

PSA / IHPF Daily Briefing — September 11, 2026

Morning update: five additional developments

TLDR

I'm avoiding the five September 11 items already covered earlier today. The strongest new find is **St. Mary's 360 in Maryland**, because it looks remarkably like a working, federally funded cousin of the IHPF concept: community-based coordinators + referral completion + telehealth + remote monitoring + mobile outreach + a digital health/community-services portal. Yesterday also brought important new implementation details for ARPA-H's agentic cardiac-AI program, new federal rural-hospital support, a **\$5 million national rural nurse-AI training initiative**, and a **\$20 million NSF investment in evidence-driven K-12 AI learning technologies**.

1. 🟡 **Maryland is funding something remarkably close to an IHPF operating model.** St. Mary's County Health Department received **\$3.53 million through Maryland's Rural Health Transformation Program** for "St. Mary's 360: Connected Care Everywhere." The county model embeds care coordinators in clinics, schools and community programs; helps people complete referrals rather than merely receive them; supports telehealth and home-monitoring devices; deploys mobile/home outreach; and uses a Health & Wellness Portal to connect medical, behavioral, dental and community services. The original county announcement was August 31, but on **September 10** technology partner WellCheck disclosed more detail about the digital infrastructure it will provide for referral coordination and digital-health literacy. ([St. Mary's County Health Department](#))

Why it matters to PSA/IHPF: I would study this one closely. It provides an actual funded example of the principle that healthcare access is not solved by supplying a diagnostic test or telehealth connection; someone—or some system—has to get the person from need → service → completed referral → continuing care. That is extremely close to the role PSA has contemplated for community navigators and AI-supported workflows.

What to do next: use St. Mary's 360 as a comparator in the next iteration of IHPF. Create a simple side-by-side matrix: *their component / IHPF equivalent / what they have that we lack / what IHPF adds*. I suspect that exercise would expose several useful design gaps very quickly.

[Official St. Mary's County program description](#)

2. ❤️ **New details show how ARPA-H intends to determine whether autonomous cardiac AI actually works in rural healthcare.** Yesterday Duke Clinical Research

Institute announced that it will lead the new **SYMPHONY Consortium**, the independent real-world testing and monitoring arm associated with ARPA-H's ADVOCATE agentic cardiovascular-AI program. Importantly, this is not limited to academic medical centers: it includes **five large health systems with substantial rural populations, rural health clinics, the American Heart Association, human-factors specialists, the Health AI Partnership and technology partners including AWS.** ([Duke Clinical Research Institute](#))

The consortium will establish a national framework for evaluating safety, effectiveness and deployment of agentic clinical AI in heart failure rather than relying solely on laboratory benchmarks or vendor testing. ([Duke Clinical Research Institute](#))

Why it matters to IHPF: this is arguably more useful to PSA than yesterday's headline about the AI itself. It tells us what serious evaluation may look like: real patients, rural sites, multiple health systems, clinical outcomes, human-factors analysis and ongoing monitoring.

What to do next: borrow the structure. An IHPF cardiac pilot evaluation plan should distinguish **device performance, AI performance, workflow performance, patient outcomes and implementation performance** instead of collapsing them into one vague measure of "success."

[Duke SYMPHONY Consortium announcement](#)

3.  **HHS puts another \$25 million directly into 132 small rural hospitals—but none are in New Mexico.** On **September 10**, HHS/HRSA announced nearly **\$25 million for 132 small rural hospitals in 13 states** through the Rural Hospital Provider Assistance Program. Hospitals may use the money to retain physicians, nurses and other staff and preserve emergency, inpatient and other essential services. ([HHS.gov](#)) HRSA's complete award list does not include a New Mexico hospital. ([HRSA](#))

Why it matters to PSA/IHPF: it highlights an important distinction in rural-health policy. Some federal money is trying to **stabilize the existing system**, while RHTP is supposed to help **transform the delivery system**. Both are necessary, but they are not the same job.

That distinction can sharpen IHPF's positioning. PSA probably does not want to present IHPF principally as another way of subsidizing current rural delivery. Its strongest argument is that distributed diagnostics, navigation, AI and remote expertise could change **how much useful healthcare capacity a community can obtain from its existing workforce and infrastructure.**

What to do next: in future IHPF funding materials, explicitly separate “**stabilization**” from “**transformation.**” Then explain which costs IHPF is intended to avoid or reduce rather than merely requesting another layer of operating support.

[HHS rural-hospital award announcement](#)

4.  **The American Nurses Enterprise launches a \$5 million AI-training program specifically aimed at rural and underserved nurses.** On September 9, the organization behind the American Nurses Association announced a three-year **\$5 million Nurse AI Training in Rural and Underserved Communities initiative**, funded equally by the Johnson & Johnson Foundation and Google.org. Training will be co-designed with nurses and focus on practical use of AI, safe evaluation of tools, communication with patients and families, ethics and AI governance. ([ANA](#))

Why it matters to IHPF: rural-AI implementation is increasingly being recognized as a **workforce-development problem**, not merely a software-acquisition problem. That applies equally to nurses, community navigators and other personnel who may sit between sophisticated AI systems and patients.

There is another useful signal here: the program explicitly intends nurses to help **shape the design and governance** of clinical AI rather than simply learn how to operate systems chosen by someone else. ([ANA](#))

What to do next: add a **human capability layer** to the IHPF model. For every technology PSA considers, specify who needs to understand it, who can operate it, who interprets it, who explains it to patients and who is responsible when the system is uncertain.

[American Nurses Enterprise announcement](#)

5.  **NSF doubles down on a different kind of educational AI: AI that improves the learning process rather than supplies answers.** NC State announced **September 10** that the National Science Foundation has awarded another **\$20 million over five years** to its AI Institute for Engaged Learning, extending an earlier \$20 million investment. Partners include Vanderbilt, UNC–Chapel Hill, Indiana University and Digital Promise. ([NC State News](#))

The next phase is particularly interesting. Researchers want AI systems that **improve during the school year based on learning interactions**, use “world models” to create interactive narrative learning environments, and give teachers and students more control over constructing the learning experience. The work builds on classroom studies rather than simply assuming generative AI improves education. ([NC State News](#))

Why it matters to PSA's EdTech interests: this points toward a much healthier use of AI than automated homework production. AI becomes a tool for creating simulations, collaborative problem-solving, inquiry and adaptive experiences in which students still have to think and act.

What to do next: put **EngageAI** and **Digital Promise** on PSA's EdTech research watchlist. Their published studies and tools could become a useful evidence source for distinguishing genuinely educational AI from products whose primary achievement is making schoolwork easier to complete.

[NC State / NSF EngageAI announcement](#)

Imaginative Healthcare Idea to Keep on the Board

The St. Mary's project suggests a provocative extension of IHPF: instead of thinking primarily about a **"community navigator,"** think about building a **community healthcare operating system.**

A person could enter through a school, library, pharmacy, community organization, mobile unit, FQHC or home device. The system would know what local resources exist, collect appropriate diagnostic information, use AI to organize it, determine the next legitimate clinical step, connect the person to that service, track whether the referral actually happened and continue follow-up afterward.

The human navigator would remain important—but would sit on top of a much more capable digital infrastructure.

That is substantially more ambitious than "AI + diagnostics." It may also be closer to the structural healthcare alternative PSA has been trying to imagine.