WHAT ONE RURAL DISTRICT BUILT IN 18 MONTHS

PREPARED FOR TEXAS HOSPITAL DISTRICTS

tap
Text a Physician

a population, not just patients.

Paid for the care you provide.
Shielded from what the system was never going to pay for.

$1.67M
SINGLE GRANT

18
MONTHS IN

$8.7M+
IN COMMUNITY RETURN

TAP TELEHEALTH

Built by a Texas ER physician · taptelehealth.com · 972.688.6330

first, the part everyone in this room already knows.

01

For decades, the reimbursement system has been routing patients to your door that it was never going to pay you to see.

For decades, your hospital has been navigating a reimbursement system that absorbs the low-acuity walk-ins the system was never going to pay you to see, on terms set by payers who don't bear the cost.

02

The patients who would balance the math are going somewhere else, or going without.

Working-age insured adults drive to urban systems. Families with deductibles skip care entirely. Geographically isolated residents disengage from healthcare altogether. The mix you need to operate is structurally drawn away from you.

None of this is your fault. None of it is being argued.
The question is what you do about it.

MEET THE COUNTY

Chesterfield County, South Carolina.

If your district looks anything like this, the rest of this case study is about you.

1
HOSPITAL, LOCATED IN CHERAW

3,328 : 1
PATIENT-TO-PCP RATIO

20.2%
POVERTY RATE (VS ~17% TEXAS RURAL AVERAGE)

800 sq mi
RURAL GEOGRAPHY

45,000
RESIDENTS ACROSS THE COUNTY

$47,620
MEDIAN HOUSEHOLD INCOME

These are not the conditions a hospital chose. They are the conditions a hospital inherited. They are the conditions Chesterfield's leadership decided to do something about.

one grant. one county. a whole-population front door.

$1.67M from the federal Rural Health Transformation Program. Built and operating in 18 months. Three pillars made it possible.

A board-certified physician network

Available by text, audio, or video. Average response under two minutes. No insurance requirement, no copay, no scheduling friction. Available continuously to every household in the county.

The technology and integration layer

HIPAA-compliant SMS — care delivered through the messaging app every household already uses. E-prescribing routed to local pharmacies — prescriptions filled in your community's existing network. Clinical referrals routed back to your hospital — patients who need in-person care arrive with full physician context. Population-level analytics — community health data your hospital owns from day one.

Municipal and community partnership

County leadership, municipal officials, school systems, EMS partners, and local employers engaged from launch. The platform appeared on city council agendas, school nurse referral lists, and EMS triage protocols — introduced by the community, for the community, from day one.

What was built in Chesterfield can be built in your district.
The platform exists. The clinical network exists. The funding pathways exist.

the county engaged. across every demographic. at a rate that surprised even us.

15,000+	9.9/10	58%	<2 min
PATIENT ENCOUNTERS	**PATIENT SATISFACTION**	**RETURNED FOR REPEAT USE**	**AVERAGE RESPONSE TIME**
in first 18 months of operation	*across all encounters surveyed*	*patients who used TAP for multiple episodes*	*from first message to physician reply*

These are the headline numbers. The rest of this case study is about what's underneath them — and what they mean for the hospital that serves this county.

every age group. every part of the county.

Telehealth platforms typically skew young, urban, and digitally native. Chesterfield's data did not.

19%

SCHOOL-AGED (UNDER 18)

Pediatric utilization rivals adult rates. Parents triage their kids through TAP before deciding on the ED. Student absenteeism drops measurably.

19%

YOUNG ADULTS (18–30)

The cohort that typically skips healthcare entirely — gig workers, college students, the chronically uninsured — is engaging from a phone they already own.

48%

WORKING-AGE (31–60)

The largest single cohort. These are insured residents whose employer plans the hospital wants in its mix. They are now in the platform — and routed to your hospital with full clinical context when in-person care is needed.

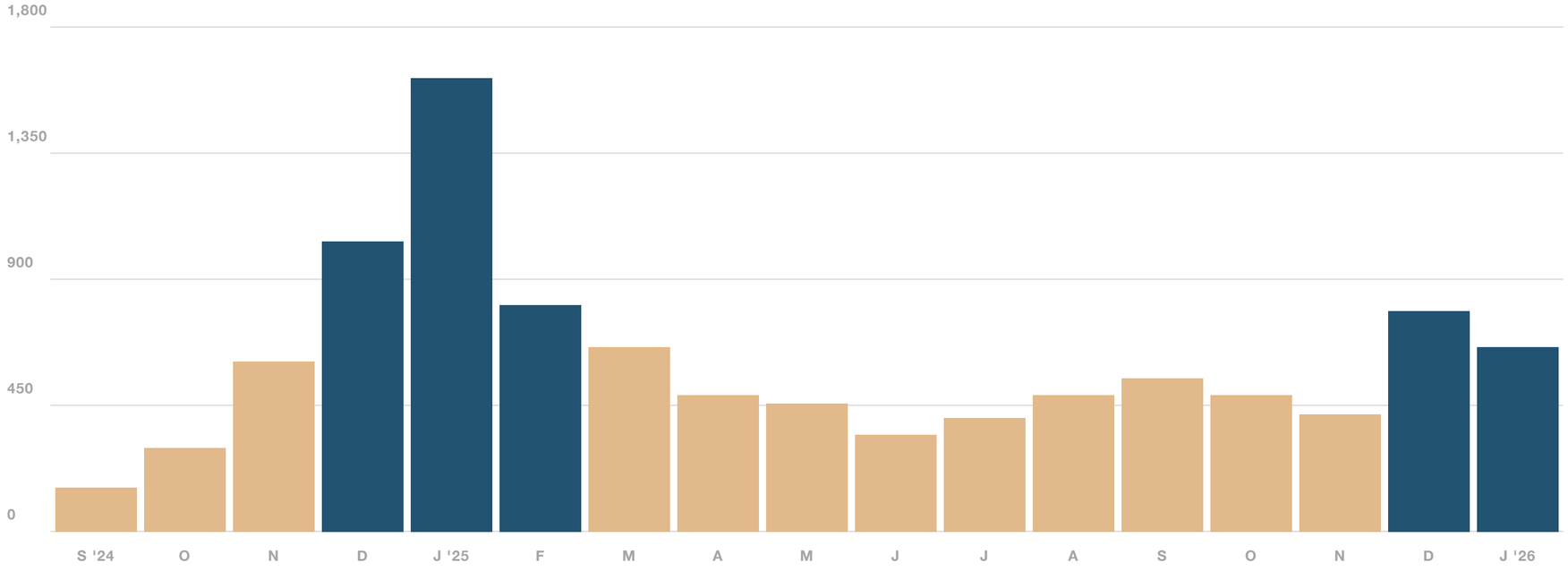
14%

SENIORS (61+)

The hardest demographic for any digital platform to capture. Mobility-limited rural seniors getting care without a car ride or a clinic appointment.

surge when the community needed it. steady access year-round.

Monthly encounters, Sep 2024 – Jan 2026. The flu-season spikes are the encounters that didn't reach the ED.



READ THE CHART

FLU-SEASON SURGE

Encounters during peak demand months. Care delivered without a $1,700+ ED visit, and without the bad debt the system was never going to reimburse the hospital for.

STEADY BASELINE

~400 encounters per month sustained year-round. Patients use TAP as ongoing care access.

This is not a launch bump that faded.
The platform is the front door, every month, for every household.

THE FINANCIAL READING OF THE DATA

the patients tap reaches are the patients the system stopped reimbursing you for.

This is the single most important sentence in the case study.

WHO TAP REACHES

The patients the system was never going to reimburse you for seeing.

- ✓ Uninsured residents across the 800-square-mile geography
- ✓ Underinsured working-age adults skipping care under deductibles
- ✓ Geographically isolated patients without transportation
- ✓ Families for whom an ED visit was a financial barrier even when care was needed
- ✓ Pediatric and senior cohorts the hospital had no scalable way to reach

WHAT THE SYSTEM ACTUALLY REIMBURSES YOU FOR

The work your hospital can sustainably do.

- ✓ Patients arriving through clinical referral channels for billable care
- ✓ Acute and high-acuity cases where your full capacity is required
- ✓ Inpatient admissions, surgical cases, and procedural volume
- ✓ Specialty consultations and follow-up infrastructure
- ✓ Care delivered to patients whose payers actually reimburse for it

WHEN A TAP PATIENT NEEDS IN-PERSON CARE

TAP's clinical evaluation determines when a patient needs in-person treatment, and the routing protocol sends that patient to your facility with full clinical context — physician's note, urgency triage, and referral pathway already documented. The flow is one-way: TAP feeds your hospital the right patients at the right time, never competes for them.

TAP did not divert your revenue. TAP intercepted the bad debt the system was never going to reimburse you for.

THE THESIS, DEMONSTRATED

Paid for the care you provide.
Shielded from what the system was never going to pay for.

FOR THE COMMUNITY

$3.6M	~$700K	$4.4M	4,000+
ED COSTS AVOIDED	**EMS COSTS AVOIDED**	**WAGES RECOVERED**	**SCHOOL DAYS RECOVERED**
2,000+ low-acuity visits	*635 ambulance avoidances*	*for working residents*	*students back in class*

FOR YOUR HOSPITAL SPECIFICALLY

- ✓ **Reduced uncompensated care exposure** — bad debt write-offs intercepted before they reach your books
- ✓ **Improved payer mix on referrals** — clinical routing brings insured patients into your billing infrastructure
- ✓ **Freed ED capacity** for the high-acuity cases that drive your operating margin
- ✓ **Population health visibility** — community-level data the funding environment now requires

Calculations: ED costs from CMS Outpatient PPS rates × encounters diverted. EMS costs from state EMS run-cost averages × deployments avoided. Wage recovery from BLS rural Texas median × work-days × engagement hours. School-day data from district attendance records.

$1.67M grant in. $8.7M+ in community return. 5.2x. Zero of it from your hospital's billable revenue.

THE ASSET YOU COULDN'T HAVE BUILT YOURSELF

on day one, your hospital sees a population it could never have reached.

Outreach budgets cannot do this. Marketing campaigns cannot do this. Community benefit programs cannot do this.

BEFORE TAP

Visibility into the patients who walked through the door.

Walk-in encounters. Scheduled visits. Inpatient admissions. The 30 to 40 percent of your county that doesn't engage with the hospital is structurally invisible. Conventional outreach reaches a fraction of that population at high acquisition cost. Community benefit reporting works from regional proxies because county-level data has not been available.

→

WITH TAP, ON DAY ONE

A demographic and clinical map of the entire county.

- ✓ Utilization patterns across every age cohort and every part of the county
- ✓ Common chief complaints, by season, by demographic, by ZIP
- ✓ Identification of residents with chronic conditions who weren't engaged with care
- ✓ Real-time signal on emerging community health concerns
- ✓ Population-level data on the demographics the hospital wasn't reaching
- ✓ Defensible underserved-population data — for IRS Schedule H, state benefit reporting, accreditation reviews, and any board or commission inquiry into community service

County-level engagement data is shared with your district. Patient-level data remains protected under HIPAA, with TAP as the covered entity. Business Associate Agreement executed at partnership initiation.

Chesterfield's hospital didn't gain a service. It gained a map of its own community.

the data your hospital now has is the data the funding environment is asking for.

Population-level engagement data isn't a nice-to-have anymore. It's increasingly the gating requirement for the programs that fund rural hospitals.

Community benefit reporting

IRS Schedule H, state benefit reporting, accreditation files. The whole-population data TAP generates plugs directly into the templates regulators are already requesting.

Federal grant applications

RHTP, HRSA, CDC, FORHP. Every federal program that funds rural health now wants population-level engagement metrics in the application package. Most rural hospitals can't produce them.

Value-based care positioning

ACOs, Medicare Shared Savings, state Medicaid managed care contracts. The pivot to risk requires denominators. TAP gives you the denominator for your county.

Board reporting that lands

9.9 satisfaction across every age cohort. 58% return rate. Whole-county demographic reach. The metrics your board has been asking for and your team has had no way to produce.

Underserved-population proof

The reach into the demographics rural hospitals are most often accused of underserving — uninsured, geographically isolated, working-age uninsured. With data, not assertion.

Population health foundation

The first piece of infrastructure your district has for managing community-level health rather than transactional encounters. Everything else builds on top of this.

Every one of these is a deliverable Chesterfield's hospital can produce now. None of them existed before.

WHERE THIS STARTED

"Doc, wouldn't it be amazing if every resident had access to a doctor like I have access to you?"

— BROOKS WILLIAMS

City Manager, Ferris, Texas — to Dr. Dirk Perritt, founding conversation

Brooks asked the question that became the company. He had access to a physician — Dr. Perritt — for any health concern, any time, by phone. He could not understand why the residents he served as city manager did not. That asymmetry — between what an individual with a relationship gets and what a community structurally cannot get — is the gap TAP was built to close.

Ferris was the first deployment. Today, 17+ communities across Texas, South Carolina, and Illinois have followed.

the grant launches it. the community sustains it.

TAP is not a grant-dependent program waiting to disappear when the funding cycle ends. The model has a built-in transition to community-level sustainability.

PHASE 1 · YEAR ONE

$1.67M

RHTP grant — Chesterfield's launch capital

Grant launches the platform

$1.67M in Chesterfield. Covers physician network, technology stack, county-wide outreach, and full population onboarding. Built once, used continuously.

PHASE 2 · YEAR TWO

5.2x

community return on grant capital

Whole-county adoption proves demand

15,000+ encounters. 9.9/10 satisfaction. 58% return rate. The grant period generates the utilization data and savings story that justify the transition.

PHASE 3 · YEAR THREE FORWARD

$3 / mo

per-resident cost via municipal infrastructure

Municipal billing is the primary path

$3 per resident per month, billed through county and city services infrastructure where the model has been adopted. The arrangement is between TAP and the local government — your hospital is the partner, not the payer.

WHEN MUNICIPAL BILLING ISN'T POLITICALLY FEASIBLE

Some communities have adopted alternative sustainability paths — continued grant layering through subsequent RHTP cycles, county appropriation, hospital-led subsidy with offsetting savings, or hybrid arrangements. The platform is flexible. The path that fits your community is the path we build with you.

Validated across 17+ communities in Texas, South Carolina, and Illinois — with several Texas districts already running the sustainability transition.

Chesterfield used SCDHHS. you have your own funding stack.

Texas Rural Health Transformation funding — branded "Rural Texas Strong" — provides $1.4 billion over five years across multiple initiatives. Three streams accessible to your district directly. Two more accessible through CIN partnership.

WHAT A CIN IS

A Clinically Integrated Network is a federally recognized structure that allows independent providers to coordinate clinical operations and access certain funding streams that single providers cannot. **Pathways Physicians Texas, PLLC** *is the CIN; your district is the partner. The CIN holds the funding contract, manages the application infrastructure, and operates as the clinical mechanism — your district receives the deployed service without taking on the operational burden or carrying any equity in the CIN itself.*

DISTRICT-ELIGIBLE — YOUR DISTRICT APPLIES DIRECTLY

~$750K	**Initiative 1, Part 1 · Rural Texas Strong**	MAY 22
$25M	**HB 18 · Rural Hospital Operational Support**	ROLLING · TARGET Q3 2026
$73.6M	**Initiative 4, Part 1 · Workforce Pool**	SPRING 2026

VIA PPTX (CIN PARTNERSHIP) — PATHWAYS PHYSICIANS TEXAS APPLIES, YOUR DISTRICT IS THE DEPLOYMENT PARTNER

$5M	**Initiative 2 · Patients in Driver's Seat**	MAY 28
$73.6M	**Initiative 3 · Lone Star Advanced AI & Telehealth**	SPRING 2026

Two streams close in May. The rest are spring-2026 windows that are about to fill.

the two deadlines that matter this month.

Initiative 1 closes May 22. Initiative 2 closes May 28. The other streams have spring-2026 windows but are filling fast.

INITIATIVE 1, PART 1 · RURAL TEXAS STRONG

~$750K

per applicant

The fastest path to launch.

- ✓ Hospital districts apply directly
- ✓ Operations, technology, outreach, physician network
- ✓ Modeled directly on what Chesterfield used
- ✓ 12-month bridge to Phase 2 funding

DEADLINE: MAY 22, 2026

INITIATIVE 2 · PATIENTS IN DRIVER'S SEAT

Up to $5M

per applicant, over 3 years

Patient-directed care models.

- ✓ Funds patient-initiated, physician-triaged care — exactly what TAP delivers
- ✓ CIN holds the contract; your district is the deployment partner
- ✓ Pathways Physicians Texas, PLLC handles application infrastructure
- ✓ Administrative burden on your team: minimal

DEADLINE: MAY 28, 2026

THE OTHER THREE STREAMS

HB 18 ($25M, rolling — recommended Q3 2026), Initiative 4 Part 1 ($73.6M workforce, Spring 2026), and Initiative 3 ($73.6M advanced AI/telehealth, Spring 2026) all stack with the May deadlines. Full per-stream detail in follow-up packet.

WHAT YEAR ONE LOOKS LIKE FOR YOUR DISTRICT

from conversation to county-wide launch in one grant cycle.

TAP and Pathways Physicians Texas operate the platform. Your district leads the partnership. The application infrastructure, the clinical network, and the technology integration are already built.

WEEK 1–2

Partnership conversation

30-minute call with Dr. Perritt. District-specific access gap review. Letter of intent and joint planning kickoff.

MONTH 1

Funding application

TAP and PPTX prepare and submit. Your district reviews, signs, and provides partnership documentation. Regulatory and reporting burden is on us, not on your team.

MONTH 2–3

Award and onboarding

Funding decision. Platform configuration for your service area. Clinical network credentialed for Texas. Municipal billing infrastructure scoped.

MONTH 4

County-wide launch

Outreach through municipal channels, schools, EMS partners, and local employers. Every household onboarded. Platform live for the entire population.

YEAR 2

Sustainability transition

Utilization data justifies the sustainability path that fits your community. Whether municipal billing, layered grants, or hybrid arrangements — the platform becomes permanent infrastructure.

Total new FTEs your district needs to hire: zero.
TAP is the operator. Your district is the partner.

Paid for the care you provide.
Shielded from what the system was never going to pay for.

A population, not just patients.

THIS IS WHAT TORCH LEADERSHIP LOOKS LIKE

The districts that move before the funding window closes — not after.

The districts whose boards see the case study and decide to be the next case study.

The districts that bring the data, the partnership, and the population to their next county commission meeting and say: this is what we built. This is what we shielded. This is what we now see.

Two May deadlines. One conversation to start.

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Thank you.

Let's give your district the same front door — before the deadline closes.

DR. DIRK PERRITT

Founder & CEO · MD Health Pathways

Health Authority, Rockwall County · Congressional Patriot Award recipient · Board-certified emergency medicine

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