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OUR TAKE

for U.S. health care providers

Defining what it means to be a best-in-class rural health system

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Rural health makes up a meaningful piece of the nation's health care infrastructure, but delivering care in rural settings is hard to do. The challenges these rural providers face are both wide-ranging and well-documented. But too often, the conversation stops at defining the problem.

To succeed in the face of major challenges in rural care delivery, we must learn from the providers finding a way to overcome the odds, innovate, and bring high-quality care and economic vitality to the roughly 20% of the country living in rural settings.

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Who is considered a "rural system"?

There is no one standard definition of "rural" or "rural system." CMS provides facility-level classifications based on the US Census Bureau definition of rural. But rural providers agree that rural looks different across geographies, and many providers serve both rural and non-rural patient populations. In the absence of a precise definition, it makes sense to be inclusive; we propose a broader definition that includes systems that self-identify either as rural or as having a significant rural footprint.

Source: Advisory Board interviews and analysis.

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The conventional wisdom

The national conversation on rural health perpetuates the idea of “rural” as “problematic”. The focus revolves primarily around obstacles—higher incidence of poverty, exacerbated workforce shortages, declining patient revenue bases—all leading to extensive hospital closures.

These obstacles are real. Workforce shortages are more dire and more difficult to mitigate in rural settings. Rural populations represent less favorable payer mixes. Rural patients are, on average, older, poorer, sicker, and have higher incidence of unmet social needs, leading to disparities in access to care. Rural areas average 13 PCPs and 30 specialists per 100,000 people compared to 31.2 and 263 per 100,000, respectively, in non-rural areas, and 60% of federally designated health professional shortage areas are rural counties.

Rural hospitals are also struggling financially: 47% are operating on negative margins; 25% are vulnerable to near-term closure; many have closed service lines in recent years. Between 2010 and 2021, 138 rural hospitals have closed their doors completely.

Sources: CMS, Rethinking Rural Health: FY 2020 Year in Review, *cms.gov*, April 2021. Michael Ratcliff et al., Defining Rural at the US Census Bureau, December 2016. Advisory Board interviews and analysis.

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OUR TAKE

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Our take

The conventional wisdom isn't entirely wrong, but it's incomplete. It paints an oversimplified picture of rural providers, and it's somewhat fatalistic. It leaves out the more optimistic parts of the picture that, if better understood, could help identify solutions and chart ways forward for rural health as a whole.

Three key observations:

- "Rural providers" are not a homogeneous group. Not all rural providers are small, independent critical access hospitals – which are indeed often struggling. Medium and large rural-only systems and systems with significant mixed rural and non-rural footprints also make up large swathes of the rural health care delivery landscape. Examining the work of these providers, we see that achieving even moderate regional scale enables providers to marshal the resources needed to attack workforce shortages, provide rural access to specialty care, secure grants, influence policy, and raise clinical quality.
- Among rural systems, we see differences in management capabilities, sophistication, and outcomes. While rural finances are challenging, some rural system leaders have demonstrated the ability to combine scrappiness with financial savvy to run healthy operations and even extend the halo of their clinical services to benefit the health infrastructure of the regions they serve. This same savvy enables these systems to actively invest in and contribute to their communities' economic wellbeing, beyond serving as major employers.
- All rural systems have room to learn and grow. In some areas, such as blending and braiding finance levers, many providers and systems have opportunities to learn from the best practices of others. In other areas, such as bolstering effectiveness in rural policy advocacy, even the strongest-performing leadership teams agree there is potential—and urgency—to improve.

Source: Advisory Board interviews and analysis.

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Six hallmarks of a best-in-class rural health system

When the landscape is full of challenges and so many providers are struggling, it is critical to identify the actions and providers that are succeeding – and understand their keys to success. To find avenues for progress and improvement, we should look to a working set of 'best-in-class' attributes observed among rural systems.

There cannot be a one-size-fits-all model for a best-in-class rural health system, especially given the diversity of the environments in which rural systems operate. However, through interviews with rural providers that appear to be performing well compared to their peers on traditional metrics of success like financial sustainability, quality, and patient access, we have identified some key characteristics and capabilities that seem to position rural systems to succeed in overcoming their unique challenges. On that basis, we propose the following set of attributes as a starting point for defining a 'best-in-class' rural system.

Source: Advisory Board interviews and analysis.

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Six hallmarks of a best-in-class rural health system

01 STRATEGY

Ensure leaders are adept at the art of rural financial leadership

02 STRATEGY

Creatively—and relentlessly– build clinical workforce pipelines

03 STRATEGY

Skew towards keeping care as local as possible (including leveraging telehealth)

04 STRATEGY

Improve the sustainability of local, non-owned providers

05 STRATEGY

Serve as the economic backbone of the community

06 STRATEGY

Consistently represent rural interests in state and national policy discussions (aspirational)

Source: Advisory Board interviews and analysis.

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BEST-IN-CLASS RURAL SYSTEMS….

01 Ensure leaders are adept at the art of rural financial leadership

The financial landscape of rural health is daunting and requires considerable executive creativity, energy, and knowledge to navigate. Most rural systems operate on thin margins or no margin at all—without sophisticated financial management, they can easily face a reality in which their entire margin may hinge on the presence of a single specialist. And the financial bar must be set higher than simple survival—rural systems need enough funding to invest in care transformation and innovation.

All of this underlines how critical it is for rural system leaders to be adept at blending rural-specific reimbursement, grant funding, and philanthropy.

The foundation of whether you're doing effective and innovative things comes down to the sophistication and operational rigor of your leadership team.

Josh Neff, VP Integration & Rural Health
Centura Health

Source: Advisory Board interviews and analysis.

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Expertise in rural reimbursement

Managing rural reimbursement requires in-the-weeds expertise in rural payment models. Rural-specific designations like Rural Health Clinics and Critical Access Hospitals (CAH) are subject to different regulatory requirements and reimbursement rates from traditional Medicare. Tracking new payment models or regulations requires active and ongoing engagement with CMS. These models can be used effectively but are not always intuitive and providers struggle to stay up to date.

Best-in-class systems maintain expertise in and awareness of reimbursement mechanisms and how best to leverage them. Whether this is an executive-level capability they hire for or cultivate through training, a designated individual or team in charge of tracking reimbursement models and requirements, or a purchased service, they guarantee access to the intellectual capital.

> Rural health has some unique opportunities with 340b, rural health clinics, FQHCs – and they aren't just nickels and dimes. But you have to actually know how to use them.
>
> **Curt Hohman, VP Managed Hospital Services**
> Avera Health

Expertise in development

While grant funding is not a sustainable business model, it is an important piece of the fabric of rural health funding. Grants from USDA[1], HRSA[2], and the FCC[3] have long supported rural hospitals, and since the onset of the Covid-19 pandemic, more dollars have flowed to rural health than ever before. But finding and applying for grants has grown increasingly complex and burdensome—applications are often long-winded, set on short timelines, and require a high level of detail. They may also be difficult to find. Resource-strapped rural providers that relegate this responsibility to the side of someone's desk are poorly positioned for success.

1. United States Department of Agriculture.
2. Health Resources and Services Administration.
3. Federal Communications Commission.

Source: Advisory Board interviews and analysis.

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Best-in-class systems have dedicated grant writers with expertise in rural health. Our research contacts universally emphasized that protecting the time and focus of grants professionals was crucial to enabling them to effectively identify, win, and best leverage grant funding. These systems use grant funding to create sustainable care models. For example, Avera's eCare platform, which they white-labeled and rolled out for 40 states before selling to Aquiline for broader commercialization, began as a grant-funded telehealth program.

Similar to grant funding, best-in-class systems are able to attract and leverage philanthropy dollars to advance rural health. One provider leader explained that rural systems often lose out on donor-based giving because "they don't know how to tell their story—it's not a skill set they've cultivated." But best-in-class rural systems motivate donors by laying out a clear, personalized vision of improving rural health, and then demonstrating a tangible return for donors.

DATA SPOTLIGHT

7%

Philanthropy dollars nationally go to rural recipients

Sanford Health leverages gift to sustainably elevate diagnostic care

Sanford used philanthropic funding to meet their goal of providing near-universal access to 3D mammography machines, since these machines offer better detection than 2D. They loaded the machines onto trucks to reach remote patients. Of the 86,000 mammograms performed in 2019, 96% were done using the 3D machines. Sanford was able to demonstrate a higher detection rate and, using that data, secure reimbursement for universal use of the more expensive screening technology. They translated giving-based funding into a sustainable care model.

Source: Allen Smart, "Family Funders: Always Important in Rural Communities", *Philanthropy News Digest*, August 2019. Advisory Board research and interviews.

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BEST-IN-CLASS RURAL SYSTEMS…

02 Cultivate rural clinical workforce pipelines

Given worsening workforce shortages and increasing complexity of rural populations, best-in-class rural systems creatively—and relentlessly—build clinical workforce pipelines, partnering with local and state educational institutions to cultivate physician, nurse, and other clinical talent. They focus on a few key avenues.

Increasing rural matriculation to medical school

Clinicians who come from rural communities are more likely to practice in rural settings, but rural students are poorly represented in medical education: less than 5% of medical students are from rural areas. Systems take different approaches to decreasing the disparity. For example, UK HealthCare (the clinical arm of the University of Kentucky) works with its partners to identify students from rural Kentucky in order to encourage them to apply for medical school and residencies in the state. University of New Mexico Health Sciences Center (UNM) takes a more upstream approach.

University of New Mexico takes an upstream approach to workforce development

Students from rural areas are often at a disadvantage when it comes to medical school application since lower educational opportunity and higher incidence of poverty mean they're less likely to have access to resources like MCAT prep courses to position them for success. To solve for this, UNM created the UNM BA/MD program. Every year, UNM guarantees a select number of high-performing high school students acceptance to UNM School of Medicine as long as the students graduate college. UNM provides students with academic support throughout their college careers to ensure readiness for medical school upon graduation. Many of these students return to their home communities to practice upon graduation from UNM.

Source: Peter Jaret, "Attracting the next generation of physicians to rural medicine," *AAMCNews*, February 2019. Advisory Board research and interviews.

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Increasing exposure to rural medicine during medical school

Many clinicians without exposure to rural living are opposed to taking on rural placements, and rural providers often can't compete with the large signing bonuses and inflated wages non-rural systems offer in order to compete amidst widespread workforce shortages. Federal investment in graduate medical education doesn't help: of Medicare's $14B investment in graduate medical education, less than 1% goes toward rural.

That's why several leading medical schools in rural states have developed rural tracks, programs, and clinical rotations that provide students with early exposure to rural medicine. Programs place students across a range of inpatient and outpatient settings. For example, with the support of the local hospital, UK HealthCare established a residency in integrated primary care and behavioral at a rural FQHC. Establishing this clinical pipeline has reversed the persistent physician shortage in the home and surrounding counties. Sanford Health is doubling its medical residency slots, including adding residencies in key specialties, to help improve rural access to specialty care.

~ 20%

Of medical schools offer a rural track, as of 2019

Federal- and state-orchestrated rural loan forgiveness programs can help systems attract clinicians once they're already practicing, but best-in-class systems tap into this pipeline upstream to increase exposure.

Source: "Rural Reckoning," *Modern Healthcare*, October 18th, 2021. Lauren Weber, "They Enrolled in Medical School to Practice Rural Medicine. What Happened?", *KHN.org*, October 2019. Advisory Board research and interviews.

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Diversifying the pipeline by broadening the health care workforce candidate pool

Traditional physician and nursing pipelines will likely be insufficient to meet future workforce demands, especially in rural health. Therefore, best-in-class providers are cultivating non-traditional workforce pipelines from their communities. In some cases, this means tapping into new populations to fill existing roles. Avera used grant funding to pay for nursing school – and childcare support – for individuals looking to enter the clinical workforce later in life. This was especially effective given many families in agricultural communities rely on stable income and benefits from hospital-related jobs to supplement income from farming. Other times, this means finding new-in-kind ways to fill gaps.

RURAL INNOVATION

UNM taps into complimentary pools to bridge gaps in workforce

- **Community health workers address SDOH.** 50% of individuals in New Mexico struggle with at least one social determinant of health, and clinicians are often not best suited or positioned to address them. UNM developed a scalable community health worker (CHW) model, hiring individuals at the high school diploma level and training them to serve the communities they come from. The CHW model was so successful in mitigating SDOH and improving population health that it became a nationally recognized model and staffing designation, reimbursable in certain states. All UNM-affiliated primary care clinics and emergency departments now include CHWs.

- **Agricultural Community Extension programs provide nutritionist capacity.** Most rural FQHCs can't afford or sustain nutritionists, but Cooperative Extension programs located in rural and frontier communities have nutritionists that can offer some capacity. This is especially critical given the high prevalence of diabetes in rural areas.

- **Health Extension agents upskill ranchers to provide prehospital trauma care.** Farming and ranching are among the most dangerous professions in the US, but rural and frontier communities have severe EMS shortages and long response times. UNM's health extension workers train ranchers in basic first aid and trauma management.

These cross-industry relationships will prove to be important: as mechanization shrinks the job market in agriculture, health care can look to absorb STEM-inclined candidates from the prospective agricultural workforce pipeline.

Source: Advisory Board research and interviews.

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BEST-IN-CLASS RURAL SYSTEMS…

03 Skew toward keeping care as local as possible

Keeping care local mitigates physical access barriers, improves patient experience, and keeps revenue in local communities. The challenge: not all rural facilities are equipped to manage all clinical care. Best-in-class systems leverage robust telehealth capabilities and partnerships with clinical and non-clinical institutions to achieve the goal of keeping as much care local as possible while guaranteeing patients receive appropriate care.

Extending the reach of scarce resources: telehealth consults allow for scale of specialty care

Use of telehealth has skyrocketed since the onset of the Covid-19 pandemic, but prior to the pandemic, telehealth was already providing a lifeline to care – especially specialty care – for rural providers. Unit closures have increased alongside hospital closures in recent years, but best-in-class systems are able to take a principled approach to service rationalization that leverages telehealth to maintain or even improve – not reduce – patient access to care. Specialists can provide direct patient care or provider-to-provider consults, synchronously or asynchronously. Best-in-class systems also extend care protocols and standards across all system facilities, ensuring accountability for hitting quality standards and providing access to the resources needed to do so.

> People shouldn’t be penalized because they live in a rural community. We recognize it’s hard to sustain a psychiatrist or rheumatologist in a small community. But if you can bring crisis care, cardiology, rheumatology, etc. to rural communities through telehealth, it improves access, enhances quality, and aligns care more closely with what they might receive in an urban setting.
>
> **Jim Sheets, VP – COO, Specialty Based Care**, Intermountain Healthcare

> Everything we do, we do better because we’re part of Intermountain Healthcare. 10 years ago, cancer patients didn’t have access to chemo in our community. Tele-oncology has allowed patients to see world-class oncologists and receive treatments without the burden of travel. And Intermountain expects our quality outcomes to be just as good as any other Intermountain hospital.
>
> **Ben Smalley, Administrator/CEO**, Cassia Regional Hospital, Intermountain Healthcare

Source: Advisory Board interviews and analysis.

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Meeting patients where they are: Community-based services eliminate transportation and logistical barriers to improve pediatric access to care

Many rural patients face barriers to physically accessing care, such as long drive times, inclement weather, or unforgiving terrain. Best-in-class systems mitigate physical access barriers by bringing care and other services out into the community. Mobile clinics have become an increasingly popular tool to make it convenient for patients to access care, but they aren't the only solution.

School-based health is a longstanding, demonstrated-effective method of improving access to care – predominantly primary care – for students. There are around 2,500 school-based clinics across the country, 35% of which are in rural areas.

Atrium's school-based clinics improve pediatric access, reduce pediatric ED use

In Cleveland County, North Carolina, Atrium Health identified elevated rates of pediatric ED visits and a corresponding lack of pediatric primary care in the county. Working with the local schools, Atrium opened school-based virtual primary care clinics in 2017 to improve access to preventive care, reduce pediatric ED use, and increase in-school days. In its first four years, the program has seen a 90% student enrollment rate, thousands of virtual primary care visits, and a 40% reduction in ED use among enrolled students. The program is beginning to offer mental health services as part of the program in the 2021-2022 school year.

Source: Emily Katz, "Realizing the Potential of School-Based Health Centers: A Research Brief and Implementation Guide," *The Education Redesign Lab*, September 2019. Mari Devereax, "School-based telehealth centers bridges gaps in care", *Modern Healthcare*, August 2021. Advisory Board interviews and analysis.

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Hardwiring escalation processes: guarantee timely access to high-acuity care

While systems prioritize keeping care local, it's imperative for rural hospitals to be able to safely escalate care when needed. Many rural hospitals, especially CAHs, aren't equipped to manage the highest-acuity patients (e.g., major traumas or medical escalations). That's not a commentary on the quality of services provided, contrary to common perception -- it's a function of the scope of services any given facility can sustain. Rural systems must have protocols in place to safely stabilize and transfer patients from local facilities to higher acuity care when clinically indicated.[1]

> Being 'best in class' means being able to meet the needs of the community, including arranging for whatever services patients might need beyond what can be provided locally.
>
> ***Population health leader at a large system in the Southeast***

For many providers, transfers involve a simple phone call from one facility to another to issue notice of transfer. But best-in-class systems, particularly those serving markets that are widely geographically dispersed or have major transportation challenges, look to impose more structure over transfer protocols to increase reliability. For example, UNM developed the Patient Access Line (PALS) to try and keep high-acuity patients local and to minimize the burden on small rural facilities of coordinating patient transport. Through PALS, rural providers are able to consult the flagship hospital for patients that may require emergency transport. The consultant can advise for immediate transport or recommend a course of treatment. The rural hospital will monitor the patient and ultimately make a joint decision with the consultant regarding whether or not the patient needs to be moved. PALS will then orchestrate transport, including air ambulance transport for patients located more than a few hours away from the flagship.

Rural health systems that are able to invest in air ambulance companies are able to facilitate nimbler and more reliable patient transfer regardless of geography.

1. Federal regulations require CAHs to have a referral relationship with an acute care hospital as a condition of participation.

Source: Advisory Board interviews and analysis..

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Keeping patients – and dollars – close to home: Backtransfers optimize patient experience and rural hospital financials

While transfers to higher-acuity sites of care are common and may be highly proceduralized, the reverse – moving patients back out to their communities when they no longer require the highest acuity level of care – is far less standardized or common. Clinically appropriate “backtransfers” can alleviate capacity constraints and improve throughput for flagship hospitals. They bring needed volumes and revenues to local communities. And they benefit patients by keeping them closer to home where the environment is more familiar and family members can more easily visit.

Unfortunately, backtransfers are logistically and financially challenging, and providers often aren’t set up to handle the complexity. Regulations around bed licensure can preclude hospitals from operating swing beds to allow for convalescence. And since DRGs are bundled and can’t easily be split across multiple facilities, backtransfers often involve revenue sacrifice on the part of the transferring facility. While this may work in one-off instances, it is not a sustainable model to scale.

OCCUPANCY PREDICTS SUSTAINABILITY

0.1% vs. 4.7%

Operating margin of rural hospitals with low versus high occupancy rates

You don’t keep the aging spouse of a farmer in a large metro hospital unless you need to – they need to be back in their community, in familiar surroundings where the RN taking care of them is likely someone they know and maybe even babysat 50 years ago.

Josh Neff,
VP Integration & Rural Health
Centura Health

Even the strongest rural provider systems tend to struggle in this area today. Overcoming these barriers will require payment and regulatory changes.

Sources: Hayley Drew Germack, et al, “When Rural Hospitals Close, The Physician Workforce Goes”, *Health Affairs*, December 2019.; Advisory Board interviews and analysis.

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BEST-IN-CLASS RURAL SYSTEMS…

04 Improve the sustainability of local, non-owned providers

Best-in-class rural systems improve the operating capacity of small, independent providers in their regions through outreach or health extension in order to protect the clinical infrastructure of the region and, by extension, the integrity of the regional economy.

Rural hospital closures threaten patient access to care, economic survival of rural communities, and sustainability of the remaining health infrastructure – which runs contrary to the mission of best-in-class, not-for-profit rural systems. When a hospital faces closure, neighboring rural systems are often faced with a decision to either make the large capital investment to acquire the facility or else take on the additional volumes formerly served by the closed hospital, which may strain their infrastructure and reduce their case mix.

8.2%

Average reduction in supply of PCPs in the six years following a rural hospital closure

From both a mission and margin standpoint, it often makes sense for neighboring rural systems to keep struggling area hospitals afloat through non-acquisition forms of support. This support can also present a revenue stream, either directly through contractual arrangements or indirectly through changes in referral patterns that result in favorable downstream volumes for the supporting system. For all these reasons, best-in-class rural systems work creatively to find ways to support the survival of their non-owned, independent peers—in ways that are sustainable to the partner system as well.

We start with the notion that people should expect the same health outcomes regardless of zip code and work to deliver on that. If there’s a need to be met, we need to shoulder that responsibility.

Bill Gassen, CEO, Sanford Health

Sources: Hayley Drew Germack, Ryan Kandrack, Grant R. Martsolf "When Rural Hospitals Close, The Physician Workforce Goes", *Health Affairs*, December 2019.; Advisory Board interviews and analysis.

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Outreach networks take varied approaches to building clinical or business capacity

Despite having the same ultimate goals, every outreach or health extension network looks different: some partnerships focus more heavily on clinical care and capacity building, while others focus on strengthening executive and board leadership and/or improving operational management. Many do both.

Avera provides shared services and regulatory support

Avera acts as a quasi-MSO to support its managed hospital network, extending shared services resources (including purchasing) and business expertise to improve the sustainability of hospital operations without taking on formal hospital leadership or decision-making. Managed hospitals pay a flat fee, and Avera also benefits from reduced purchasing prices gained from having greater scale. For example, when Avera needed to order new CT scanners, the system was able to combine its order with scanners for managed hospitals, increasing the order size from 10 to 23 scanners and reducing the unit cost.

Avera also works closely with rural boards and executive leadership to provide ongoing policy expertise and guidance, since smaller rural facilities typically have less capacity to closely track policy developments.

When a new regulation comes out, independent rural hospitals are either going to a free CMS seminar to learn about it at a high level, hiring a consultant to help them comply with the rules – which is not financially sustainable in the long term – or figuring it out as they go and reinventing the wheel every time. We're doing that work anyway – we can just share what we learn.

Curt Hohman, VP Managed Hospital Services
Avera Health

Source: Advisory Board interviews and analysis.

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UK builds service line capacity

UK HealthCare provides affiliate hospitals in Kentucky with 'a la carte' access to service line capacity building. They share clinical protocols, advise hospitals on how to adhere to national and state guidelines (e.g., Meaningful Use), and support quality improvement efforts. Specifically, through these contractual arrangements, UK service line experts help affiliate hospitals develop clinical workflows and EMR protocols, provide training to affiliate staff, and have considered providing direct software support (e.g., by appropriately extending UK's software license agreements).

Service lines supported by UK:

- Neurology/Stroke
- Stroke
- Cancer
- Pediatrics
- Cardiovascular services
- Maternal/Fetal Medicine

Centura combines leadership development and clinical affiliation

Hospitals in Centura's managed hospital network are managed by Centura and governed locally – CEOs are Centura employees, but the boards, who retain decision-making power, are independent, often quasi-governmental agencies or special tax districts. The network focuses on two goals: upskilling the board and executive leadership and filling unmet clinical needs by improving local access to primary and specialty care.

1. *Filling the void on rural health leadership development*

While there is increasing focus on developing a clinical rural workforce, few organizations focus on cultivating rural leadership capabilities. Centura provides affiliated hospitals with a range of operational services, including comprehensive board governance education and leadership mentoring. Consultants provide hands-on guidance, helping affiliates delineate the roles and responsibilities of leaders tasked with governance versus management. Centura's collaborative approach has enabled them to act as a trusted advisor to rural hospitals and avoid the common pitfall of steamrolling rural affiliates. As a result, they've helped bring multiple hospitals back from the brink of closure in recent years.

Source: Advisory Board interviews and analysis.

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2. *Taking a 'non-growth approach to growth' through clinical outreach*

Centura provides clinical support to affiliate hospitals as an exercise of its mission and vision – in many cases, it doesn't charge for clinical outreach services. This allows affiliate hospitals to retain as much local volume and revenue as possible. The result is improved access to higher levels of care in the region, direct care revenue for the affiliate hospital, and incremental downstream revenue for Centura.

As part of outreach efforts, physicians also provide capacity building. Specialists partner with local clinical teams and create formalized care collaboratives to improve continuity of care between Centura and host providers, forging deep community relationships and resulting in improved clinical outcomes for Centura and its affiliates.

It's a non-growth approach to growth. We do it as part of our mission and vision. At the end of the day, if I send a specialist to a rural community, we'll likely see some volume growth at the system level. But the primary driver is that our mission calls us to care for our most marginalized and underserved communities across Colorado and Western Kansas.

Josh Neff, VP Integration and Rural Health
Centura Health

Source: Advisory Board interviews and analysis.

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BEST-IN-CLASS RURAL SYSTEMS…

05 Serve as economic backbones of their communities

Rural health systems serve as backbones of their communities, advancing not just clinical but economic health for the communities they serve. Most rural hospitals are the major employers in their communities; best-in-class systems take that role a step further and take active part in improving the economic landscape as well. They accomplish this by filling a few different roles.

1. Leading the charge

Health systems can take on the primary role of spearheading initiatives or directly leading efforts to improve economic health.

Avera empowers local businesses

Avera Health extends its purchasing power and grant writing capacity beyond its owned and affiliated hospitals to include other businesses in its communities. Avera PACE, Avera's GPO, helps local schools, long-term care facilities, etc. access supplies at lower cost. And Avera's Rural Health Services department provides pro bono grant support to organizations in its rural communities, writing grants when need and bandwidth align and sourcing grant ideas to inform grant development.

Sanford invests in community vitality

Sanford Health is making a direct investment in increasing both the physical wellness as well as the tax base of the areas surrounding its home city of Sioux Falls, SD. Leveraging part of a philanthropic gift to expand the Sanford Sports Complex, Sanford aims to attract over one million visitors to the community every year and increase employment opportunities, making the community a more attractive place to live (which in turn makes it easier to recruit talent and industry to the area).

Source: Advisory Board interviews and analysis.

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2. Supporting community efforts

Systems don't always need to take charge – they also support other community-based entities. At a baseline, it is common for health system staff to take on leadership roles elsewhere in the community, for example, within congregations or on school boards. Taking it a step further, systems work to amplify existing efforts to address shared needs in the communities they serve.

Many rural areas still experience limited access to broadband, compromising access to care and remote school and work. This is a problem throughout areas of Appalachia, including UK HealthCare's service area. Rather than lead the charge, UK supports existing efforts orchestrated by Supporting Our Appalachian Region (SOAR), a regional non-profit that has developed a blueprint to realize universal access to broadband in Eastern Kentucky.

>40%

Of people living 70+ minutes from a PCP have the necessary internet bandwidth to support a telehealth visit

3. Convening community stakeholders

Finally, best-in-class systems act as conveners, bringing together community stakeholders in service of improving the health of the community. When an individual donor spearheaded the initial building of a green belt in their community, Tanner Health System partnered with the local government to have a section of the green belt run through the hospital campus and connect to Tanner's existing walking trail. They worked with the local government and other community partners to create a bikeshare program on the green belt and provided training on how to organize community events (e.g.,5ks) that encourage use of the space.

Advisory Board interviews and analysis.

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BEST-IN-CLASS RURAL SYSTEMS…

06 Represent rural interests in state and national policy

(even if this remains aspirational)

Rural health leaders simultaneously identify advocacy as a ‘need-to-have’ capability for leading rural health systems and acknowledge that to date, few if any systems have realized this imperative. Rural needs are chronically underrepresented in health policymaking, especially at the federal level, resulting in regulations and policies that fail to accommodate the realities of working in rural settings. Policies and funding opportunities are then reactive to the consequences. For example, the CAH model was created after ~400 rural hospital closures in the 1980s and 1990s. Billions of federal grant dollars have been flushed into supporting rural providers in developing telehealth infrastructures and support for telehealth parity has grown after the pandemic shone a light on the critical role telehealth plays in mitigating rural access barriers to care.

Most rural systems have roles or even teams dedicated to health policy and/or government affairs. Still, they acknowledge that advocacy has been limited to date because it’s not internally viewed as a core priority or competency. Those working to move the needle on influencing policy point to two key areas to develop in order to improve effectiveness.

> Some of the best policy leaders and advocates are rural community hospital CEOs. They understand their communities’ needs and difficulties. They have creative ideas for solutions. But it’s really hard to run a facility in those environments – running operations is higher on the list of ‘need to do.’

Population health leader at a large system in the Southeast

Source: Advisory Board interviews and analysis.

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1. Amplify the voices of rural hospital CEOs

The individuals that are perhaps best positioned to weigh in on policy are exceptional frontline rural hospital administrators – those transformational leaders who display the innovation and creativity needed to successfully navigate the rural landscape. But their primary priority lies in hospital operations – and the stakes for success are high. Best-in-class systems need to develop intentional avenues and mechanisms to collect, channel, and amplify these frontline leaders' ideas. Designated government affairs staff can then leverage their deep relationships with policymakers to incorporate them into policy discussions.

It comes back to relationships; you must make time to show up where lawmakers are and to provide them opportunities to come see the reality on the ground and hear it directly from their constituents.

Barbara Petee, Chief Advocacy and Government Affairs Officer
ProMedica

2. Cultivate and leverage relationships with advocacy organizations and public representatives

Best-in-class systems have staff dedicated to forming and maintaining relationships with key players in government and health agencies. Because rural health is a heavily relationship-based business, it's crucial to maintain personal rapport between the system and the institutions with strong or direct influence over policy. Effective government affairs/advocacy leaders serve as conduits, communicating policy ideas or concerns generated by the health system while also providing avenues for agencies to actively engage with, hear from, and witness the realities of the constituents they represent, firsthand. These relationships are more prevalent at the state level; national-level engagement remains more difficult.

Source: Advisory Board interviews and analysis.

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Sample policy/regulatory areas that need greater rural representation:

- **Facility designations.** The CAH model was intended to improve sustainability of rural hospitals but created an inpatient-dependent infrastructure for rural care delivery. The new Rural Emergency Hospital model aims to mitigate that but doesn't currently allow for swing beds that could accommodate back transfers and support sustainability.
- **Payment models.** Inflexible payment bundles may prevent rural hospitals from offering services they're equipped to offer, compromising patient access and rural hospital revenue (see backtransfer example on page 17).
- **Quality measurement.** Rural hospitals are often precluded from national quality benchmarking (e.g., CMS Star ratings) because they can't meet minimum volume thresholds to report data, but people take this to mean the hospitals offer lower quality. Recent efforts to mitigate these challenges inadvertently removed rural-relevant measures, further reducing reporting eligibility.
- **Medicaid expansion.** Rural hospitals aren't financially well positioned to sustain charity care, but not all rural states have expanded Medicaid. From 2007-2017, 63% of rural hospital closures were in non-expansion states.

With a growing national awareness of rural/urban disparities and billions of dollars being directed to support rural providers, rural health system leaders have an opportunity to establish a seat at the table and elevate rural interests in federal health policymaking.

Sources: Cheryl L. Damberg, Maria DeYoreo, Ashley M. Kranz, Claire E. O'Hanlon, Justin Timbie, "Overall Hospital Quality Star Rating: Overview For Flex Programs and Rural Stakeholders", *National Rural Health Resource Center*, May 2021. "Foundation Funding to Improve Rural Health Care", *HealthAffairs*, 2019. Advisory Board interviews and analysis.

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Parting thoughts

Right now is a unique time for rural health. While the challenges facing rural providers remain persistent as ever, a convergence of factors is setting the stage for best-in-class rural health systems to take on a more prominent voice in the national health care discourse.

Covid-19 shone a light on rural areas. It increased the awareness of the structural barriers to health and resulting disparities faced by rural populations; it also increased the appeal of rural living for many, demonstrated by increased migration from urban to rural areas with the expansion of remote work. The explosion and predicted staying power of telehealth, and the acknowledgement of the role it plays in providing rural access to care will benefit rural systems in both the near and long term. Record amounts of federal funding are pouring into supporting rural providers and tackling longstanding rural challenges like access to internet. And support for improving rural health comes from both sides of the political aisle, meaning it's unlikely to go away soon.

But a brighter spotlight and an increase in grant funding, while positive in the short term, will not solve the challenges rural providers face. To take advantage of the opportunities presented in this moment, best-in-class rural systems need to chart the way. And that starts with establishing goal posts for what it means to be a 'best-in-class rural system': leveraging resources and scale to combat obstinate barriers to care delivery, improve the health and economic infrastructure of a region, and ultimately amplify rural voices in national decision-making.

Source: Advisory Board interviews and analysis.

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