadership board, select and support implementation of a limited number of **Hub Access** and **discretionary localized** programs annually.
- › Clarify roles and responsibilities among partners for each selected program.

2.4.4 Governance and Decision-Making Structure

⁸ See section 2.4.6 for further details

2.4.4.1 Hub Leadership Board Responsibilities

The Hub Leadership Board is responsible for:

- Establishing bylaws and voting rules.
- Reviewing local needs and performance metrics.
- Selecting **Hub Access** and **localized** program priorities annually.
- Approving partner roles and workflows.
- Providing input, supported by data or other forms of analysis, on allocation of Hub funds across projects.
- Identifying operational barriers and requesting support from the RCN or RHTO as needed.

2.4.4.2 Participation Expectations

Participation expectations include:

- **Monthly Hub Leadership Board meetings** (1–2 hours), with more frequent meetings (weekly) during the onboarding / needs assessment period.
- **Quarterly in-depth reviews** of metrics, budgets, and strategic priorities.
- An **initial setup period of approximately 3–6 months** to establish governance, workflows, and staffing (timing dependent on Hub Anchor capacity).

Day-to-day operational responsibilities are expected to be carried primarily by the Hub Program Coordinator and staff, rather than executive leadership.

Participation in value-based payments will be encouraged and may be expected over time, if the model applies to the Anchor organization. Providers will have the opportunity to give input on the design and will have opportunity for support in implementation.

- Early on, the focus of the Hub is on coordination, workflows, and data to support health outcomes.
- Over time, as the alternative payment model matures, Hub providers will have the opportunity to participate more directly in an alternative payment model. Support will be provided to Hub-participating organizations over time to support model adoption.
- Being an Anchor positions providers and partners to benefit when those models are implemented.

The Hub Anchor is responsible for **facilitating and coordinating**, not for controlling partner behavior. Expectations include:

- Clear communication of expectations to partners.
- Documentation of roles and agreements (e.g., MOUs).
- Use of data to identify gaps and performance challenges.
- Engagement with the RCN to address emerging issues.
- Coordinate with RCN and RHTO to review compliance and KPO tracking.

2.4.5 Partnership Model and Scope of Services

2.4.5.1 Clinical Service Provision

The Hub model is structured around **partnership, not vertical integration**. The Anchor:

- Coordinates across **multiple providers and CBOs**.
- Aligns responsibilities among participating organizations.
- Ensures there is **no “wrong door”** for individuals seeking care.
- Tracks and monitors referral closure.

Clinical services remain the responsibility of **existing providers** (e.g., hospitals, FQHCs, primary care providers, behavioral health agencies, EMS, pharmacies), with the Hub strengthening coordination among them.

2.4.5.2 Eligible Hub Anchor Organizations

No organizations are ineligible to be an Anchor, but ideally Anchors will have the infrastructure required to support closed loop referral systems and additional staffing to coordinate local providers. Examples of eligible Hub Anchor organizations include:

- Hospitals (especially rural or critical access hospitals)
- FQHCs / RHCs
- Local Public Health Agencies (LPHAs)
- Behavioral health providers (e.g., CCBHCs)
- Multi-site primary care organizations
- In some cases, large multi-service CBOs with strong health partnerships

The selection of Hub Anchors is not based on the type of organization, but the organization's understanding of TORCH Care, **ability to convene partners, manage a coordination team, and steward shared work effectively**.

2.4.5.3 Potential Shared Anchor Responsibilities

In some regions, shared leadership arrangements may be appropriate, such as:

- A hospital and FQHC to share Anchor responsibilities, or
- A LPHA and hospital to co-lead the Hub, or
- Other numerous potential collaborative structures

In such arrangements, one organization remains the **formal Anchor**, but responsibilities can be shared through:

- **A joint leadership agreement,**
- Co-chairs on the Board, or
- Delegated responsibilities (e.g., one manages data, the other manages governance).

2.4.6 Staffing, Workload, and Funding

Hub staffing model: Guiding principles

The RCN overarching non-profit-entity is responsible for employee contracting

- Funding and direct employee reporting lines route through the Regional Coordinating Networks
- Hub Anchors and other Hub partners do not act as fiscal agents

Placement of RHTP Navigators¹ is flexible based on local needs

- During the application period, Hubs will work to select priorities for health outcome improvements
- Based on those needs, Hubs will decide where RHTP Navigators sit
- Recruitment, selection, and employee oversight will be routed through the organization in which the RHTP Navigators sit

Placement of Program Coordinators (PCs) is always with Hub Anchors

- Program Coordinators will always sit with the Hub Anchor organization to assist with Hub Anchor responsibilities

2.4.6.1 Workload Considerations

Serving as a Hub Anchor entails additional responsibilities; however, **dedicated staffing support is allocated** (Program Coordinator & RHTP Navigators allocated to Hubs according to local needs⁹) to prevent overextension of existing roles. The objective is to **centralize coordination** functions and reduce duplication across organizations.

⁹ Retitle of previously named "Community Health Workers" as these roles will be focused on implementing ToRCH priorities and aligning community partners, not providing direct care services

See appendix A for details on RHTP Navigators allocated per Hub according to Medicaid populations.

Executive engagement is particularly important during early implementation. As processes stabilize and staff are in place, Hub operations are intended to become **structured and repeatable**.

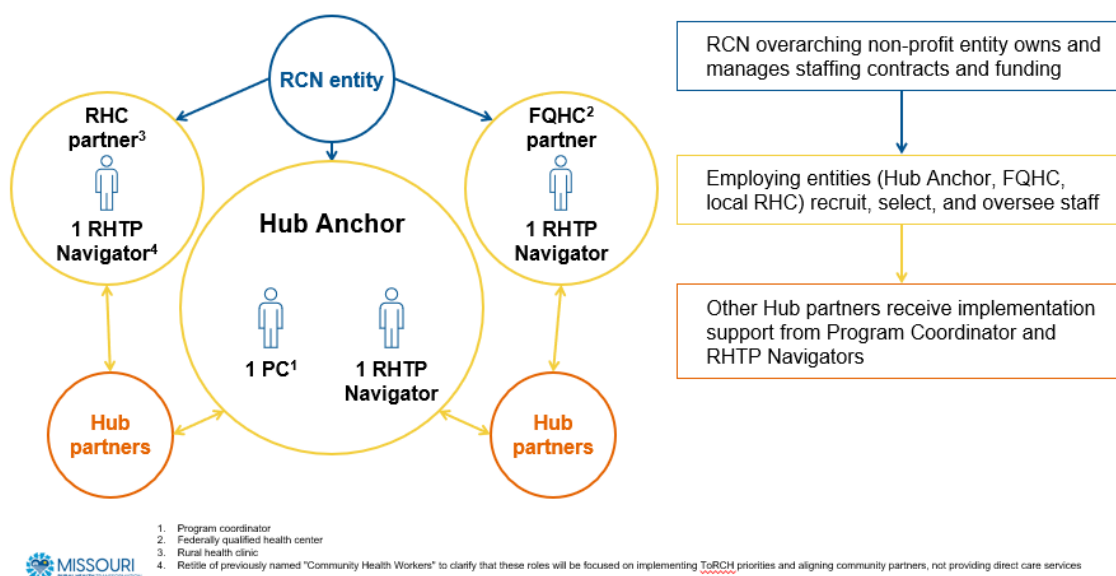
2.4.6.2 Funding and Resource Access

Anchors may access:

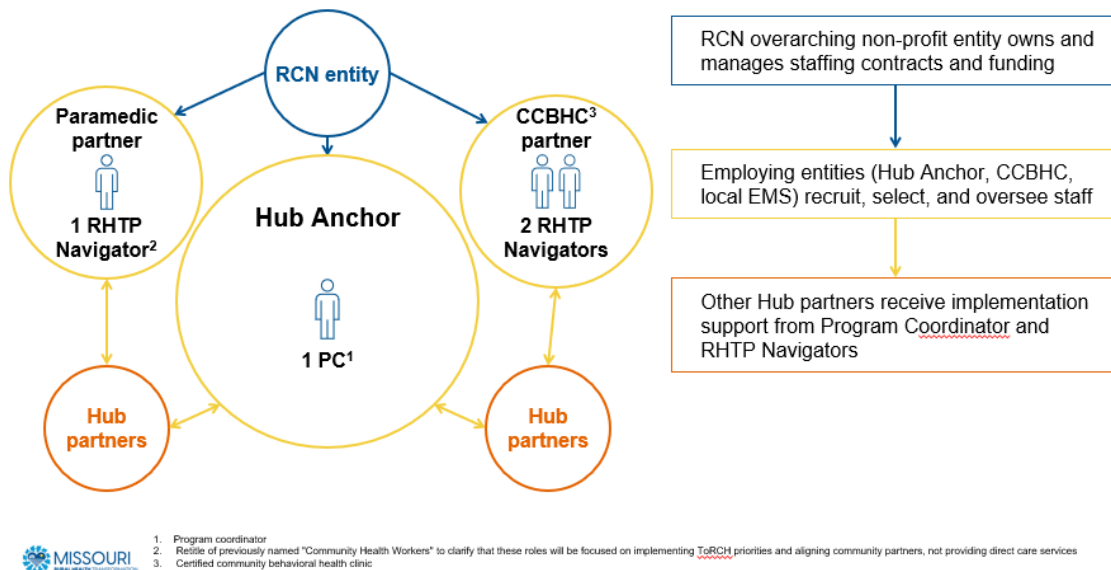
- Direct allocation of Hub-dedicated staff positions (Program Coordinator & allocated RHTP Navigators).
 - RHTP Navigators may be assigned to Anchors or other Hub partners depending on local needs with reasoning for placement provided.
- **In-kind support** via RCN TA, training, templates, and data infrastructure.
- Positioning for long-term participation in **shared savings and performance-based payments** as alternative payment models mature.

2.4.6.3 Illustrative Hub staffing models

Illustrative Hub staffing model: Hub prioritizes reducing emergency visits



Illustrative Hub staffing model: Hub prioritizes improving behavioral health



2.4.7 Data and Technology Participation

Hub Anchors are expected to:

- Coordinate provider transformation technologies (Ambient AI, telehealth, RPM) from the vendor to IT teams as a point of contact – Anchors are not expected to be data experts.
- Participate in the **Community Information Exchange (CIE)** and digital health backbone.
- Support Hub staff in documenting referrals and services using shared tools.
- Ensure basic data flows among partners (e.g., referral completion and service delivery tracking).
- Use dashboards to inform decision-making and report progress to the Leadership Board.

Anchors are not expected to develop independent technology systems but are expected to **use provided tools** and **leverage their existing infrastructure / expertise** (e.g., EHR workflows).

2.4.8 Relationship with the Regional Coordinating Network and RHTO

2.4.8.1 Interaction with the RCN

The Anchor works closely with the RCN Regional Director and technical assistance staff. Responsibilities include:

- Submission of required Hub data to the RCN for aggregation and analysis.

- Participation in performance review and program adjustment discussions.
- Engagement in scaling and replication of effective practices.
- Coordination on funding and contracting processes where applicable.

The RCN functions as the **regional backbone**, while Anchors operate as the **local engine**.

2.4.8.2 Support from RCN and RHTO

Anchors can expect:

- **Standardized onboarding materials** (checklists, templates, example workflows).
- Training and TA on:
 - › Governance and running effective Hub meetings
 - › Using the CIE and digital backbone
 - › Data reporting and dashboards
 - › Implementing specific localized programs
- Help troubleshooting **partner engagement, data issues, or operational bottlenecks**.
- Access to **regional learning forums** with other Hubs.

2.4.9 Readiness support

Organizations that are interested but uncertain of their readiness will receive structured support from the RCNs and RHTO. Anchors may expect:

- A comparative **readiness assessment** (governance, staffing, digital, partnerships) based upon Hub Anchor applications.
- Concrete feedback on what needs to be in place.
- TA to help Anchors move from “interested” to “ready” over time.

Anchors are not expected to be perfect on Day 1; they are expected to **engage honestly and commit to building capacity**. The RHTO will provide support to move Hubs from one stage of readiness to the next.

SECTION FIVE – HUB ONBOARDING AND OPERATIONAL CHECKLIST

2.5.1 Hub Onboarding & Operational Stage Gate Checklist

Stage Gate	Focus	Core Readiness Areas	Standard Timeline
0 – Application and Community Alignment	Community engagement	Hub Anchor identified, partner support documented, needs assessment completed, readiness confirmed	May 15 – Early July (Anchor application release through Hub Anchor selection)
1 — Governance Formation	Organizational foundation	Board, charter, COI, cadence, Anchor board briefing	~1 month
2 — Staffing & Partner Commitments	People & partnerships	PC/RHTP Navigator; MOUs; DSAs; partner onboarding	~3 months
3 — Program Implementation	Core operations	Escalation pathway, operating rhythm, localized program selection, implementation plans	~2 months
4 — Workflow Design & Technical Integration	Systems & training	Care coordination, SDOH, intake, documentation; CIE, digital backbone, workflow testing	~3+ months <i>(dependent on CIE vendor capabilities)</i>
5 — Full Launch Verification	Go-live certification	Referral testing, data tests, partner access, RCN certification	~1 month

STAGE GATE 0 — Application and Community Alignment

Objective: Confirm that the applicant has completed the foundational, community-facing work required to submit a credible Hub application reflecting real community alignment

Items:

Hub Anchor Application

- ☐ **Identification of proposed Hub Anchor and executive sponsor:** Hub Anchor applicants self-identify and provide executive sponsor name
- ☐ **Summary of community engagement activities:** Hub Anchors report how community stakeholders were engaged in the application process, and the plan to continue engaging the wider community throughout its existence

- ☐ **Readiness to proceed confirmed:** RHTO reviews and confirms sufficient readiness from applicants to begin full launch support with consultation from associations
- ☐ **Initial needs assessment completed:** Hub Anchor with the assistance of Hub members use data-based information (such as Community Health Needs Assessments) to identify and select priorities for health outcome improvements aligned with RHTP and ToRCH Care priorities
- ☐ **RHTP Navigator distribution decided:** Following the initial needs assessment, Hubs work to decide what provider locations RHTP Navigators sit in based on those needs

Governance & Leadership

- ☐ **Preliminary Leadership Board composition:** Hub Anchor applicants put together a leadership board of local leaders across clinical and non-clinical care providers in their community willing to participate in ToRCH Care leadership. Hub Anchor works together with partners to identify voting and non-voting members, ensuring diversity of partners and availability for all members to listen and participate regardless of voting rights.

Partner Engagement

- ☐ **Partner letters of support / intent:** Local clinical and community partners endorse Hub Anchors through letters of support

STAGE GATE 1 — Governance Formation & Foundational Agreements

Objective: Establish the leadership structures and core commitments needed for the Hub to function as a coordinating entity.

Items:

Governance & Leadership

- ☐ **Leadership Board established:** Hub has formally convened its required multi-sector governance body with confirmed members
- ☐ **Governance charter approved:** Board has adopted a written charter outlining roles, responsibilities, and decision-making authority
- ☐ **Conflict-of-interest statements completed:** Board members have submitted required disclosures to ensure transparent and impartial governance
- ☐ **Meeting cadence established (minimum monthly):** Recurring schedule for Board meetings has been set and communicated to all members

Operational Processes

- ☐ **Programmatic selection controls & processes in place:** Implement repeatable programmatic controls, clear decision rights, and established use of data to select programs addressing local needs for current and future years of the program

Program Activation

- ☐ **Community needs assessment reviewed and program priorities confirmed:** Hub leadership board coordinates and finalizes a comprehensive needs assessment to

identify and rank priority localized programs and confirm alignment with initial priority programs as outlined in the Hub Anchor application

STAGE GATE 2 — Core Staffing, Workforce, & Partner Commitments

Objective: Ensure the Hub has operational capacity (people + partners) to coordinate local systems of care.

Items:

Staffing & Workforce

- ☐ **Program Coordinator hired:** Hub full-time FTE responsible for daily operations, coordination, and compliance has been onboarded. FTE is recruited, selected, and overseen by lead Anchor provider with identified supervision structure of staff
- ☐ **Program RHTP Navigators hired:** Trained community-facing workforce is in place to support outreach, navigation, and local CBO participation. FTEs are recruited, selected, and overseen by their respective employing entities as determined by Hub partners with identified supervision structure of staff
- ☐ **All staff trained on ToRCH Care fundamentals:** Program staff have completed orientation on program goals, expectations, operating principles, and base level technology training

Partner Engagement

- ☐ **Hub Anchor organization's leadership (e.g., hospital board) informed of the ToRCH Care program (if needed):** Hub leadership board (e.g., program coordinator) has presented to the Anchor's existing board of directors on the ToRCH Care program and its impact on provider functions and interactions
- ☐ **Partner directory completed (healthcare, CCBHC, EMS, LPHA, pharmacies, non-clinical providers, CBOs):** Hub has compiled a comprehensive directory of clinical, behavioral, EMS, pharmacy, LPHA, non-clinical providers, and CBO partners with key personnel contact information and services offered
- ☐ **All required MOUs (provided) executed:** Standardized written agreements establishing roles and responsibilities with key partners have been signed
- ☐ **Data Sharing Agreements (to be provided) completed:** Partners have approved the standardized data-sharing terms required to exchange information securely¹.
- ☐ **Partner onboarding/orientation sessions delivered:** Partners have received training on workflows, expectations, base level technology, and coordination processes
- ☐ **Partner contact directory distributed:** Centralized, updated list of partner contacts is shared with Hub staff and collaborators

Program Activation

- ❑ **State reviews and confirms Hubs local programs:** Local programs are proposed and guidance from the RHTO and RCN are issued to ensure alignment of programs with ToRCH Care priorities
- ❑ **Priority programs finalized and requests for applications are launched:** Hubs finalize priority programs from RHTO and RCN guidance and open an application period to select specific implementation partners

STAGE GATE 3 — Program Implementation

Objective: Establish the core operating processes and program infrastructure that allow the Hub to coordinate care consistently and reliably

Items:

Operational Processes

- ❑ **Escalation pathways defined (Hub → RCN → RHTO):** Protocols are in place for elevating clinical, operational, or technical issues to the RCN or RHTO (see governance and operating procedure templates)
- ❑ **Partner referral support escalation pathways defined:** Hub point of contact is identified to support CBOs requiring assistance from the Hub on referral issues, and timelines on referral steps are finalized (e.g., time for CBOs to act on a referral, close referral loops, etc.)
- ❑ **Operating rhythm established (partner meetings, reporting cadence):** Hub has set and communicated its recurring internal and partner meeting schedule and reporting timelines

Program Activation

- ❑ **Initial localized program selections approved and procurement pathways launched:** Hub has chosen local programs/interventions based on community needs, leadership board recommendations, RCN guidance, and RHTO approval and opens a period for local organization applications to fulfill needs
- ❑ **Implementation plans completed for selected programs:** Hub has planned implementation progress tracking and activation for local programs/interventions selected
- ❑ **Community communication plan deployed:** Program launch announcements and outreach materials have been distributed to local stakeholders
- ❑ **Update partner directory:** Hub has identified at least one primary partner (such as a non-emergency medical transportation CBO if transportation needs are prioritized) to drive every outlined local priority

Program Activation

- ❑ **Localized programs contracted:** Implementation partners for localized programs are selected and enter contracting with RCN non-profit entity to provide services prioritized by Hubs

STAGE GATE 4 — Workflow Design and Technical Integration

Objective: Confirm that technical systems are in place to support coordinated care.

Items:

Technical Integration

- ☐ **Digital trainings rolled out by CIE vendor:** Once vendor is onboarded, workflow, digital, and programmatic training and education will be implemented for Hub Anchor and partner staff.
- ☐ **Care coordination workflow finalized:** Hub has defined and documented its full referral, follow-up, and handoff processes for both clinical and social care referrals and handoffs (e.g., through EHR and CIE platforms). Support to be provided from state, RCNs, and vendors, with state-wide standards and guardrails to be shared.²
- ☐ **Intake & documentation procedures finalized by CIE Vendor:** Hub has set consistent rules for how client interactions are recorded and tracked with support from the state, RCNs, and vendors. State-wide standards for platform-level automation, data validation, and role-based access controls to be shared.
- ☐ **SDOH screening workflow finalized:** Staff follow a standard process for identifying social needs and initiating appropriate referrals using the standardized social needs screening tool and specifications as defined by DSS
- ☐ **Care coordination and SDOH workflows finalized:** Once CIE and EHR vendors are fully onboarded, full referral, follow-up, and handoff processes through the new or existing platforms are finalized
- ☐ **CIE access provisioned, accounts created and tested:** Staff and partners have working accounts and can successfully execute referral and documentation functions³
- ☐ **EHR and CIE backbone connectivity validated:** Hub confirms technical connection to the statewide data backbone for reporting, communication, and interoperability in coordination with the state and RCN
- ☐ **Workflows tested among all partner types:** Successful testing of CIE platform and referral workflows by all provider types present in the Hub, and successful testing of broader data integrations (e.g., HER system connections) with support of vendors and RCNs to enable system integrations
- ☐ **Data-entry processes/workflows established with connection to state:**
Procedures are in place to ensure accurate and timely input of required data fields and metrics per data sharing agreement and MOU

Program Activation

- ☐ **Hub Anchor and Hub partner staff trained on CIE, referral workflows, & compliance:** Hub Anchor staff and partner providers staff (supported by Hub FTE) understand how to use digital systems, follow workflows, and adhere to security and privacy requirements

STAGE GATE 5 — Full Launch Verification (Go-Live Eligibility)

Objective: Validate that the Hub can operate safely, reliably, and consistently at go-live

Items:

Pre-Launch Verification

- ☐ **End-to-end referral pathway tested:** Hub has successfully run simulated referrals through key clinical (e.g., EHR, care management systems, etc.) and community partners (CIE)
- ☐ **Data submission test passed:** Hub confirms it can produce and transmit all required reporting elements accurately
- ☐ **Partner system access validated:** Hub confirms all Partners have access to required operating systems and referral workflows (e.g., CIE platform, appropriate HER workflows and access as needed for documentation and coordination)
- ☐ **RCN readiness certification received:** RCN verifies that the Hub meets all required criteria to move forward with go-live

SECTION SIX - LOCALIZED PROGRAM DETAILS

Localized program selection is a structured way for Hubs to fund initiatives meeting local needs. Hubs will work together to complete data-based analysis feeding into decision making on program selection. The initiative is designed to ensure that Hubs can tailor **high-impact, evidence-informed programs** tailored to the needs to their own communities.

Each localized program proposal is defined by:

- What it entails (core program model)
- Community needs fulfilled
- Potential delivery partners
- Enablers of Hub success
- System-level benefits
- Connections to Hub metrics, workflows, and processes

Below is an overview framework that applies across proposed localized programs, followed by examples of how it works in practice. As localized programs are adapted over time, Hubs will have the option to continuously identify and launch priority programs. Programs identified should follow the following template:

2.6.1 CORE COMPONENTS OF LOCALIZED PROGRAM OPTIONS

Each localized program option should be documented in a standard format that includes:

1. **Program Description (“What It Entails”)**
 - A concise description of the program model (e.g., *perinatal home visiting, school-based health access, nutrition and food-as-medicine, non-emergency medical transportation, behavioral health linkage*).

- Core activities (e.g., home visits, screening, group education, referral and follow-up, remote check-ins).
- Operational “footprint” (who does what, where, and how often).
- Criteria that must be met prior to deploying the program (e.g., readiness review)

2. Community Needs Fulfilled

- Primary need(s) targeted (e.g., maternal health, pediatric behavioral health, chronic disease, housing/food insecurity, transportation barriers).
- Target populations (e.g., pregnant/postpartum, dual eligibles, medically complex, youth, seniors).
- Linkage to known local gaps identified through:
 - CHNA / LPHA data
 - Hub needs assessment
 - ED utilization patterns
 - Stakeholder input

3. Potential Delivery Partners

- Likely lead implementers:
 - Hospitals / FQHCs / RHCs
 - LPHAs
 - CBOs / food banks / housing orgs
 - EMS / MIH-CP
 - Pharmacies
 - Schools / school-based health
- Role clarity: **who owns** outreach, screening, service delivery, follow-up, documentation, and reporting.

4. Enablers of Hub Success (Hub-Level Responsibilities)

- Hub’s role in **convening partners**, defining the local model, and aligning workflows.
- Use of **standard templates** (MOUs, referral forms, consent forms, scripts, care pathways).
- Ensuring **data connections** to CIE and digital backbone (e.g., integration with relevant health information exchanges) to track referrals, services, and outcomes.

- Defining **staffing and capacity** (e.g., CHWs, navigators, nurses, EMS CP, peer supports) and ensuring training is completed.
- Setting **clear performance expectations** and review cadence (e.g., monthly review of enrollment, follow-up, closed-loop referrals).
- Establishing a risk management plan with mitigation strategies to ensure success is achieved
- Supporting adoption of provider transformation technologies as appropriate (e.g., Ambient AI, remote patient monitoring, telehealth)

5. System-Level Benefits

- How the program moves the system from reactive care to **proactive, coordinated care** (e.g., preventing crises, avoided ED visits, earlier connection to services, providing services where the patient lives).
- How it supports **Hub and RCN objectives**, such as:
 - Reducing preventable ED and inpatient utilization
 - Improving disease control (HTN, diabetes)
 - Improving maternal/infant outcomes
 - Increasing behavioral health access and follow-up
 - Improving long term sustainability of health care system through improved health outcomes
- How it supports **RHTO value-based goals** by shifting care upstream and coordinating across sectors.

6. Connections to Hub Metrics, Workflows, and Processes

- **Key metrics** to be tracked by vendors associated with ToRCH Care objectives and local needs assessment, such as:
 - # screened, # enrolled, # visits completed
 - Changes in ED visits/hospitalizations for target group
 - Condition-specific measures (e.g., BP control, A1c, missed appointments)
- **Workflow integration:**
 - Where in the patient journey the program plugs in (e.g., ED discharge, prenatal intake, school nurse referral, CHW screening).
 - How referrals are entered and tracked in the CIE (Finalized following CIE vendor onboarding, Support to be provided from state, RCNs, and vendors, with state-wide standards and guardrails to be shared).
 - How follow-up tasks get assigned and closed.

- **Reporting cadence:**
 - Monthly Hub-level dashboard
 - Monthly RCN review
 - Quarterly RHTO roll-up

2.6.2 EXAMPLE LOCAL PROGRAM OPTION: SCHOOL BASED CLINICS

School-Based Health & Behavioral Support

What It Entails

- School-based clinics or telehealth stations link students to primary care and CCBHC services.
- School nurses, counselors, and CHWs identify and refer students with health or behavioral concerns.

Community Needs Fulfilled

- Addresses unmet pediatric primary care and behavioral health needs in rural communities with few pediatric providers.
- Supports early identification of mental health, asthma, chronic conditions, and unmet SDOH.

Potential Delivery Partners

- School districts, school nurses, counselors
- FQHCs, pediatric practices, CCBHCs, dentists
- CBOs providing youth services, mentoring, or family supports

Enabling Success (Hub-Level)

- Hub convenes school leaders and clinical partners to define the referral and consent process.
- Sets protocols for when a student is referred to telehealth vs in-person care.
- Ensures technical readiness (telehealth station, broadband, private space).
- Aligns with existing safety, privacy, and communication policies between schools and providers.

System-Level Benefits

- More consistent preventive care and behavioral health access for children and adolescents.

- Reduced absenteeism, minimized classroom disruptions, fewer crisis visits, improved continuity of care.
- Early intervention for behavioral and developmental concerns.
- Reduction in children within the community developing long-term chronic conditions later in life.

Connections to Metrics & Workflows

- Potential metrics: # student visits, # behavioral health referrals, # of telehealth visits, follow-up rates, avoidable ED visits for school-aged children, Follow Up after Hospitalization for Mental Illness (FUH) and Follow Up After ED Visit for Mental Illness (FUM), HEDIS measures.
- Workflow: school identifies concern → parent consent → telehealth or clinic referral → EHR documentation → behavioral health or primary care follow-up.

2.6.3 EXAMPLE LOCAL PROGRAM OPTION: NUTRITION PROGRAMS

Food-as-Medicine Programming

What It Entails

- Programs that leverage nutritious food and nutrition education to prevent, manage, and treat diet-related conditions, integrating food access with clinical care through interventions like medically tailored meals or produce prescriptions to improve health, nutrition security, and health equity.
- May include medically tailored meals, produce prescriptions, or nutrition education.

Community Needs Fulfilled

- Addresses food insecurity and diet-related chronic disease (diabetes, HTN, obesity).
- Particularly relevant for communities with limited access to healthy food.

Potential Delivery Partners

- Food banks, local farms, community kitchens.
- FQHCs, primary care clinics, pharmacies (for produce prescriptions).
- CBOs providing nutrition education, cooking classes, or medically tailored meals.

Enabling Success (Hub-Level)

- Hub aligns clinical partners and food providers on eligibility criteria and referral process.
- Ensures referral workflows are documented and tracked in the CIE.
- Defines how clinical partners integrate food-as-medicine into care plans (e.g., nutrition referral as part of diabetes visit).

- Monitors capacity and adjusts program scale based on demand and available resources.

System-Level Benefits

- Improved chronic disease control and reduced ED visits linked to poorly managed chronic conditions.
- Integrates clinical and social supports into one coordinated journey.

Connections to Metrics & Workflows

- Potential metrics: # referred, # receiving services, changes in A1c/BP, ED visits among participants.
- Workflow: clinic identifies eligible patient → nutrition referral via CIE → food provider fulfills → CHW follow-up.

2.6.4 EXAMPLE LOCAL PROGRAM OPTION: NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

What It Entails

- Local augmentation of NEMT, provides essential rides for people needing to reach healthcare appointments, bridging gaps for those with disabilities, the elderly, or lack of transport, using options like accessible vans, taxis, public transit passes, or mileage reimbursement, all while reducing strain on emergency services by offering cost-effective, reliable transport for non-life-threatening needs like dialysis or doctor visits..
- Focus on connecting patients to routine visits, diagnostic tests, and follow-up care.

Community Needs Fulfilled

- Reduces missed appointments, late/cancelled visits, and follow-up failures due to transportation barriers.
- Particularly critical for pregnant women, seniors, diabetics, dual eligibles, and high utilizers in remote communities.

Potential Delivery Partners

- Local NEMT vendors, volunteer driver programs
- CBOs coordinating rides
- Hospitals, clinics, and EMS for back-up support

Enabling Success (Hub-Level)

- Hub maps existing transportation assets and gaps.
- Works with transportation partners to define priority populations and scheduling processes.

- Ensures referrals into NEMT are captured via existing vendors (or CIE for non-covered rides) and linked to clinical encounters (e.g., ED discharge, appointment scheduling).
- Creates quick escalation channels when transportation breaks down.

System-Level Benefits

- Improved coordination between clinical providers and NEMT providers
- Improved appointment adherence and follow-up completion.
- Reduced preventable ED visits due to missed primary care or specialty visits.

Connections to Metrics & Workflows

- Potential metrics: rides completed, missed visits, ED visits for ambulatory-sensitive conditions.
- Workflow: clinician/CHW schedules ride → NEMT partner confirms → ride status tracked → outcomes reviewed at Hub level⁴. (Note: there may be instances where CHWs may be asked to provide rides by patients, they should refrain and follow NEMT workflow)

SECTION SEVEN – STANDARD GOVERNANCE DETAILS

2.7.1 Hub Roles & Responsibilities

2.7.1.1 Hub Leadership Board

- Provides strategic direction and governance
- Approves localized program selections
- Oversees Hub performance and priorities
- Ensures community needs necessary to improve health outcomes shape Hub programming
- Publish copies of meeting agendas and minutes to RCNs and RHTO for awareness

2.7.1.2 Hub Program Coordinator

- Oversees daily Hub operations and staff
- Coordinates workflows and clinical partner engagement
- Works with CBOs in-person to provide training on how to operate CIE screenings in coordination with the CIE vendor and the RCN
- Monitors all dashboards related to the Hub

- Submits reporting, manages compliance, and coordinates data reporting with RCN (including RHTP finances monthly)
- Serves as primary liaison to RCN and Hub leadership board
- Manages performance dashboards
- Socialize ToRCH Care to CBOs and assist them in onboarding to CIE
- Ensure CBOs understand their role in Hub alternative payment model

2.7.1.3 RHTP Navigators

- Manage integrity of CIE referrals over time
- Ensure a streamlined social needs screening process is established within the Hub and identified needs are resulting in closed-loop social care referrals through the CIE
- Manage closed-loop referrals and warm handoffs across Hub partners
- Confirm service receipts, document outcomes and re-engage residents when referrals or services are not completed
- Monitor Hub-level CIE data and troubleshoot issues from CBOs
- Provide direct patient support in situations with no identified partner
- Liaise with CHWs/care coordinators at urban facilities to coordinate local post-treatment care when necessary
- Engage provider-based CHWs within the Hub on RCN-level training opportunities

2.7.1.4 Partner Organizations (including Hub Anchors)

- Participate in referral workflows (e.g., initiate and close the loop on referrals as appropriate) and alternative payment models
- Attend partner orientation, coordination meetings, and any necessary training sessions (e.g., RHTP webinars, CIE, telehealth, remote patient monitoring)
- Support care coordination and program operations
- Familiarize all staff with ToRCH Care and provide role clarity

2.7.1.5 Regional Coordinating Networks

- Provide TA (technical assistance) to Hubs
- Coordinate procurement and contracting for Hub programs
- Review and escalate Hub performance reporting to the state

- Ensure data quality and timely submissions of Hub performance dashboards
- Coordinate Hub learnings across regions
- Ensure non-duplication of Hub programming
- Liaise cross-Hub community partnership opportunities
- Clinical lead responsibility

2.7.2 Standard Governance and Operating Procedures

2.7.2.1 Governance Onboarding Procedures

Establish the Hub Leadership Board

Steps:

1. Identify required sector representation.
2. Confirm participation and membership.
3. Approve governance documents (charter, bylaws).
4. Establish meeting cadence and decision-making processes.

Required Governance Documentation

- Governance Charter
- Meeting schedule
- Board roster
- Conflict-of-interest disclosures
- Decision rights framework
- Annual workplan

2.7.2.2 Staffing & Training Procedures

Hiring Requirements

Required roles prior to launch may include:

- Program Coordinator
- Program RHTP Navigators

Onboarding Requirements

All Hub staff must complete a:

- RHTO orientation
- RCN regional workflow training
- CIE + Backbone technical training
- Privacy/security compliance
- Referral and care coordination training

2.7.2.3 Partner Engagement Procedures

Build Partner Directory

Directory must include all relevant sectors:

- Hospitals and FQHCs
- LPHA
- EMS/MIH-CP
- Behavioral health providers
- Pharmacies
- Community-based organizations

Execute Required Agreements

- MOUs (when shared)
- DSAs (when shared)
- BAAs (if applicable)
- RFPs (if relevant)

Partner Orientation

Each partner must be briefed on:

- Hub workflows
- Referral and documentation expectations
- Contact lists
- Escalation pathways
- CIE usage

2.7.2.4 Technical Onboarding Procedures

CIE Setup

Steps:

- Create accounts
- Onboard social need referral partners, obtain BAAs
- Complete training modules
- Validate referral sending/receiving
- Run a simulated referral test

Backbone Integration

- Validate access
- Test data submission
- Confirm reporting templates

Alignment to state level standards of participation

- Complete any additional state-level onboarding or registration (e.g., CBOs receiving reimbursements through MCOs must enroll as a non-traditional Medicaid provider with MO HealthNet)
- Execute Business Associate Agreements (BAAs) with other entities
- Complete technical testing beyond referral functionality depending on final platform design (e.g., authorization workflows, other integrations)

2.7.2.5 Operational Workflow Procedures

Care Coordination Workflow

Support to be provided from state, RCNs, and vendors, with state-wide standards and guardrails to be shared.

In line with future state standards, Hub partners (including Anchors) must define:

- Intake and screening
- SDOH assessment
- Referral routing
- Warm handoffs
- Follow-up protocols (7-, 30-, 60-day touchpoints)

Documentation Workflow

Requirements:

- Use required fields in the CIE (used for social needs referrals) / EHR (used for clinical referrals)
- Timely documentation
- Records retention

Escalation Pathways

- Hub → RCN
- RCN → RHTO

Operating Rhythm

Recommended cadence:

- Weekly team huddles
- Monthly partner coordination meetings
- Monthly reporting submissions
- Monthly performance reviews

2.7.2.6 Localized Program Activation Procedures

Localized Program Activation

Steps:

1. Review local needs assessment.
2. Submit proposed programs to RCN.
3. Submit implementation plans to RCN.
4. Confirm RCN and RHTO approval of program selection.
5. Train Hub teams and partners.
6. Launch program.

Communications

- Use communications toolkit
- Conduct local announcements
- Notify partners and community stakeholders

2.7.2.7 Pre-Launch Verification (Per Stage Gate Timing)

Before launch, the Hub must:

- Validate complete alignment with all Hub stakeholders on goals, metrics, and the methodology in which they will be measured
- Validate alignment on financial timelines with all Hub stakeholders
- Complete referral pathway testing
- Validate data submissions
- Confirm partner readiness
- Ensure staffing is complete
- Receive RCN launch readiness certification
- Elevate any issues prior to launch (e.g, identification and elevation of issues before launch verification)

2.7.2.8 Documentation & Archiving Requirements

Hubs must retain the following for a minimum during **the 5 years of RHTP funding**:

- Governance records
- Staffing and training documents
- Partner agreements
- Reporting files
- Communications materials

APPENDIX A – RHTP NAVIGATOR ALLOCATION BY HUB

RHTP Navigators are frontline public health professionals serving as a liaison between residents and health/social services. Across Hubs, RHTP Navigators are allocated proportionally according to total Medicaid populations. Every Hub is guaranteed at least one RHTP Navigator.

Hub #	Hub counties	RHTP Navigator allocation
1	Atchison, Gentry, Holt, Nodaway, Worth	1
2	Andrew, Buchanan	3
3	Grundy, Harrison, Livingston, Mercer	1
4	Caldwell, Clinton, Daviess, DeKalb	1
5	Johnson, Lafayette, Ray	2
6	Bates, Henry, St. Clair, Vernon	2
7	Cedar, Dade, Dallas, Hickory, Polk	3

8	Barton, Jasper, McDonald, Newton	8
9	Barry, Lawrence	2
10	Christian, Stone, Taney, Webster	6
11	Douglas, Howell, Ozark, Texas, Wright	4
12	Camden, Laclede, Miller	3
13	Benton, Cooper, Moniteau, Morgan, Pettis	3
14	Carroll, Chariton, Howard, Randolph, Saline	2
15	Linn, Putnam, Sullivan	1
16	Adair, Knox, Macon, Shelby	1
17	Clark, Schuyler, Scotland	1
18	Lewis, Marion, Monroe, Pike, Ralls	2
19	Audrain, Callaway, Montgomery	2
20	Franklin, Lincoln, Warren	4
21	Gasconade, Osage	1
22	Crawford, Dent, Maries, Phelps, Pulaski	4
23	St. Francois, Ste. Genevieve, Washington	3
24	Iron, Madison, Reynolds, Shannon	1
25	Bollinger, Cape Girardeau, Perry	3
26	Butler, Carter, Oregon, Ripley, Wayne	3
27	Dunklin, Mississippi, New Madrid, Pemiscot, Scott, Stoddard	7

APPENDIX B – EVALUATION CRITERIA

Scoring Summary (100 points total)

Category	Points
1. Governance & Leadership	25
2. Partnerships & Engagement	25
3. Operational & Staffing Readiness	25
4. Digital & Data Readiness	10
5. Priorities & ToRCH care Alignment	15
Total	100

Detailed considerations for applications that meet the state’s readiness goals below:

1. Governance & Leadership:

Purpose: Assess the strength, structure, and cross-sector representation of the Hub Anchor’s proposed leadership board and the applicants demonstrated experience with multi-partner initiative leadership.

	Score:	Considerations for applications that meet the state’s readiness goals:
Distinctive	25	Prospective Hub Anchor demonstrates willingness to participate from a strong and diverse set of potential board members and demonstrates high local partner buy-in. There is strong reasoning and ambition for participation as a Hub Anchor and in the wider program.
Superior	20	Strong leadership board buy-in with broad representation, but some key partner types (for example – select fire, faith, or schooling organizations) are not fully represented. Strong enthusiasm for participation, though long-term commitment and durability of engagement may be less clear.
Satisfactory	15	Moderately diverse leadership board sector representation across clinical and non-clinical providers (e.g., sectors such as non-clinical providers not included to the degree of clinical providers). Demonstrates baseline engagement and enthusiasm for the program and the Hub Anchor role,
Marginal	10	Limited leadership board diversity across providers, and shallow governance planning. Limited non-clinical partner engagement both in prospective leadership board and in engagement planning. There are some concerns over enthusiasm towards the program from select leadership members sitting in the Anchor organization (e.g., low-level executive sponsor).
Unsatisfactory	5	Proposed Hub leadership board has limited diversity across clinical and non-clinical sectors (e.g., some sectors such as CBOs not represented), as well as shallow governance planning. There is a clear lack of engagement planning, especially for non-clinical partners (e.g., CBOs, LPHAs, etc.). There are serious concerns for ambition/enthusiasm for the program itself and for the prospective role as Hub Anchor.

2. Partnerships & Engagement:

Purpose: Assess the breadth, depth, and authenticity of the applicant's existing and anticipated partnerships, and the strength of their plan for ongoing community engagement beyond application submission.

	Score:	Considerations for applications that meet the state's readiness goals:
Distinctive	25	Local partners come together and provide support across a diverse set of clinical providers, EMS, LPHA, pharmacies & CBOs (≥3 letters of support from multiple groups, i.e. clinical providers, EMS, LPHA, pharmacies & CBOs and/or ~15+ total letters of support). The Hub Anchor has distinctive experience in the past with community leadership of other healthcare coalitions. The prospective anchor has significant existing and anticipated Hub partners across partner types, and a strong community engagement approach that considers multiple methods of engagement and integrating partner feedback tailored to the role of the Anchor and for the local community.
Superior	20	Above average level of support from a diverse set of clinical providers (~2 letters of support from multiple groups, i.e. clinical providers, EMS, LPHA, pharmacies & CBOs and/or ~13+ total letters of support) with some past leadership experience of multi-partner collaborations. Strong engagement plan to ensure feedback and input from both clinical and non-clinical community partners.
Satisfactory	15	Slightly above base level support from local partners (~2 letters of support from multiple groups, i.e. clinical providers, EMS, LPHA, pharmacies & CBOs and/or ~10+ total letters of support) with moderate anticipated partnerships across partner types based on experience paired with realistic explanations for expected new partnerships to come to fruition. The Hub Anchor has some experience with multi-partner collaboration, but limited experience leading the collaborations. Base level engagement mechanisms and feedback mechanisms from the community are planned but may be rote or templated.
Marginal	10	Base level partner support (1 letter of support each from a clinical provider, EMS, LPHA, pharmacy, & CBO –

		with select sectors providing more support; ~5+ total letters of support). Limited expected partners across the local area, and limited experience participating in community-based collaborations.
Unsatisfactory	5	The Hub Anchor only receives the minimum threshold support from local partners (1 letter of support each from a clinical provider, EMS, LPHA, pharmacy, & CBO – 5 total letters of support) with no existing partner ecosystem or anticipated new partners. The Hub has no experience as a community leader in any context. The community engagement plan is not feasible or shallow.

3. Operational & Staffing Readiness:

Purpose: Assess the applicant's immediate operational capacity to launch, staff, and sustain Hub functions with minimal dependencies on RCN/RHTO remediation.

	Score:	Considerations for applications that meet the state's readiness goals:
Distinctive	25	Fast anticipated hiring timeline (<2 months) with limited gaps requiring RCN/state support in recruitment, onboarding, staffing, and operationalizing (e.g., existing staff already available and qualified to transition to RHTP Navigator or PC roles). Experience providing and/or partnering to provide primary care services.
Superior	20	Moderately fast anticipated hiring timeline (~2 months) with clear existing FTE available to be shifted to dedicated Hub staffing roles (e.g., PC and RHTP Navigator). Limited or minor risk/activation gaps requiring support (e.g., limited training resources, HR capacity). Has experience partnering with other organizations to provide primary care services.
Satisfactory	15	Moderately timed anticipated hiring timeline (~2 months) with some existing FTE available to shift to be dedicated to RHTP Navigator/PC roles. There are some base level risks/activation gaps requiring support, but without extreme strain to either RCNs/RHTO to aid with and resolve. Experience providing and/or partnering to provide relevant care services (e.g., emergency department, urgent care center) but no primary care.

Marginal	10	Moderately long anticipated hiring timeline (~2+ months) with a singular FTE available to transition into a Hub staffing role. There are clear gaps requiring state or RCN support to recruit, select, or oversee this staff. Limited care services provided.
Unsatisfactory	5	Long hiring timeline (≥ 3 months) without any existing staff capable of transitioning to the newly planned roles. There are multiple systemic and difficult-to-bridge gaps to timely onboarding (e.g., limited HR recruitment infrastructure, RHTP Navigator pipeline shortage). No relevant care services are provided.

4. Digital & Data Readiness:

Purpose: Assess the applicant's readiness to participate in shared data infrastructure, including experience with interoperable platforms, performance measurement, and transparent reporting.

	Score:	Considerations for applications that meet the state's readiness goals:
Distinctive	10	Demonstrated experience with shared platforms, modern APIs, and data sharing (e.g., care coordination systems, community-based platforms, EHRs, MCO systems, HIE participation) aligned with modern interoperability standards. Extensive experience utilizing performance reviews demonstrating consistent transparency/accountability. Strong cybersecurity controls, data governance policies, and privacy safeguards.
Superior	8	Above average experience with shared platforms and data sharing, but some gaps to modern interoperability standards. Semi-regular use of detailed metric tracking performance reviews demonstrating transparency/accountability that feed into the businesses' decision making. Baseline cybersecurity controls and data governance.
Satisfactory	6	Some shared platform experience and some identified barriers to data sharing that may be feasible to solve in a timely manner. Moderate experience with metric tracking and performance reviews that feed into decision making and an iterative approach to strategy and operations.

Marginal	4	Limited shared platform or dashboard experience and very limited experience with data sharing. Metric tracking and performance reviews are not part of regular operations, and there are barriers to implementing such a system. Some serious data governance / privacy concerns.
Unsatisfactory	2	No experience with shared platforms/dashboards and systemic known barriers to data sharing that are difficult to resolve. Minimal digital standards and governance maturity. Limited prior performance review use, or stark transparency/accountability concerns for said performance reviews. Significant data governance / privacy / cybersecurity concerns.

5. Priorities & ToRCH Care Alignment:

Purpose: Assess whether the applicant's early strategic priorities are data-informed, feasible, aligned with ToRCH Care metrics, and supported by a clear adaptive learning framework and holistic understanding of the ToRCH Care program.

	Score:	Considerations for applications that meet the state's readiness goals:
Distinctive	15	Feasible, focused, and ToRCH Care aligned early win focus areas for localized program selection (e.g., behavioral health access, transportation) aligned with community needs. There is clear alignment between the early win goals and ToRCH Care goals and metric tracking, as well as established feedback loop and iterative planning. Strategies are based on data analysis or community health needs assessments.
Superior	12	Strong focus areas for localized program selection with data-based insights, but some small gaps to the highest community needs (e.g., slight deviations from what could have the highest impact). Strong enthusiasm and alignment with RHTP goals and the ToRCH Care model with demonstrated understanding of the model and well-defined feedback and data collection planning.
Satisfactory	9	Realistic early win priority areas are somewhat aligned to ToRCH care priorities and local community needs (e.g., slight deviations from ToRCH metric focus areas). Moderate understanding of the ToRCH Care program.

		There is only base level data collection and feedback loop planning for iterative change to occur.
Marginal	6	Priority focus areas are not related to community needs and are based on subjective analysis rather than data analysis. Directly repeats (e.g., copy and pastes) state provided ToRCH Care information in its narrative, rather than adapting it to its own perspective to demonstrate understanding. Mentions data collection and feedback planning, but not a holistic plan to ensure proper engagement and iterative planning over time.
Unsatisfactory	3	Non-feasible and unaligned with community needs priority focus areas and data collection planning not aligned to ToRCH care priorities. There is limited demonstrated understanding of the ToRCH care program, and no demonstrated understanding of how to iterate programs/strategies over time.

APPENDIX C – ACRONYMS AND ABBREVIATIONS

Whenever the following terms and acronyms appear in this document or any addendum thereto, the definitions or meanings described below shall apply.

- **APM:** *Alternative Payment Model – A payment approach that rewards quality and cost efficiency.*
- **CBO:** *Community-Based Organization – Local nonprofit or entity providing social services.*
- **CCBHC:** *Certified Community Behavioral Health Center – Behavioral Health provider meeting state/federal certification standards to deliver care.*
- **CHNA:** *Community Health Needs Assessment – Formal assessment identifying priority health needs in a community.*
- **CHW:** *Community Health Worker - Frontline public health professional*
- **CIE:** *Community Information Exchange – Platform for closed-loop social care referrals.*
- **CMS:** *Centers for Medicare & Medicaid Services – Federal agency overseeing Medicaid and Medicare.*
- **COI:** *Conflict of interest – Person or organization with competing interests that could influence decision making.*
- **DSA:** *Data Sharing Agreement – Formal agreement outlining how organizations share data, including privacy, security, permitted uses, and responsibilities.*

- **DSS:** Missouri Department of Social Services – State agency overseeing Missouri’s Medicaid program.
- **ED:** Emergency Department – Hospital department for urgent and emergency care.
- **EHR:** Electronic Health Record – Digital version of patients medical records used by healthcare providers to document and share clinical information.
- **EMS:** Emergency Medical Services – Pre-hospital care and transport services.
- **EMS-CP:** Emergency Medical Services Community Paramedic – EMS professional trained to provide non-emergency, preventive, and follow-up care in communities.
- **FTE:** Full time equivalent - Unit of measurement representing the total hours worked by a full time employee.
- **FQHC:** Federally Qualified Health Center – Community-based health provider meeting federal standards.
- **HEDIS:** Healthcare Effectiveness Data and Information Set – Standardized set of performance measures used to evaluate health plan quality.
- **HIE:** Health Information Exchange – A network/platform that enables secure sharing of health information across participating organizations.
- **HIPAA:** Health Insurance Portability and Accountability Act – Federal law protecting patient health information privacy and security.
- **HRSN:** Health-Related Social Needs – Social factors like housing or food that affect health outcomes.
- **HTN:** Hypertension – High blood pressure.
- **IT:** Information Technology – Systems and infrastructure used to manage digital data, networks, and cybersecurity.
- **LPHA:** Local Public Health Agency – County or regional public health authority.
- **MCO:** Managed Care Organization – Health plan that contracts with Medicaid to provide services to enrolled members.
- **MH:** Mental Health – Services addressing psychological and emotional well-being.
- **MHD:** Missouri HealthNet Division – Missouri Medicaid agency within DSS managing Medicaid eligibility, benefits, and claims.
- **MIH-CP:** Mobile Integrated Healthcare – Community Paramedicine – Paramedics providing preventative or follow-up care outside traditional emergency responses.
- **Missouri EATs:** Missouri EATs program – Missouri state nutrition access/food security initiatives.
- **MO HealthNet:** Missouri’s Medicaid program
- **MOU:** Memorandum of Understanding – Written agreement between two or more parties outlining working expectations.
- **NEMT:** Non-Emergency Medical Transportation – Transportation services that help Medicaid beneficiaries travel to medical appointments.

- **OB:** Obstetrics – Medical care related to pregnancy, childbirth, and postpartum care.
- **PC:** Program Coordinator – Hub-level staffed individual responsible for organizing, implementing, and managing program operations.
- **PCP:** Primary Care Provider – Healthcare professional (e.g., physician) who provides routine and preventative care.
- **RCN:** Regional Coordinating Network – Regional structure for organizing Hubs and resources.
- **RHC:** Rural Health Clinic – Clinic certified to provide primary care services in rural underserved areas and receive enhanced reimbursement.
- **RHTO:** Rural Health Transformation Office – Office dedicated to driving the RHTP initiative.
- **RHTP:** Rural Health Transformation Program – Missouri initiative to strengthen rural healthcare.
- **RHTP Navigator:** Rural Health Transformation Program Navigator - Frontline public health professional serving as a liaison between residents and health/social services
- **RPM:** Remote Patient Monitoring – Technology for tracking patient health data outside clinical settings.
- **SDOH:** Social Determinants of Health – Non-medical factors that influence health outcomes (e.g., housing, food access, transportation, education, income, etc.)
- **SOP:** Standard Operating Procedure – Documented process for consistent task execution.
- **TA:** Technical Assistance – Support provided to organizations to help implement programs, meet requirements, and improve operations.
- **ToRCH:** Transformation of Rural Community Health – Missouri pilot program including six rural hospitals to transform rural healthcare.
- **ToRCH Care:** Transformation of Rural Community Health Care – Missouri program using federal funding to integrate social and clinical care and improve rural health outcomes expanding off the success of the ToRCH pilot.