



FINAL RECOMMENDATIONS

FUTURE OF RURAL HEALTH CARE TASK FORCE

MAY 2021

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AHA TASK FORCE ON THE FUTURE OF RURAL HEALTH CARE

Kris Doody, R.N. (Chair)

CEO, Cary Medical Center
Caribou, ME

Nancy Agee

President and CEO
Carilion Clinic
Roanoke, VA

Benjamin Anderson

Vice President
Rural Health and Hospitals
Colorado Hospital Association
Greenwood Village, CO

Kimberly Hupp Bordenkircher

Former CEO
Henry County Hospital
Napoleon, OH

Thomas Buckingham

Former EVP, Strategy
Select Medical Corporation
Mechanicsburg, PA

Christina Campos

Administrator
Guadalupe County Hospital
Santa Rosa, NM

Casey Cooper

CEO
Cherokee Hospital
Cherokee, NC

Elaine Couture

Regional CEO
Providence St. Joseph Health
Spokane, WA

David Dill

President and CEO
LifePoint Health
Brentwood, TN

Christopher Dorman

President and CEO
Tift Regional Health Systems
Tifton, GA

William Ferniany, M.D.

CEO
UAB Health System
Birmingham, AL

Keith Heuser

Market President
CHI Mercy Health
Valley City, ND

Rex McKinney

President and CEO
Decatur County Memorial Hospital
Greensburg, IN

Timothy Moore

President and CEO
Mississippi Hospital Association
Madison, MS

Karen Murphy

Chief Innovation Officer
Geisinger
Danville, PA

Jon Ness

CEO
Kootenai Health
Coeur D'Alene, ID

Kirk Norris

President and CEO
Iowa Hospital Association
Des Moines, IA

Greg Poulsen

SVP, Policy
Intermountain Health
Salt Lake City, UT

Mary Ellen Pratt

CEO
St. James Parish Hospital
Lutcher, LA

David Ressler

CEO
Aspen Valley Hospital
Aspen, CO

Carrie Saia

CEO
Holton Community Hospital
Holton, KS

David Schreiner

President and CEO
Katherine Shaw Bethea Hospital
Dixon, IL

Joanne Schroeder

President
Munson Charlevoix Hospital
Charlevoix, MI

Rachelle Schultz

President and CEO
Winona Health
Winona, MN

Terry Scoggin

CEO
Titus Regional Medical Center
Mount Pleasant, TX

Erik Thorsen

CEO
Columbia Memorial
Astoria, OR

Roxie Cannon Wells, M.D.

CEO
Cape Fear Valley Hoke Healthcare
and Valley Bladen Healthcare
Fayetteville, NC

Thomas Worsley

President
Regional Spearfish Hospital
and Hills Markets
Rapid City, SD

EXECUTIVE SUMMARY

As we write this report in December 2020, health care providers across the nation are working around the clock to battle the COVID-19 pandemic. More than 2.2 million rural residents have tested positive since the beginning of the pandemic — 15.6% of U.S. cases, even though rural residents represent only 14% of the overall population.¹ With cases and hospitalizations surging, hospitals and health care providers have worked tirelessly to respond to the growing demand for care. In rural areas, with fewer providers of both primary and specialty care, the situation has been doubly challenging.



We've been waving the flag for years about vulnerability in rural hospitals. The pandemic really exposed those gaps in the system.

— Member Observation at December 2020 Rural Health Care Task Force Meeting —

Rural providers have stepped up despite those challenges. Not only have rural hospitals taken the lead in testing and public health messaging in their own communities, but many have also received patients from urban hospitals overwhelmed with complex COVID cases.

Against this backdrop, the Future of Rural Health Care Task Force met regularly to focus on long-range solutions for rural health care while simultaneously immersed in the crisis of the pandemic. Convened by the American Hospital

Association in July 2019, the group of 28 rural hospital CEOs and state hospital association executives was charged with exploring the challenges and strengths in rural hospitals and identifying and developing bold solutions and promising practices to help ensure ongoing access to care for the 60 million² U.S. residents who live in rural areas. The critical nature of their task became more evident as COVID-19 quickly revealed weaknesses in our health care system, especially in rural areas.

Envisioning Rural Health Care Transformation

In early 2019, the American Hospital Association (AHA) released “Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care.” The report identified the obstacles and opportunities in rural health care and laid out a roadmap for action, including proposed federal policies and investments to support rural hospitals and communities.³

But, as the 2019 report acknowledged, federal policy alone will not ensure the future of rural health care. Creative thinking and innovation on a state, community and institutional level are essential to the operational transformation of rural health care in America — as well as the improved health of rural residents.

The Future of Rural Health Care Task Force was tasked with envisioning a range of bold solutions and promising practices to achieve that transformation. This report is the result of that visioning process. It depicts the landscape of rural health care today, then describes a set of innovative solutions and promising practices for care delivery as well as financial models to ensure the financial stability of rural hospitals and access to care for rural residents.

The four innovative solutions include:

1. Public-private Funding for Core Services.

Recognizing that some of the most essential health care services in rural areas are also costly to deliver because of geography and low population density, the Task Force proposes a new funding system by which public and private payers pool funds to pay for a defined set of essential services to a particular community. Designed in collaboration with payers, providers and communities themselves, this bold solution reframes both health and health care, promotes preventive care, addresses the social determinants of health and builds a community investment in improving health and health outcomes.

2. Flexible Funding Programs to Support Rural Hospital Infrastructure Transformation. Rural hospitals face a perennial problem: low patient volumes drive up the cost of care delivery while low reimbursement rates necessitate thin margins. As a result, rural hospitals often do not have access to the capital needed to maintain and adapt infrastructure, including buildings, clinical equipment and technology. The Task Force recommends developing new ways to fund infrastructure by promoting existing resources (e.g., Community Development Financial Institutions and other government programs and philanthropic opportunities), while building regional collaborations with other providers to develop complementary rather than competitive services. The eventual goal would be to develop a rural health care infrastructure that blends people, processes and technology and allows for clinical transformation across facilities and specialties to deliver appropriate care regardless of location.

3. Create a Rural Design Center Within CMMI.

Established in 2010 by the Patient Protection and Affordable Care Act, CMMI tests innovative

payment and delivery models to improve quality of care while lowering costs. However, rural hospitals rarely meet the patient volumes and other requirements for participation in these programs. Creating a Rural Design Center would provide CMMI with the expertise and insights necessary for developing programs to adapt existing projects to a rural framework and also give rural hospitals the opportunity to innovate on the local level.

4. Grant-Writing Gig Economy. Government agencies, non-profit organizations and philanthropic groups have grant programs available for health care organizations, including those in rural areas. However, many rural facilities do not have the staff time or expertise necessary to successfully apply for, receive and manage grant funds. An online platform and corresponding app that matches rural hospitals with qualified grant writers may help smaller facilities secure funding for needed services and programs.

In addition to these four innovative solutions, the Task Force identified eight promising practices — programs and initiatives already underway in parts of the country — that should be scaled up and spread nationally to support rural hospitals. These include:

1. Global Budget Payment Model. Global Budget Payment Models — like the Pennsylvania Rural Health Model and All Payer ACOs in Maryland and Vermont — have been credited with providing a more reliable funding stream that gives hospitals more flexibility and allows greater innovation in times of need.

2. Rural Hospital Federal Tax Credit Program. In Georgia, the Rural Hospital Tax Credit Program, which took effect in 2017, has increased donations to rural hospitals by offering donors a tax credit (rather than a tax deduction) on their

state taxes. Expanding this tax credit program nationally with a federal tax credit can provide essential funds to support rural hospitals in all states, including those without state income taxes.

3. Telemedicine. The rapid adoption of telemedicine during the COVID-19 pandemic has highlighted both the benefits and the obstacles connected with effective deployment, especially in rural areas. Addressing regulatory obstacles (relaxed during the pandemic but not permanently) and promoting underutilized resources can help build this capability nationally.

4. Strategic Partnerships and Affiliations. Models are evolving for new types of partnerships and affiliations that achieve objectives for both rural and urban organizations and revitalize healthcare delivery in rural areas. Options exist short of acquisition, including clinical affiliation or hospital management or telemedicine arrangements. By building on their role as connectors in their communities, rural hospitals can optimize the services they offer while becoming more sustainable and more effectively addressing challenges that affect patient care.

5. Broadband and Mobile Technology. Increasing availability of broadband and/or high-speed mobile networks holds the potential to improve health care delivery and health monitoring for a broad swath of the country. Broadband and mobile technology – including texts; video and audio calls; and apps – can help providers expand their scope of services, extend their service area and provide more reliable connectivity.

6. Leadership. Rural communities need an investment in transformational leadership development for health care leaders; visionary leaders are critical to innovation and

sustained change in rural health care. Training programs specifically targeted to health care administrators, hospital board members and others can help create and transform health care systems in rural areas.

7. Rural Philanthropy. Integrating philanthropy into a hospital's strategic plan should be a part of a long-term trajectory to promote investments in the health of a community. Forming long-term partnerships with funders and building relationships over time can lead to more funding opportunities and more secure financial footing for rural hospitals.

8. Maternal Health. Increasing national awareness of maternal health outcomes — and disparities among different racial/ethnic groups — in the U.S. provide an opportunity to expand current models and best practices that hold promise. These include increasing access to doula services, targeting and improving outcomes for high-risk women and instituting group prenatal care appointments to improve engagement and information sharing among pregnant women.

The solutions needed in rural health care are not one-size-fits-all. Rural America is not a monolith, but a patchwork of unique communities and populations. Recognizing this reality, the Task Force created these solutions and highlighted these promising practices because they can be tailored to the contexts of rural hospitals and the communities they serve.

Likewise, ensuring the future of rural health care is not the responsibility of any one segment or stakeholder in rural health care. Collaboration and contributions at all levels — facility, community, non-profit and corporate, state and federal governments — are necessary to implement these proposed solutions and to continue to inspire and sustain innovations that promote the health of rural residents and their communities.

INTRODUCTION

In 2019, the American Hospital Association brought together a group of 28 rural hospital CEOs and state hospital association executives from clinical and non-clinical backgrounds to form AHA's Future of Rural Health Care Task Force. The goal was to build out expertise in long-term strategic policy planning for rural health care and develop sustainable approaches and actionable solutions to finance and deliver care in rural settings. Led by Board Chair Kris Doody R.N., CEO of Cary Medical Center in Caribou, Maine, the group represents independent and system-owned hospitals, as well as different Medicare designations, including critical access hospitals.

In 2019, the group knew the task ahead would be difficult. In 2020, they faced even greater challenges than they could have imagined as the COVID-19 pandemic ravaged the country, sending health care institutions from coast to coast into crisis mode.

After the launch of the Task Force, members were interviewed between July and October 2019 to collect



Rural hospitals should lead as a community convener and/or convening partner to leverage the collaborative, resilient, and resourceful nature of their communities, local businesses, regional partners and payers. Flexible solutions should result in vibrant, healthy communities with equal and seamless access to essential health care services that are sustainably funded, safe for the patient and health care workforce, and appropriate.

– AHA Future of Rural Health Care Task Force –

their early insights about the charge and vision for the work ahead. A few themes emerged:

- Desire for strategies and solutions they could put to work in their communities
- Cultivate collaborative relationships with their peers
- Learn about the roles and capacities of fellow Task Force members' organizations
- Develop a clearer understanding of policy options to address the needs of rural health care

The Task Force has worked (both during meetings and in separate interview/pre-work sessions) to refine and finalize comprehensive solutions that address the well documented needs in rural health care and that build a pathway toward sustainable care delivery and financing mechanisms.

AHA staff captured the content from Task Force discussions and curated them into recommendations. We received additional input from the Leadership Forum, an external group of 16 leading voices working on rural health issues, who offered diverse perspectives, expertise and broad thought leadership on the proposed solutions that emerged from Task Force deliberations. The Task Force has continued to show resiliency in creating long-range solutions, despite the challenge of looking beyond the short-term in the midst of a fluctuating pandemic.

BACKGROUND

The United States rural health care system provides services to 60 million people: roughly one in five residents of this country.⁴ For the most part, these services are provided by rural hospitals and health systems, institutions that are central to their local community and culture. Delivering health care in rural areas has never been easy, but the challenges to these institutions have increased and intensified in recent years, leading to a crisis that must be addressed.

Rural hospitals are often the first point of contact in the health care system for rural communities. They hold the opportunity to guide, coordinate and build patient experiences that connect community members to their



care. Rural communities are resilient, self-reliant and adept at optimizing resources, even when scarce. Knit by close relationships, rural hospitals form strong bonds across agencies and sectors, often bringing together people of diverse backgrounds and beliefs through the common interest in a healthy, vibrant population.

Rural hospitals are an economic anchor in their communities as direct employers, and purchasers of services and driver of economic activity. The availability of local access to health care is an important factor for businesses considering whether to invest or locate in a particular area. Moreover, private sector employment generated by rural hospitals supports a strong tax base, which funds services such as public education, fire, police and road maintenance.⁵ This status contributes to the influence of rural hospitals, but also adds to the pressures they experience and the responsibility they feel for their communities and neighbors.

When Task Force members were asked to describe strengths of rural communities, several key takeaways emerged:

- **Community.** Rural hospitals embody the principles of collaboration and the importance of relationships as a core strength.
- **Culture.** Rural hospitals are diverse, resilient and nimble. Independent and proud, rooted in heritage, faith and purpose, they find purpose in providing high quality health care to their neighbors, family members and friends.
- **Challenges.** The same environment that creates close relationships and builds tight communities can

also produce isolation and lead to limited resources. Many rural communities face difficult economics and tough workforce challenges. Low hospital volumes, inadequate payer mix and dependence on government payers are directly linked to these challenges.

The unique nature of the challenges in rural health care are well-documented. Some challenges are persistent (such as negative operating margins stemming from disproportionate dependence on Medicare and Medicaid); others are more recent (such as a shift from inpatient to outpatient care that for rural hospitals has meant lagging revenue); as well as emerging challenges (such as the opioid crisis, which is particularly acute in rural settings).³

Among the more pressing challenges:

- **Hospital Closures.** The need for quality care close to home does not go away when rural hospitals close. 134 rural hospitals have closed since 2010.⁶ The National Rural Health Association estimates that one third of rural hospitals are at risk for closure.⁷ A 2015 report found that hospital closures led to losses ranging from \$902,000 to \$9.5 million in wages, salaries and benefits for rural residents.⁸
- **Shortage of Health Care Workers.** The majority of designated Health Professional Shortage areas are rural, according to U.S. Department of Health and Human Services (HHS). According to the National Rural Health Association, the patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared with 53.3 physicians per 100,000 in urban areas.^{9,10}
- **Challenging Reimbursement Models.** Rural hospital's revenue depends primarily on reimbursement from Medicare and Medicaid, which sometimes lags behind private payers. About 40% of rural hospitals have negative operating margins. Exemplified by the ACA, the recent shift to reward value, rather than volume, of care has not helped the situation. Many rural hospitals are too small, financially tenuous, technologically bereft or understaffed to benefit from programs instituted as part of this legislation, according to a 2016 report by the HHS about rural hospital participation in value-based purchasing programs.¹¹ Shifting care to

ambulatory settings only exacerbates already low inpatient volumes in rural hospitals.¹²

- **Overall Mortality Rate.** Mortality rates for the five leading causes of death — heart disease, cancer, unintentional injury, lower respiratory disease and stroke — are all higher in rural areas. Research shows that the mortality disparities between urban and rural areas have been growing in recent decades. Studies show that mortality rises in areas where hospitals have recently shuttered.

The pandemic only compounded rural hospitals' ongoing concerns with financial viability. Since March 2020, hospitals have been forced to interrupt or defer elective services and increase spending on personal protective equipment and other equipment, leading to intensified pressure on already thin margins.¹³ Across the country, rural facilities have stepped up to coordinate local response, organizing testing, corralling PPE supplies and marshalling public awareness campaigns to flatten the curve and save lives.¹⁴

As the pandemic wreaked havoc, rural hospitals rose to the occasion — simultaneously highlighting the challenges they face and the potential they hold for addressing the health care needs of rural residents in the United States. Rural hospitals are not only critical sources of health care and healing, they are also the hearts of their communities, pumping economic vitality and leadership into rural areas.

to labor and delivery and heart attacks are extremely time-sensitive and must be easily accessible to avoid preventable deaths. In addition, convenient access to routine specialty care for chronic conditions is necessary to supporting patient care plans. Providing the right care at the right time in the right setting is key to improving outcomes, yet for too many rural residents, essential services are not accessible or reliably available close to home.

Barriers to care in rural areas include distance and transportation, health insurance coverage, poor health literacy, social stigma and privacy issues and workforce shortages.¹⁵ Another major factor is the current reimbursement system and the tenuous financial viability of rural hospitals. Hospital closures in rural areas are on the rise.¹⁶

Payment for health care services in most areas of the country is currently tied to volume, which is often unstable and unpredictable, especially in rural areas. Lack of consistent funding threatens access to essential services and undermines the health and health outcomes of rural residents.

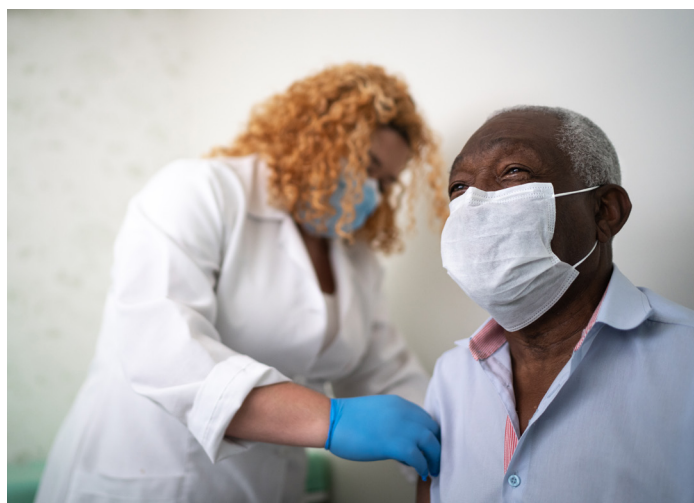
Rural health care's affordability, geographic proximity and overall quality are less than that found in non-rural areas.¹⁷ Significantly, some of the most difficult-to-access services are among the most needed in rural areas, including mental health and substance use services to address high rates of suicide and opioid overdose. There is also the pressing need for home health, hospice and palliative care for older residents and those with multiple chronic diseases.

SOLUTIONS

Public-Private Funding for Core Services

Background

A central role of rural hospitals is to provide medically appropriate care close to patients' homes. Communities need ready access to core, essential services like emergency and specialty care, regardless of how frequently those services are used. Specialized medical services that provide care for emergency conditions such as trauma and major injury, strokes, complications related



Core Essential Services

The Task Force identified the following core essential services:

- Primary Care
- Psychiatric and substance use treatment
- ED, EMS and observation care
- Maternal care
- Transportation
- Diagnostics
- Home Care
- Dental
- Robust Referral System
- Telehealth

The lack of these services — combined with significant low-income populations without health insurance or access to primary care — has led to substantial increases in rural emergency department (ED) utilization for semi-urgent care, further compromising continuity and quality of care. Rural EDs are less likely to be staffed by emergency medicine physicians and more likely to be staffed by family medicine or internal medicine physicians. Rural EDs are also sometimes staffed by advanced practice providers such as nurse practitioners and physician assistants.

The current fee-for-service (FFS) model — which rewards volume as opposed to value — puts rural hospitals at an inherent disadvantage due to their unstable and unpredictable volumes. FFS models can unintentionally force providers to focus on income-generating services to sustain their facilities, rather than the core services that the community needs but must be operated as a loss. By moving to a value-based care environment, payers can utilize “fixed” payments as a tool to help providers focus on delivering care without prioritizing revenue-generating services.

A recent Viewpoint published in the *Journal of the American Medical Association* explained how rural hospitals that are participating in the Pennsylvania Rural

Health Model were able to respond to the rapidly evolving COVID-19 pandemic public health crisis.¹⁸ Those hospitals reported that capitated payments — a feature of the model — offered them a protective factor against the reduction in services experienced during the first wave of the pandemic. (The Pennsylvania Rural Health Model is discussed more on page 22).

There is growing acknowledgment that payment policies that offer more predictable, stable funding provide flexibilities for providers to focus on providing the right care to the right patient at the right time. The Task Force believes that creating public-private funding pools to cover core services would improve access to care while spreading the expenditures across all payers in a market.

Solution

The Task Force recommends setting up a system by which public and private payers pool funds to pay for a defined set of core, essential services, such as emergency services or obstetrics.

This would allow rural institutions to establish a reliable and adequate funding flow for essential services while easing reliance on volume-based income sources. Payments to the fund would be tied to each payer’s market share in that region.

Using funds from the pool, each participating hospital would hire a care coordinator/navigator to ensure that patients have access to core services while preventing overuse. The program would also involve the local community and individual patients in devising ways that patients with insufficient health insurance coverage can earn credits toward care and build a culture of health and an investment in wellness.

Below are the key features of this solution from each group’s perspective.

Payers:

- Payers and hospitals identify and agree upon core, essential services and quality measures for beneficiaries’ care.
- Payers provide funds to providers to cover these core services for the community on a population, not volume-driven, basis.

- Payers must commit to three years of participation. Any payers who opt to leave a market within that time period must pay a pre-determined penalty to the fund. Penalties should be severe enough to discourage early withdrawal.

Hospitals:

This solution would provide flexible funding that hospitals can use to 1) ensure access to the agreed-upon core services and 2) provide care coordination and navigation services for patients who have trouble accessing care or who are high-utilizers of services.

This is a variation on the care coordination model that is often focused on a particular service line (such as emergency room use) or condition (such as diabetes



or cancer) and may allow coverage of services not traditionally considered to be health care, such as transportation, food and housing. Other examples of flexible spending include hiring a physician on salary, utilizing Certified Nurse Midwives (CNMs) for OB care and providing health care consults via telehealth.

Care coordinators/navigators can be used to help high-utilizer patients meet their health care needs while reducing unnecessary utilization.

- Hospitals will be accountable for meeting negotiated quality measures related to core services rendered. If quality measures are not met, payers could reduce future allocations. Importantly, hospitals would still receive full funding for any time period in which they don't meet their quality measures. They wouldn't have to issue refunds to payers but would receive less funding during the following period.
- Hospitals can choose to invest in the services and/or health-promoting activities that best meet the community's needs and achieve quality outcomes, even if those services fall outside traditional health care (such as housing, transportation and healthy food).

Individuals and Patients:

The goal should be to convey the message that prevention and wellness carry tangible benefits for individuals and communities.

To ensure access to care for uninsured or under-insured populations, programs would devise a sliding fee scale or equivalent donation of time/resources/investment in

Rural Emergency Hospital (REH) Designation

In December 2020, the House and Senate approved the Consolidated Appropriations Act, 2021 – legislation that includes roughly \$900 billion in COVID-19 relief and a number of provisions beneficial to hospitals and health systems.

The legislation establishes a REH designation under the Medicare program that will allow existing facilities to meet a community's need for emergency and outpatient services without having to provide inpatient care. Emergency services would be provided 24 hours a day, 365 days a year, and communities would have the flexibility to align additional outpatient and post-acute services with community needs. REH's will receive a fixed monthly payment plus a 5% add-on to the Outpatient Prospective Payment System (PPS) rate for outpatient services. The fixed monthly payment will be 1/12th of the average annual payment critical access hospitals received in excess of the PPS (for all services – inpatient, outpatient, skilled nursing facility) in 2019. The fixed amount will be adjusted each year by the hospital market-basket update.

This designation will help ensure patients in rural communities maintain access to essential emergency and outpatient services.



health or well-being. One potential way to build a culture of health in a community is for payers and hospitals to work together to set up systems by which patients can earn “care credits” through volunteer work or investments in their health.

Additionally, uninsured or underinsured patients will receive support and information from the care navigator to help them access all available financial resources to support clinical care and promote overall health.

Patients will receive education about how best to navigate the health care system and access covered care using appropriate channels. In the process, they will increase their health literacy and, in turn, be able to assist family members and other community members with how best to access care without overusing resources.

Considerations

This proposed solution reframes both health and health care as essential and encourages cooperation among all payers in a market. Such a solution could help further resources/support for individual and community health. The overarching goal is to increase perception of good health, community involvement and access to quality care as attainable and worthy goals.

Because this solution creates a new framework for payer-hospital-community involvement, designing and implementing it will be a complicated endeavor. Below are a set of considerations when designing this framework:

Financial obligations among multiple organizations will require unprecedented coordination and transparency.

Cultural changes will be required by all parties, including payers, hospitals and patients. These cultural changes will need to be sustained long-term for the public-private partnership to remain viable.

- Clear expectations must be articulated among all parties at all times. Expect some challenges as organizations work to adapt to new ways of doing things.
- Strong, innovative leadership at the highest levels will be essential to achieve success. Bold initiatives like a public-private funding pool may require at least one high-profile, effective champion to lead change and convince others to follow suit.
- Location-agnostic care must be allowed for public-private partnerships to succeed. This will also require a shift in thinking among both payers and hospitals from competition to cooperation.
- Extensive resources must be available for community education to help low-health literacy community members see the value in emphasizing healthy behaviors and preventive care.
- Concerns about low volumes for some core services could still prove challenging.
- Working with multiple funders and service lines could introduce more scrutiny — including state and federal regulations — similar to the attention given to mergers and acquisitions.

Despite the challenges, public-private funding for core services will increase access to essential health care services for rural populations.

Flexible Funding Programs to Support Rural Hospital Infrastructure Transformation

Background

Securing funding for large infrastructure projects is a major challenge for rural hospitals. Moreover, health

care delivery is changing rapidly because advances in technology have enabled some types of care to shift from the hospital to ambulatory settings and into the home. Hospital facilities often are not designed and equipped to support these changes in care delivery.

Rural hospitals also face a sustainability problem: typically, they do not have enough patient volume to support the same health care economics that benefit more densely populated areas, and their payer mix is skewed toward payers that do not cover the full cost of care. In 2017, AHA annual survey data showed that Medicare and Medicaid made up 56% of rural hospitals' net revenue. Overall, hospitals receive 87 cents for every dollar spent caring for Medicare and Medicaid patients.¹⁹

Accessing capital has become increasingly difficult for rural hospitals that lack the financial margins to support capital investment, leading to continued deterioration of hospital infrastructure. Existing opportunities to secure funding often depend on strong bond ratings, which is hard to come by for rural hospitals.

Common funding sources for rural hospitals include bonds, federal loan grants, corporate capital allocations, local, county and state funding, Community Development Financial Institutions (CDFIs)²⁰ and self-funding. While these funding sources provide some support, the spectrum of current funding mechanisms cannot adequately meet the needs for rural hospitals.

Solutions

The Task Force recommends prioritizing infrastructure development using a "now-near-far" framework that originated with Jim Hackett, CEO of Steelcase and later Ford Motor Co.²¹



- **Now:** Be successful in the "now" while also making the critical pivot to the "far"
- **Near:** Place bets on the future and allocate resources to support those bets
- **Far:** Envision a future state, knowing that any prediction is uncertain and subject to change

Specifically, the Task Force recommends using the "now" and the "near" to invest in rural infrastructure using existing funding streams such as grants and innovative strategies such as contingent payment programs (an example of which is described in the next section) and forming regional collaboratives. Looking to the "far," the recommendation involves designing a rural infrastructure funding program that is tied to clinical transformation and reimagines the way health care is delivered in rural communities. The group envisions a "Hill-Burton 2.0," in the hopes that it can have the same transformative impact on rural infrastructure that the original Hill-Burton program did nationally.²²

Below is the Task Force application of the Now, Near, Far framework to making rural infrastructure investments:

Now (1-2 years): Using Existing Resources

Use non-traditional funding structures where agreements between hospitals and private companies such as engineering/construction organizations are contingent on mutually agreed upon results and shifts the risk to the company. This provides hospitals the opportunity to spread out infrastructure costs over a manageable period of time. An agreement between Cornell College in Iowa and Johnson Controls offers an example of how this model might work: the company provided financing to the school for improvements to building systems, and the college's installment payments on the loan were contingent on achieving mutually agreed-upon goals for the project — an arrangement which placed the company at financial risk if the goals were not achieved and made it a partner in the project rather than merely a contractor.²³

Raise awareness and further utilize/expand resources such as:

- **Community Development Financial Institutions (CDFIs).** These are public-private-philanthropic



funding options, partially supported by the U.S. Treasury,²⁴ that offer financing and development services to rural communities and build credibility to make rural borrowers more attractive to other investors. CDFIs strategically provide loans for a range of projects, often infrastructure, and can partner with other funders to strengthen the capacity of a local endeavor.²⁵

- **National Telehealth Resource Centers.** (See [Telemedicine](#) section)
- **Initiatives** through agencies such as the Federal Communications Commission and the U.S. Department of Agriculture to expand rural broadband access.
- **Philanthropic Opportunities.** (See [Philanthropy](#) section)

Regulatory/Legislative Initiatives

AHA is working to pass a bill H.R. 3967 Municipal Bond Market Support Act of 2019 to make it easier for small, community banks to help their local hospital through tax-exempt financing.²⁶

Near (2-5 years): Regional Collaboratives

Regionally focused care delivery partnerships offer several benefits. Providers develop greater expertise as they treat a higher number of patients within a given specialty. Partnerships can also mitigate the challenges associated with supply and demand of health care providers in rural communities. Such partnerships have the potential to improve quality outcomes by reducing duplication of services and decreasing competition across hospitals and health systems.²⁷

Regional collaboratives could expand beyond the clinical realm to include administrative benefits such as, consolidated purchasing power for supplies and services and working together on large capital investments such as information technology/telecommunications infrastructure. (See [Strategic Partnerships](#) section for more about collaborations.)

These collaborations could include:

- Contractual collaborations, such as referral and co-location arrangements or an agreement for the purchase of clinical and/or administrative services
- Formation of a consortium or network that allows for sharing of clinical and administrative functions, as well as facilitate the continuum of care

Possible strategic areas for collaboration could include:

- Allowing each entity to dedicate its resources to a different set of services, focusing on what it does best, eliminating duplication in services and allowing a community to use its limited resources more efficiently.
- Developing virtual care models with an integrated primary care infrastructure
- Upgrading technology for telehealth and remote/virtual services
- Sharing access to patient care records
- Creating quality improvement programs that operate across primary care, behavioral health and oral health, as well as secondary and tertiary care.
- Sharing administrative and management and medical leadership functions, consolidating capacity or combining efforts to apply for grants that could increase financial support for personnel, equipment or facilities.

Regulatory/Legislative Initiatives

Recently announced revisions to Stark Law and Anti-Kickback Statute that promote care coordination activities would be advantageous to these collaborations/regional arrangements.²⁸

Far (5+ years): Location Agnostic Care

Rural health care has an unprecedented opportunity to tie infrastructure modernization to a clinical transformation agenda. Clinical transformation involves assessing and continually improving the way patient care is delivered at all levels in a care delivery organization. It occurs when an organization rejects existing practice patterns that deliver inefficient or less effective results and embraces a common goal of patient safety, clinical outcomes and quality care through process redesign and IT implementation. By effectively blending people, processes and technology, clinical transformation occurs across facilities, departments and clinical fields of expertise and engenders the ability to deliver appropriate care regardless of location.

One example is the Rural Home Hospital Program,²⁹ a collaboration between the University of Utah and Ariadne Labs, an innovation center run by Brigham and Women's Hospital and Harvard T.H. Chan School of Public Health. The program relies on specially trained local paramedics who travel to the patient's home, supervised via videoconference by a hospital-based physician. Such programs can avert crises among the chronically ill and address acute illnesses without transporting the patient long distances to the hospital — keeping scarce beds for patients who can't be successfully treated any other way.

Another approach, originally developed overseas and deployed in the Mississippi delta, prioritizes preventive care and creates “care pods” to help equalize access to all services between rural and urban settings. Each pod connects facilities and public health offices in smaller towns and rural areas with facilities in larger cities. A network of “health houses” and community health workers is the backbone of the system.³⁰ The smallest towns have an emergency medical service and a public health office. Larger towns have a nurse practitioner. Small cities have primary care clinics, and hospital care is available in large cities. Under this model, prevention becomes the first mission of the system, reducing the need for care to address specific health problems and easing pressure on clinics and hospitals.

Regulatory/Legislative Initiatives

Regulatory and legislative barriers to interstate licensing, modified during the Covid-19 pandemic, should be

permanently removed to allow clinicians to practice across state lines, and reimbursement policies should be permanently adjusted to achieve parity for telehealth.

Congress should consider adopting policies to increase hospital access to capital in vulnerable communities, including grants, tax credits, credit enhancement programs to support enhanced access to loans and innovative public-private partnerships.

Considerations

The use of telehealth technology has grown in recent years as health care providers expand patients' access to remote providers and enhance access to services. Establishing telehealth capacity, however, requires investments in significant start-up costs for videoconferencing equipment, reliable connectivity to other providers and patients, staff training and other resources to manage and maintain services. Rural capital investments, grants and subsidies will also ensure wider patient access to telehealth services for specialty care.³¹

Create a Rural Design Center within CMMI

Background

CMMI was established in 2010 by the Patient Protection and Affordable Care Act to test innovative payment and delivery models that improve or maintain the quality of care provided in Medicare, Medicaid and the Children's Health Insurance Program (CHIP), while also decreasing cost of care. Models are designed to be temporary, lasting less than five years in the experimental phase. These experimental models are identified, developed and tested with the goal of expanding successful practices into permanent programs.

CMMI models are often not designed in a way that allows broad rural participation. Evaluation criteria for potential models do not specifically address rural settings.³² Large swaths of the country are unable to participate in care transformation models because they do not meet the minimum number of patients required to participate or because their financial situation does not allow them to

The CHART Model

In August 2020, CMMI released a new payment model for rural hospitals that would provide increased financial stability through predictable upfront payments, as well as increased flexibility with respect to rules governing care delivery.

The Community Health Access and Rural Transformation (CHART) Model¹³³ is an example of the type of model that the proposed Rural Design Center might develop, participate in developing, or offer input on. The CHART model includes the following two tracks:

Community Transformation Track

CMS will select up to 15 Lead Organizations (for example, state Medicaid agencies or Offices of Rural Health, local public health departments, independent practice associations or academic medical centers) that represent a rural community.

- Each organization will work with hospitals and other key entities in the community to implement new care models.
- Each organization will receive up to \$5 million in funding.
- Participating hospitals will receive a prospectively set annual payment that will provide a stable revenue stream and create incentives to reduce both fixed costs and avoidable utilization.
- Models will receive operational and regulatory flexibility as needed to test new models, including waivers of certain Medicare requirements, expansion of telehealth, and the ability to offer patients incentives for participating in chronic disease management programs.

Accountable Care Organization (ACO) Transformation Track

CMS will select up to 20 rural-focused ACOs to receive advanced payments as part of joining the Medicare Shared Savings Program.

- A CHART ACO will be able to receive a one-time upfront payment equal to a minimum of \$200,000 plus \$36 per beneficiary to participate in the 5-year agreement period in the Shared Savings Program.
- A CHART ACO will be able to receive a prospective per beneficiary per month (PBPM) payment equal to a minimum of \$8 for up to 24 months.

take on any more risk, even on an experimental basis. Rural hospitals may also not have sufficient staff to comply with reporting requirements intended for larger and better financed institutions in more densely populated areas.

Solution

The Task Force recommends establishing a Rural Design Center, a new division within CMMI that would fall under the category of “Initiatives to Accelerate the Development and Testing of New Payment and Service

Delivery Models.” With criteria and requirements adjusted for the needs and reality of rural health care, this special designation would allow rural-specific models to be developed, tested, improved and scaled. The Rural Design Center would also consult with internal CMMI model teams to create separate tracks/options within new or existing models that are specifically tailored to meet the needs of rural hospitals and communities.

The Rural Design Center would focus on smaller-scale initiatives that meet the needs of individual communities and encourage participation of rural hospitals and facility

types (federally qualified health centers, critical access hospitals, Medicare-dependent small rural hospitals, etc.) that represent the diversity of communities. With participation requirements that don't rely on patient volume or other measures that tend to exclude rural providers, these small-scale models would provide rural hospitals an opportunity to innovate on the local level without incurring significant risk.

The Rural Design Center would help develop and increase the number of new rural-focused CMMI demonstrations while also expanding successful existing rural demonstrations such as the ACO Investment Model (AIM) to more regions and successful state initiatives to all regions.

To advise this initiative, The Task Force proposes establishing a cadre of rural stakeholders and experts for the CMMI Rural Design Center as a first step toward this solution. With representation from payers, technology consultants, retail pharmacy, funders, academics, and of course providers and hospital CEOs working in rural areas, this group would help design and adapt projects to increase participation and applicability to rural hospitals and other rural health care providers.

Considerations

Since CMMI has the authority to create a new division with the agency, it could establish the proposed Rural Design Center by allocating appropriate funds without legislative action. Ideas coming out of the center would by definition be designed to yield savings to CMS.

Currently, CMMI's models are developed in conjunction with stakeholders, clinical and analytical experts and relevant federal agency representatives. The Rural Design Center's cadre of rural hospital stakeholders and experts would give CMMI access to a greatly expanded rural-specific input to improve its ability to develop new models that address the unique needs of rural providers and patient populations. These stakeholders and experts would also provide a rural perspective to ensure new model ideas align with rural considerations.

For example, one of the criteria, diversity (including demographic, clinical and geographic diversity), has significantly different implications for rural populations than for general populations. This team of experts

would help CMMI fully capture the diverse needs of rural hospitals across the country when developing new models.

The Task Force proposes two preliminary models for CMMI to pilot/test through the Rural Design Center:

- Public-Private Funding Pool for Core Services (one of the proposed solutions)
- Promising practices identified in the section on Maternal Health.

Grant-Writing Gig Economy

Background

Government agencies, non-profit organizations and philanthropic groups stand ready to help health care organizations address financial challenges of rural health care delivery. But accessing these funds requires applying for grants. That process takes time, resources, and skills that can be difficult to come by, especially for rural providers who are already stretched thin.

From researching potential opportunities to securing and maintaining a grant, the grant process requires significant time and resources. Rural hospitals often do not have the resources to hire a full-time grant writer and may have limited access to people with the necessary skillset. Grant writing often falls to existing staff who already have a full plate of responsibilities. As a result, rural hospitals may forgo opportunities to apply for funding. Many grant



writers work on a freelance or contract basis, but rural hospitals may not know where to start to find a qualified grant writer.

Successful grant-funded projects require a combination of a well-written and researched proposal matched with a funding source that aligns with the needs of the organization. Grant availability depends on a multitude of factors including, but not limited to, geographic location, priority issue, capital resources and need and impact in the community. Minor errors in the grant-writing process can leave a rural hospital without a grant and waste already constrained resources. Grant money usually comes with tight restrictions on funds and strict reporting requirements that add extra work to project management — constraints that experienced grant writers can recognize and work with but catch some organizations off guard.

Solution

Apps like Uber, InstaCart and DoorDash match the needs of consumers with people willing and able to fill those needs. Applying a similar approach to grant writing can help connect hospitals and rural health care providers with qualified professionals who have the skills and experience to write grants that secure funding for needed services and programs.

The AHA intends to create an online platform and corresponding app that helps connect hospitals to qualified grant writers who will work on a contract or per-project basis. Supporting and encouraging a gig-economy approach can help rural hospitals submit applications for grants or participate in demonstration projects sponsored by the Centers for Medicare and Medicaid Services' Innovation Center and other funders. This service will allow for a sliding fee scale with pre-negotiated rates or a fixed amount of time/dollars to ensure equitable access for small, rural and other low-resource hospitals. Grant writers would agree to the fee structure in exchange for connections to potential clients. The app would be developed by AHA and publicized to member hospitals.

Many small and rural hospitals lack the existing strategic relationships with grant program officers that larger systems with more resources often benefit from. Large or non-local funders may also have misconceptions about rural communities that affect the likelihood of

Grant Writing Process

The grant writer handles all stages of the grant writing process:

1. Conduct preliminary proposal research to identify needs and focus, find prospective grants and develop a general proposal and budget.



2. Once a funding source is identified, tailor a detailed proposal to the funder's specifications and align the narrative with the organization's needs and goals.



3. Submit proposal and monitor progress to ensure all application requirements are satisfied.

understanding and funding rural hospitals. A professional grant writer can help paint a more accurate picture of rural health care challenges, fill in gaps in understanding and create new connections based on their area of expertise and contacts, opening the door for new opportunities. In addition, a contracted grant writer will have dedicated time to devote to the project and ensure complex regulatory requirements are met. They may also have additional knowledge of program evaluation, including specific measures to use in reporting outcomes that help ensure grant success.³⁴

Once the service is established, possible enhancements might include programs by which larger, better-resourced hospitals share or loan their grant writing staff members to smaller hospitals as well as alliances to provide training to build the pool of qualified grant writers.

Considerations

The online platform will create a “runway” for small/rural hospitals to pursue innovation in care delivery with new and expanded financial resources that may be out of reach today. Successful grant application and implementation will allow small and rural hospitals to secure funding resulting in significant improvements for the hospital and community it serves.

This offering may require some oversight and funding from AHA or an association of grant writers to ensure the program meets the needs and expectations of participating hospitals and writer/contractors. Connecting participants with educational resources for rural hospital administrators to learn more about the grants process and for grant writers to learn more about rural health care might help accomplish this goal.

PROMISING PRACTICES

Global Budget Payment Model

Background

Policymakers increasingly recognize that the current health care ecosystem, in which health care expenditures consume an ever-growing percentage of the nation's gross domestic product (GDP), is not sustainable.³⁵ However, the most widely used policy levers to address skyrocketing health spending — reducing benefits, lowering provider payments and curtailing program eligibility — have failed to rein in health care costs.

Some policy experts explain these failures by noting that we must incentivize different behaviors among all parts of the system to achieve meaningful and sustainable health care spending reductions. Payment policy reform is often called out as a necessary next step to bend the spending curve in American health care. Support from Republican and Democratic administrations has accelerated the shift from the existing fee-for-service (volume-based) payment model to a variety of “pay-for-value” programs.

To date, hospital and health system leaders have shown a range of responses to these “pay-for-value” payment arrangements. Some have been willing to enter into value-based payment arrangements for a subset of their patient populations, while others remain enmeshed in the fee-for-service model.

The Task Force believes that expanding population-based payments is a viable cost-containment strategy that should be encouraged for broader adoption, including

among rural institutions. Population-based payments take many forms, including pre-payment, partial capitation, capitation models and bundled payments, among others. These models create distinct advantages for hospitals, offering flexible access to resources while providing incentives for early intervention and innovative thinking to improve outcomes while keeping costs down.

The basic framework is that health care providers receive a set, risk-adjusted payment for each plan enrollee during a defined period of time. Payers make their contractual payments to providers regardless of whether the enrollee receives care during that period.

The common element in these payment models is their potential to offer budget predictability and cash flow stability to hospitals, while encouraging quality gains in preventive health and other outcomes. This financial stability is likely to be viewed favorably by rural hospitals, where inconsistent patient volumes can wreak havoc with fee-for-service-based budgets.

One promising solution to help rural health care leaders overcome their wariness of value-based payment is to adopt a global budget payment model.

Overview

The global budget payment model is a population-based, value-oriented model that shifts reimbursement for health care services away from volume-based payments to a single payment that encompasses certain costs associated with caring for a population. Payers compensate participating hospitals with a fixed amount set in advance — to cover all inpatient and hospital-based outpatient items and services. Hospitals then use those funds as needed to provide that care.

In their most basic form, global budget payments provide a fixed amount of reimbursement for a fixed period of time for a specified population — rather than fixed rates for individual services or cases. Therefore, if a provider's costs are less than the budget, they retain the difference; if a provider's costs exceed the budget, the provider must absorb the difference.

The global budget payment model is not intrinsically tailored to any particular care setting — urban or rural. But rural communities may be well-situated to take advantage

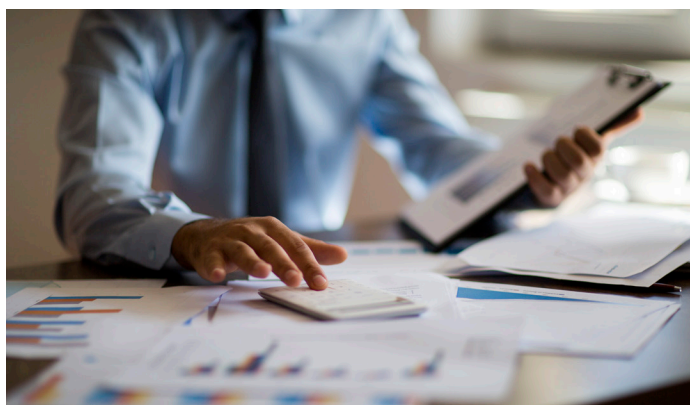
of the model's advantages while avoiding its potential disadvantages. To test this model, the CMS Innovation Center partnered with the State of Pennsylvania to create the country's first large-scale rural global budget payment program, the Pennsylvania Rural Health Model.

Pennsylvania Rural Health Model

The Pennsylvania Department of Health administers the Pennsylvania Rural Health Model (PARHM) jointly with CMS.³⁶ Its goal is ambitious: To combine the use of hospital global budgets with care delivery transformation efforts. PARHM seeks to improve care access and quality for rural Pennsylvanians while increasing participating hospitals' financial viability and reducing the growth of hospital expenditures across all payers, including Medicare. Knowing how difficult it is for rural hospitals to innovate given their many financial uncertainties, PARHM is designed to test whether the financial stability global budgets offer will encourage participating rural hospitals to explore the care innovations best suited to their local communities.

To that end, PARHM features two key components:

- **Hospital Global Budgets.** Pennsylvania prospectively sets the all-payer global budget for each participating rural hospital. Budgets are based on the hospital's historical net revenue for inpatient and outpatient hospital-based services from all participating payers. Each participating payer pays each participating hospital for all inpatient and outpatient hospital-based services based on the payer's respective portion of this global budget. CMS retains review and approval privileges for the Medicare fee-for-service (FFS) portion of the global budgets that Pennsylvania proposes for each participant. CMS also reviews and approves the State's methodology for calculating the global budgets are subject to CMS review and approval.
- **Hospital Care Delivery Transformation.** Participating hospitals must also refine and redesign their care offerings as outlined in their annual Rural Hospital Transformation Plan. Each hospital must show how it intends to get continuous feedback from stakeholders in the community and tailor its services to the needs of their local community. Specifically, each hospital must describe how



it intends to improve quality, increase access to preventive care and generate savings to the Medicare program. The state provides rural hospitals with technical assistance as needed in preparing Rural Hospital Transformation Plans each year. The State of Pennsylvania and CMS must approve each participating hospital's Rural Hospital Transformation Plan.

PARHM participation is open to both critical access hospitals and acute care hospitals throughout rural Pennsylvania. The 13 hospitals that currently participate represent a mixture of both types of hospitals and cover a broad swath of the state.

Pennsylvania has contracted with a broad range of payers, including Medicare, Medicaid and a variety of commercial plans. PARHM is funded through 2024 and consists of seven performance years, including one pre-implementation planning year in 2017-2018.

Vermont & Maryland All-Payer ACOs

To date, Pennsylvania is the only state whose global budget payment model focuses exclusively on rural hospitals, but CMS has explored global budget payments in two other states, Maryland and Vermont.

CMS partnered with the State of Maryland in 2014 to launch the Maryland All-Payer Model.³⁷ This program established global budgets — an annualized fixed amount of revenue to cover an entire year — for participating hospitals to reduce Medicare hospital expenditures while improving care for beneficiaries. CMS and the State of Maryland decided to pilot this project with rural hospitals because they might have a greater incentive to work through any difficulties compared with their urban

counterparts, who could simply refer patients to nearby competitors as needed. Although this program created significant savings for Medicare, its focus on the inpatient setting limited its future successes.

Its successor, the Maryland Total Cost of Care (TCOC) Model, includes three programs:³⁸

- **Hospital Payment Program.** In this demonstration of population-based payments, each hospital receives a payment amount to cover all hospital services provided during the year. This approach creates a financial incentive for hospitals to reduce unnecessary hospitalizations, including readmissions.
- **Care Redesign Program.** Hospitals that have saved a predetermined sum may make incentive payments to non-hospital health care providers who develop quality-improvement offerings. The effect is neutral to overall Medicare expenditures because the incentive payments cannot exceed the amount saved.
- **Maryland Primary Care Program.** Participating primary care practices receive an additional monthly payment from CMS to cover care management. The

program includes a performance-based incentive payment to providers who reduce their Medicare hospitalization rate.

Since 2017, CMS has offered the Vermont All-Payer Accountable Care Organization (ACO) Model.³⁹ The initiative includes a Medicare ACO model tailored to the state, as well as Medicaid and all private payers. CMS provided Vermont up to \$9.5 million in start-up investment to providers to cover care coordination and fund collaborations with community-based providers. The Vermont All-Payer ACO Model builds on the Maryland All-Payer Model by bringing statewide health care transformation beyond the hospital.

Considerations

The Task Force emphasizes that global payments should be made at a predictable, stable and sufficient level to allow providers to build the infrastructure and capability to redesign care delivery.

Additionally, successful global budget payment models should have these traits:⁴⁰

- **Broad Provider Participation.** Participation may be limited to hospitals or could be expanded to include additional health care providers (e.g., physicians). The broader the participation, the more alignment between health care providers and accountability for the health care services offered within a community.
- **Mix of Public and Private Payers.** Participation by all commercial and government-funded health plans affords hospitals the most opportunity to focus their efforts on success, rather than attempting to simultaneously operate under fee-for-service and global budget payment models. However, this could be the most difficult factor to achieve.
- **Appropriate Quality Measures.** In order to ensure quality oversight, standardized metrics must be established to capture the quality of care, population health outcomes and patient experience.⁴¹ These metrics should be implemented by setting pre-defined benchmarks or by rewarding hospitals that continuously improve over time. Global budget payment models should also include ways to track and measure the success of the program, such

Pennsylvania Rural Health Model (PARHM)

As part of the Pennsylvania Rural Health Model (PARHM), the State of Pennsylvania has set three key goals related to population health outcomes and access. Participating hospitals must meet these goals each year:

- Increased access to primary and specialty services
- Reduced rural health disparities due to improved chronic disease management and preventive screenings
- Decreased substance use disorder-related deaths, along with improved access to treatment for opioid misuse

PAHRM purposefully applies equal weight to both financial and quality improvement goals.

as the financial viability of the health system and reductions in preventable inpatient admissions.

Additionally, global budget payment models should be adaptable to the specific needs and culture of each participating institution, with acknowledgement that hospitals may be in various stages of adoption or moving away from fee-for-service.

CMS acknowledges that rural providers have generally had lower rates of participation in alternative payment models, so customization is key, as is the ability to partner with compatible organizations. For example, partnering across regions to build out telehealth platforms is very effective.

Flexibility in global budget program design can have an unexpected benefit of providing operational stability during unexpected challenges. For example, the Task Force learned that PARHM's capitated payments provided a financial buffer against the reduction in services provided during the COVID-19 pandemic. They have not experienced the same pandemic-related cash-flow problems compared to their counterparts not operating in a global budget payment environment.

The Task Force recommends that any new global budget models include a capital infrastructure component in order to ensure hospitals have the necessary resources to provide appropriate patient care services. Capital improvements also allow health care institutions opportunities to customize their care offerings to respond to their communities' specific needs. One weakness of the otherwise successful Pennsylvania Rural Health Model is that it does not currently fund any infrastructure improvements.

A further limitation is that global budget payment programs are challenging to set up due to their technical requirements. Rural hospitals could not reasonably expect to create this model on their own because of the technical skills needed to create the methodology.

More needs to be understood about global budget payments, but payment policies that offer more predictable, stable funding that lets providers focus on providing the right care to the right patient at the right time seems directionally correct. The Task Force believes global budgets offer a promising path forward for

overhauling our costly health care delivery system to rein in costs while improving care.

Rural Hospital Federal Tax Credit Program

Background

Most rural hospitals operate on the edge of financial sustainability. Profit margins — already thinner than urban hospitals — declined from 2011 to 2017, the same time period in which many urban hospitals improved their financial position.⁴² Small hospitals (fewer than 25 beds) appear to be the most vulnerable, especially if they are not critical access hospitals and do not receive the extra reimbursement from Medicare.

Since 2010, more than 134 rural hospitals have closed. States with the most rural hospital closures are Texas, Tennessee and North Carolina. The National Rural Health Association estimates that one third of rural hospitals are at risk for closure.⁴³

Those closures can have a devastating effect on the communities they serve. Sixty million rural residents across the nation rely on their local hospitals not only for health care but also for jobs, community investment and leadership.⁴⁴ According to a working paper published by the National Bureau of Economic Research, rural hospital closures are associated with a 5.9% increase in mortality rates. Death from sepsis increased by 9% when rural hospitals closed, the report found.⁴⁵ The COVID-19 pandemic demonstrated the precarious financial situation of many hospitals and the critical importance of accessible, quality care close to home.

Many nonprofit hospitals depend on donations and philanthropy to shrink the gap between operating costs and reimbursement rates, especially in rural areas. Rural residents and local businesses have traditionally stepped up to donate to community hospitals. However, an unintended consequence of the 2017 Tax Cut and Jobs Act⁴⁶ was to reduce tax incentives for those contributions. With the increase in the standard deduction for most families, fewer households were eligible for a tax deduction for charitable giving. While nonprofits did not see the hit that some predicted, individual giving did

not rise as expected in 2018 and 2019, a 2020 report to Congress found.⁴⁷ The effects of the tax change may be felt more keenly in rural areas, where incomes are lower and less likely to benefit from itemizing their tax deductions (versus taking the standard deduction).

Overview

In 2016, Georgia passed the Rural Hospital Tax Credit Program, which took effect on January 1, 2017. Under the law, individuals and corporations can receive a credit on their state income tax for donations to eligible rural hospitals and health care organizations. Georgia is the only state in the nation that has tried this approach to raising funds for rural hospitals, and it shows promise that could be replicated and improved on a national basis.

The main features of the program are as follows:

- Individuals are eligible for tax credits of \$5000 per individual/\$10,000 for married filing jointly. (Tax credits cannot exceed donor's tax liability.)
- Corporations can receive tax credits up to 100% of contribution or 75% of state income tax liability.
- Rural hospitals chosen for the program can receive up to \$4 million in donations per year, with donations subject to approval and/or a cap during the second half of the calendar year.
- Donors must apply for the tax credit and be approved by the Department of Revenue.
- If the donor does not designate a hospital to receive the funds, or if the hospital designated has already reached the donation cap, funds are distributed to other eligible rural hospitals.

An evaluation of the program by the Georgia Southern University found that Georgia's Rural Hospital Tax Credit program provided needed funds to support rural hospital operating costs, debt reduction, infrastructure and service expansion. However, the evaluation also found room for improvement in the program.⁴⁸

During the first year of the program, donations quickly exceeded the \$60 million tax credit cap. However, after the new federal tax law reduced financial incentives for charitable donations, program participation fell off. According to a review of the program by the Georgia Department of Audits and Accounts Performance Audit Division, donations did not always go to the hospitals with the greatest financial need.⁴⁹

The Task Force believes that expanding this tax credit program nationally with a federal tax credit can provide essential funds to support to rural hospitals in all states, including those without state income taxes. (Texas and Tennessee, two of the states with the highest rates of hospital closures,⁵⁰ do not have state income taxes.) It can also address some of the weaknesses of the Georgia program and distribute the funds more equitably.

The Task Force believes that the Georgia model holds great potential to encourage charitable giving to rural hospitals as one strategy to help ensure local access to health care in rural communities.

Considerations

While hospital CEOs in rural Georgia feel the tax credit program is helpful and has great potential, they also pointed out some challenges associated with the program that the Task Force believes should be addressed in a federalized version. As noted above, the Georgia program experienced a drop-off in donations after the new federal tax law made it more difficult to claim federal tax deduction in addition to the state tax credit. A state tax credit has limited appeal, especially in states with no income tax. Expanding the model nationally and applying a federal tax credit would greatly increase the appeal and therefore the impact of the program.

The Task Force also recognized the challenges of raising money in economically distressed areas. Many people living in rural areas have low incomes. The complexity of the Georgia program, including the different caps



and the need to apply for the credit and make donation within a specific amount of time, may have hampered its effectiveness and community participation. Changes to the Georgia program after the first year — even ones that improved the program — may have further confused potential donors.⁵¹ However, the idea of attracting community members to invest even in a small way in their local hospital increases their personal stake in rural health care providers and in the health of their communities. Developing effective ways to publicize the program to local residents and businesses and make it accessible and appealing to people who can only donate a small amount may have benefits far beyond the monetary value of the donation.

Another weakness in the Georgia program was the finding that funds were not prioritized for maximum impact and hospitals most at-risk for closure. To ensure that funds go to the hospitals and communities in greatest needs, eligibility requirements for hospital participation must be carefully designed and targeted.

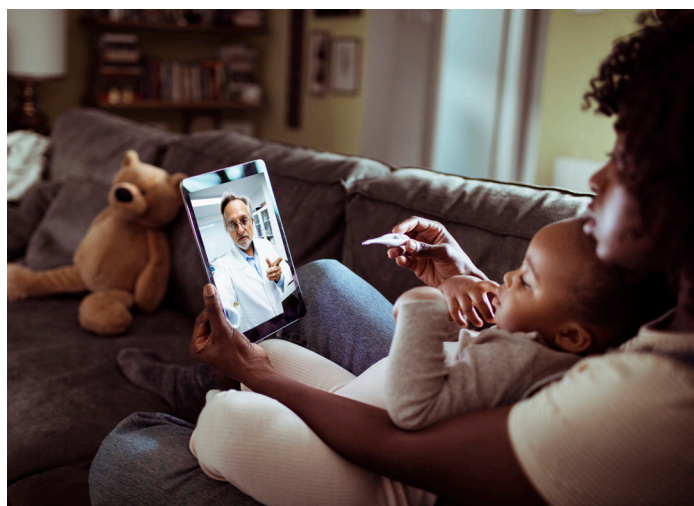
The Task Force believes that these challenges can be overcome with a thoughtfully designed and implemented federal tax credit program that supports and strengthens rural hospitals and helps improve the health of America's rural residents.

Telemedicine

Background

Telemedicine (or telehealth) — health care provided remotely using telecommunications networks — has grown rapidly in the past decade, along with the spread of broadband networks. AHA surveys show that three out of four health systems had telehealth capabilities by 2017, up from one in three in 2010.⁵²

Those capabilities went largely underutilized until COVID-19 rapidly transformed telemedicine to a core service for many health systems and providers. Telemedicine has been key both for disseminating effective COVID-19 treatments⁵³ and maintaining routine health care services without in-person office visits.⁵⁴ At NYU Langone Medical Center in New York City, urgent care tele-visits grew six-fold between the beginning of



March and the middle of April 2020. Over that same period, telemedicine came to account for 70% of non-urgent visits for the health system, up from a negligible amount prior to the pandemic.⁵⁵ The NYU example is far from isolated. FAIR Health, an independent nonprofit that collects health insurance claims data, shows an astonishing 30-fold increase in telemedicine claims between August 2019 and August 2020.⁵⁶

The abruptly accelerated adoption of telemedicine has highlighted both the benefits and the obstacles connected with effective deployment. The continuing need to provide care in a context of COVID-19 infection control has motivated all parties — providers, payers, and regulators — to find ways to remove those obstacles.

Telemedicine and Rural Health

Rural health care can benefit profoundly from a robust national commitment to telemedicine. Prior to COVID-19, telemedicine had been regarded as especially critical for rural areas.⁵⁷ The advantage for these areas is clear: access to a broad range of clinical services without the need to travel long distances.

Specialists often travel to rural areas only a few times a month to see patients, which limits opportunities for face-to-face contact. Rural areas also lack certain key essential services, including mental health and substance use services. In 94% of the 734 counties classified as “entirely rural,” there are no licensed psychologists.⁵⁸ Telemedicine solves both problems by allowing patients to schedule virtual appointments with clinicians in other areas during their regular office hours.

Telemedicine can lower overall costs for rural emergency department patients by thousands of dollars according to a 2017 University of Iowa study.⁵⁹ The telemedicine program at Avera McKennan Hospital in Sioux Falls, S.D., showed a net savings of more than \$4,000 every time a patient could receive needed emergency care without being transferred to another location, including reduced expenses related to transportation, missed time at work, and costs for family members who accompany patients.

Telehealth can take a variety of forms:⁶⁰

- Patient/provider video or teleconference in real time
- Remote patient monitoring (RPM)
- Store and forward transmission of medical information such as medical records and images
- Mobile health communication (mHealth) using patient cellphones for text, audio and video communication, health reminders, and health-promoting apps

More than two dozen state and regional telehealth networks are currently active in the U.S.⁶¹ Growth has been steady and significant as telecommunications and related technologies have improved: Telemedicine use among Medicare beneficiaries in the rural United States increased by about 28% annually between 2004 and 2013.⁶² COVID-19 has only accelerated that expansion.

Barriers to Telemedicine

The growth in telemedicine and telehealth has occurred despite numerous impediments: legal, financial, technical, clinical, and administrative. As with many aspects of the health care system, laws and regulations governing telehealth are state-based and inconsistent from state to state.⁶³ Overall barriers include:

- **Inadequate Infrastructure.** Rural areas lag more populated areas in broadband capabilities required for video-based telehealth. (See section on [broadband](#) for more information on how to strengthen technology infrastructure in rural areas.)
- **Lack of Interstate Licensing.** The service area for a rural telehealth network can span several states. Under current licensure requirements (suspended

during the COVID-19 pandemic but not permanently), clinicians must be licensed in all of them individually in order to provide care for a patient regardless of their respective locations.

- **Lack of Reimbursement.** Medicare, Medicaid and commercial insurers do not consistently reimburse telehealth services at rates commensurate with the amount of investment and effort they represent.
- **Problems with Data Flow.** Patients' electronic health records and other pertinent information are not always readily available to clinicians during telehealth visits, due to problems with interoperability or lack of data-sharing arrangements among providers.
- **Not Enough Trained Clinicians.** Delivering services through telehealth requires developing new skills and strategies to engage patients, elicit useful information and perform effective examinations.
- **Lack of Patient Engagement.** Both clinicians and patients have to be comfortable with telehealth encounters.

Overview

Telehealth can play a key role in improving rural health care, and there are significant underutilized resources available to help providers establish and expand these services.

The **National Consortium of Telehealth Resource Centers** (NCTRC)⁶⁴ was established in 2017 and grew out of a telehealth grant program funded by the federal Health Resources and Services Administration (HRSA) in the early 2000s. The consortium continues to be funded by the Department of Health and Human Services (HHS) and HRSA and administered through a grant from HRSA's Office for the Advancement of Telehealth. There are 12 regional and two national TRCs that work collaboratively to ensure telehealth programs are up and running in rural and underserved communities, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Staffed by experts in policy, technology and implementation, the regional centers cover all the states and territories of the U.S., and many of their services are provided at no charge. Providers and health systems wishing to establish



or expand telehealth services should take full advantage of the expertise of their regional TRC.

Project ECHO (Extension for Community Healthcare Outcomes),⁶⁵ which receives funding from state and federal government agencies as well as other sources, is a collaborative model of medical education and care management that increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions. Expert teams, located at “hubs,” lead virtual clinics, amplifying the capacity for providers to deliver best-in-practice care to the underserved in their own communities. Project ECHO has supported such diverse efforts as training community health workers to operate as part of care teams, expanding remote consults between primary care providers and endocrinologists to improve diabetes care, and educating health professionals on pain management and opioids.

Administered out of the University of New Mexico School of Medicine, the project currently operates 423 hubs in 44 countries, including 239 in the U.S. that draw on expertise of numerous universities, government agencies, professional societies, and not for profit organizations. Project ECHO recently received \$237 million in funding as part of the COVID Aid, Relief and Economic Security (CARES) Act and is one of six finalists for a potential \$100 million grant from the MacArthur Foundation⁶⁶ to be awarded in 2021. In September, the New Mexico Congressional delegation, joined by 44 other legislators in a bipartisan effort, formally requested that HHS issue guidance on ways that the Medicare and Medicaid programs might be enabled to provide financial support for the programs and services of Project ECHO.⁶²

Considerations

As noted above, many stumbling blocks to more effective rural telehealth deployment can be addressed with changes in laws and regulations. COVID-19 has presented a unique opportunity to speed those changes. To encourage the adoption of telehealth during the pandemic, the Centers for Medicare and Medicaid Services made several emergency changes at the direction of Congress:⁶⁷

- Waiving limitations on the types of health care professionals that can furnish telehealth services to include all those that are eligible to bill Medicare for their professional services. This waiver opened telehealth to physical therapists, occupational therapists and speech language pathologists, among others.
- Allowing hospitals to bill for telehealth services as they would for on-site services for Medicare patients registered as outpatients, including the originating site facility fee and therapy, education, and training services (e.g., counseling, psychotherapy, group therapy and partial hospitalization).
- Changing its process during the emergency so that it can add, on a sub-regulatory basis, new services to the list of Medicare services that may be furnished via telehealth.
- Formalizing the Coronavirus Aid, Relief, and Economic Security (CARES) Act provision that authorizes payment for Medicare telehealth services provided by rural health clinics and federally qualified health clinics acting as distant sites.
- Broadening providers’ ability to furnish services via audio-only communication and increasing payment for telephone visits to match payments for similar office and outpatient visits.
- Permitting assessments to be performed via audio/video or audio-only telehealth as part of CMS’s bundled payment program for opioid treatment plans.

Making these changes permanent, as outlined in AHA’s July 2020 telehealth fact sheet,⁶⁸ would give rural hospital leaders the opportunity to bolster telehealth and greatly

increase access to “right care, right place, right time” for their far-flung patient populations.

Broadband and Mobile Technology

Background

As noted in the section on telemedicine, rural health care can benefit significantly and uniquely from offering its patients remote access to care. This benefit has been highlighted during the COVID-19 pandemic to meet the demand for health care services while limiting direct contact. The pandemic has led to rapid growth in what might be called “classic” telehealth — patient and clinician connecting in real time via linked computer screens — as it called attention to the potential for mobile phones to act as transformative tools for rural health care, both in real time and asynchronously.

However, both computer-based telehealth and mobile telehealth depend on robust communication networks, an area where rural infrastructure lags significantly.⁶⁹ In addition to direct patient care, high-capacity broadband and mobile networks are also essential for health information exchange, other forms of telemedicine (for example, e-consults between providers, tele-radiology, and remote ICU monitoring) and general hospital operations. High-capacity broadband would allow providers to take advantage of cloud-based services for both clinical and general administrative applications and would give them more ready access to remote workers for back-office operations — a key advantage because of shortages of qualified workers in many areas.

The availability of high-capacity broadband is limited in rural areas. Where it exists, it can be very expensive for both individual and organizational users. Federal Communications Commission 2019 data shows that while more than 97% of urban areas had access to 100Mbps broadband networks, their reach in rural areas was only 67% and in tribal lands only 64%. The disparities are even greater for broadband speeds of 250 Mbps: almost 95% of urban areas have at least one provider that offers this capacity, while only 56% of rural areas and 50% of tribal areas have at least one.⁷⁰ High-speed LTE mobile

networks (10Mbps/3Mbps) showed better penetration — 70% in rural areas and 64% in tribal lands — but they still lagged urban areas (90.5%), according to a 2018 FCC report.⁷¹

In 2019, the Veterans’ Health Administration’s Office of Rural Health estimated that 42% of rural veterans enrolled in VA do not have internet access adequate to support their use of VA telehealth and other online services.⁷² That is a considerable portion of the population to leave unserved by the potential of this technology.

The FCC recommends that hospitals have access to a minimum of 100Mbps broadband capacity to support functions such as simultaneous use of EHR and high-quality video consultations, real-time image transfer, continuous remote monitoring and consultations using high-definition video. For large academic medical centers, 1,000 Mbps is recommended.⁷³ For rural hospitals to take advantage of greater telehealth possibilities or forge e-consulting relationships with larger hospitals, they too would presumably need more than the bare minimum broadband capacity.

In addition to broadband, high-speed mobile networks would also benefit health care delivery in rural communities. Rural communities face a real shortage of providers and need ways to stretch the capacity of the ones they have. The asynchronous communications enabled by telehealth allow providers to provide care on a schedule that does not depend on coordination with the patient.

Mobile technology — including texts, video and audio calls and apps — can help providers extend their services to hard-to-reach communities. Improved mobile patient engagement can have a substantial positive impact on population health in rural and small community care settings.

Mobile communication tactics, including texting, can complement telehealth visits by enhancing pre- and post-visit navigation, supporting medication adherence and reinforcing behavior change to improve health outcomes. Texting is particularly fundamental because it doesn’t depend on smartphone capabilities and can be used with even the most basic mobile phone, reaching populations that are underserved by health care and technology. Unlike some health innovations that can deepen health



disparities due to the digital divide, texting offers an accessible channel for all populations. Pew Research estimates that 96% of Americans own a cell phone, while 81% of adults own smartphones and 73% have home broadband.⁷⁴ Increasing availability of broadband and/or high-speed mobile networks holds the potential to improve health care delivery and health monitoring for a broad swath of the country.

With the implementation of 5G mobile networks, providers will be able to share real-time video/audio feedback, and even “haptic” feedback — fine motor and sensory movements — which can in turn enable procedures to be safely performed remotely with robotic instruments.⁷⁵ Such networks can also enable the “Internet of Things,” for example, allowing patients to be monitored continuously in their homes in real time with heart rate or blood glucose sensors.

Rural areas must be included in the rollout of this next-generation capability.

Overview

Several states with large rural populations have taken the lead in investing in broadband, using a combination of state and federal funding. In addition to supporting online opportunities for education and business purposes, these infrastructure investments also aim to expand advanced telehealth services to previously unreached areas.

Earlier this year, Virginia allocated more than \$18 million to provide “last-mile” broadband connectivity to 12 counties, part of a multi-year initiative to wire up all unserved parts of the state.⁷⁶ Governor Ralph Northam called out telemedicine as a key function to be enabled by

the investment. Last year, Illinois earmarked \$420 million over six years to expand broadband throughout the state as part of its “Rebuild Illinois” infrastructure program.⁷⁷

Before the pandemic, Maine had identified access to broadband services as one of the obstacles to wider use of telehealth among the state’s rural residents, many of whom are over 65 and depend on Medicare coverage for health care. In 2019, the state passed a law that requires Medicaid and private insurers to reimburse for telehealth on a par with in-person services.⁷⁸ However, lack of broadband access in rural areas — along with limitations on Medicare reimbursement for telemedicine — lessened the impact of the legislation. The state’s Congressional representatives have been on the forefront of efforts to address both issues.⁷⁹

In the meantime, some rural communities in Maine have spearheaded their own efforts to bring broadband to their areas. The Maine Broadband Coalition — representing organizations, communities and internet users in the state — is actively advocating and supporting broadband expansion by collecting data on the state’s digital divide.⁸⁰ In November 2020, the governor announced that \$5.6 million in coronavirus relief money will fund the infrastructure needed to expand broadband access in rural Maine.⁸¹ Other states with significant rural populations — including Idaho, Iowa, Missouri, Oregon and Vermont — also earmarked pandemic relief funds to address connectivity issues that affect access to telehealth services.⁸²

Some providers already maintain active telehealth networks, and increased capacity will allow them to expand their scope of services, extend their service area and provide more reliable connectivity. Avera Health serves a large rural area across the upper Midwest and operates the single largest telehealth network in the U.S.; Avera eCARE, which provides innovative telemedicine services to more than 300 locations across South Dakota, North Dakota, Minnesota, Iowa and Nebraska. Avera eCARE also provides telehealth services to other health systems, hospitals, long-term care facilities, schools, correctional health facilities and other sites nationally — a total of 400 locations in 18 states. Its activities include collaboration with Indian Health Service (IHS) to provide emergency support, behavioral health and specialty appointments to reservation communities.

Considerations

The need to support the build-out of broadband in rural areas is well understood in regulatory circles, and several funding efforts are in progress, including the \$20.4 billion Rural Digital Opportunity Fund, launched by the FCC in early 2020.⁸³

Specific to health care, the FCC's Connected Care Pilot Program will provide up to \$100 million from the Universal Service Fund (USF) over a three-year period to selected applicants to support the provision of connected care services. The Pilot Program will provide funding for selected pilot projects to cover 85% of the eligible costs of broadband connectivity, network equipment and information services necessary to provide connected care services to the intended patient population. The application period opened November 6, 2020 and closed December 7.⁸⁴

It is essential that rural health care leaders press for continued government support to expand and strengthen broadband/mobile communication networks in rural areas. This will involve engaging both broadband infrastructure companies as well as telecommunications firms. Fortunately, the benefits of this expansion are not unique to health care, and industry leaders can join forces with their colleagues in education and agriculture, as well as with businesses and consumers, to make the case.

All local assets should be identified, and communities should work together to develop a holistic plan that addresses local and regional health and health care in addition to these other essential services.

Health care leaders should talk directly with elected officials and invite them to see firsthand how improved broadband and mobile service can enhance care.

Strategic Partnerships and Affiliations

Background

The COVID-19 pandemic highlighted the critical role rural hospitals play in community health as well as the

challenges they face to survive. As the pandemic raged across the country, rural hospitals and their staff stepped up to provide critical care close to home — even as their already significant fiscal challenges increased.

Rural hospitals operate on razor thin margins, often depending on elective procedures and commercially insured patients to make up for shortfalls in reimbursements for uninsured, Medicaid and Medicare patients. This dependence put many facilities at risk in Spring 2020 when the pandemic forced hospitals to cease non-urgent and elective services to focus resources on COVID-19 patients. Early numbers on hospital closures in 2020 showed they were at least on pace with 2019's record rates — and might likely have been higher without relief funds from the CARES Act.⁸⁵ To survive, many hospitals forged partnerships or accelerated alliances with larger systems and academic hospitals to provide additional expertise and resources. At an April meeting of the Future of Rural Health Task Force, several members reported that strategic alliances helped their organizations respond more effectively and efficiently to the pandemic. Examples included working with local health boards and providers to ensure proper PPE and resources, consulting with regional tertiary health centers to transfer critically ill patients and increased communications with state, regional and national hospital associations to stay informed on the latest information.

Strategic partnerships and affiliations can benefit both rural and urban health care organizations. Rural organizations are looking for access to technology, staff recruitment, expanded services, group purchasing opportunities and increased access to capital. Urban organizations may be motivated by a desire to increase their referral base, strengthen rural communities or allocate costs more effectively.

Rural hospitals are deeply rooted in their communities, and their local impact goes far beyond the health of local residents. As one of the largest employers in rural communities, hospitals play important roles in communities' economic health. With connections to local social service and other community-based organizations, rural hospitals have opportunities to impact housing, transportation, childcare, education and other services that keep communities vibrant and alive. Rural hospitals, therefore, can give larger hospital systems an entry point



into these communities, resulting in synergies that benefit both entities — and the populations they serve.

In recent years, many rural hospitals have merged or become affiliates of larger hospital systems. These arrangements can take various forms. Possibilities include management agreements (where the larger system takes control of operations without assuming ownership), joint ventures (in which hospitals combine efforts for a particular task), acquisition/lease (in which the larger entity purchases assets or equity ownership or takes a share of distributions) and other models. One of the core drivers of these partnerships is the need to shore up the local facility, including capital and clinical infrastructure, so that when possible, patients can receive care at the local rural hospital rather than transferring to tertiary facilities.

The idea of merging with a larger facility often goes against the grain for fiercely independent rural hospitals. Rural hospitals pride themselves on their personal touch, their knowledge of the local community and the idea of neighbors caring for neighbors. Used to working autonomously, they may associate larger systems with more regulations, oversight and bureaucracy. Increased efficiency and streamlining may mean layoffs or re-assignments of local staff. However, there are ways rural hospitals can extend their reach both inside and beyond their communities to address their goals and challenges, while maintaining as much autonomy as possible.

Overview

Rural hospitals are already connectors in their communities. By building on this role — reaching both inside their own communities and outside to state,

regional and national entities — hospitals can optimize the services they offer the community while addressing challenges that affect patient care, more sustainably. Models are evolving for new types of partnerships and affiliations that achieve objectives for both rural and urban organizations and revitalize health care delivery in rural areas. Options exist short of an acquisition, including clinical affiliation or hospital management or telehealth arrangements. For example, hospitals can identify service lines that are lacking in the community and partner with healthcare organizations in a neighboring area to provide that service. Hospitals can take a leadership role in improving transportation options in their communities by getting involved with efforts toward public transportation efforts or providing vouchers for a local taxi services or ride-hailing app.

By looking carefully at the needs of the community and how best to meet those needs now and in the future, rural hospitals can recalibrate the focus of their services and find the most effective and sustainable way to deliver what the community needs. Some of these models include:

Hub and Spoke System. In these partnerships, most intensive medical interventions are provided on a main campus, or hub, with more limited and targeted basic services offered at sites distributed across the region. For example, the Willis-Knighton Medical Center in Shreveport, LA, serves as the hub for a system that includes 8 smaller health systems and three rural health partners to serve most of western Louisiana. These types of arrangements can result in more consistent and efficient quality care for a larger service area while also offering improved responsiveness to market developments or environmental conditions. The availability of telehealth options can expand these models so that centers of excellence can exist far away, and services are ultimately less geographically constrained.

Integrated Structures for Payer Contracts. Through organizations or structures such as Accountable Care Organizations (ACOs) and Clinically Integrated Networks (CINs), smaller organizations can pursue joint contracting with larger organizations leading the way while still maintaining a degree of autonomy.

Joint Venture Affiliations. Affiliating with larger health systems for a specific project can bring resources and

expertise to rural areas and set the stage for further collaboration. These can be arranged around a service line — extending availability of specialty care to rural areas — either as an individual agreement or part of a high-level affiliation, such as a management agreement.

- Service line joint ventures are an example of a moderate integration arrangement: they provide options for co-ownership so that smaller organizations only cede some control, where necessary, for core services that are not readily accessible in rural communities. Relationships forged in service line agreements can then evolve as other needs emerge. For example, Sky Lakes Medical Center in Klamath Falls, OR, turned to Oregon Health and Sciences University — with whom they have partnered on a family medicine residency program since 1992 — for expertise and “family medicine manpower” during the pandemic.⁸⁷
- Management agreements: an example of a full-integration arrangement, these can vary depending on how the governance agreement is structured. For example, the organization can retain full ownership of the facility but tap into the expertise of the large health systems.

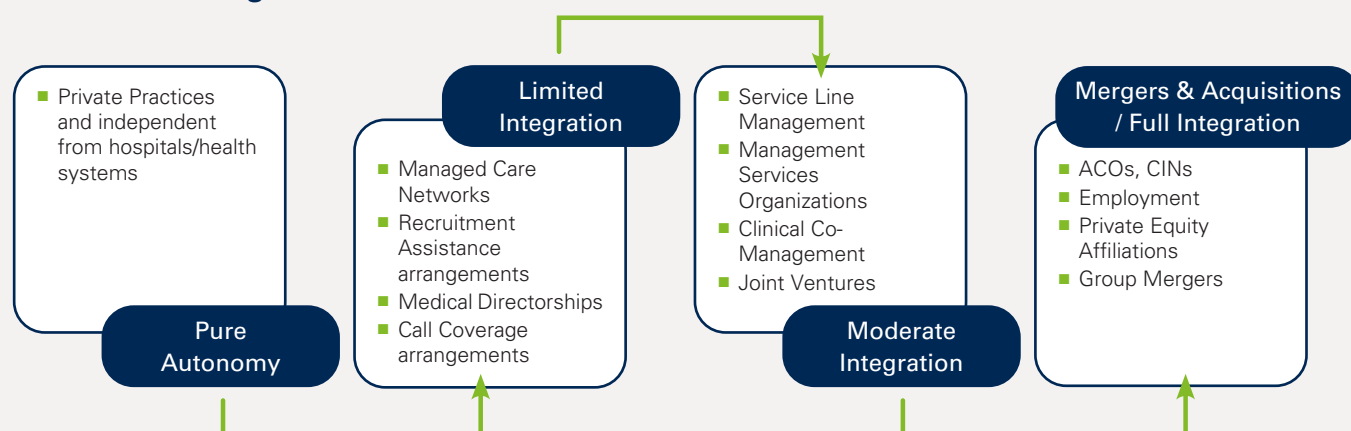
Collaboration with public or private entities: These innovations can take many forms. Technology collaborations can use data analytics with other creative strategies to improve patient outcomes and operational efficiency. Technology groups can help build infrastructure and expand capabilities in such key areas as

telehealth and secure information exchange. Community organizations, such as YMCAs and housing groups, can help hospitals reach out with preventive screenings, address the social determinants of health and target the specific needs of the community. Joining forces with other smaller facilities can create buying power and economies of scale usually unavailable to independent and isolated hospitals.⁸⁸

Participation in state and national programs: Rural hospitals can build their support networks by actively participating in state and national certification or standardization programs, such as pursuing official recognition as a Patient-Centered Medical Home (PCMH), joining a data sharing agreement on the state level or applying to become a federally qualified health center (FQHC).⁸⁹

Partnering with local organizations: Building and strengthening connections with local community-based organizations can lead to new opportunities to improve the health of local residents and address their overall health needs. Board representation — both hospital leaders serving on community boards and community members serving on hospital boards — is one way to build partnerships.⁹⁰ Hospitals can also provide financial or in-kind support to community groups, build volunteer programs and encourage hospital employees to volunteer for other local organizations and churches and develop focus groups to gauge public response to hospital programs. As the Southcentral Foundation in Anchorage, Alaska, has demonstrated through its Nuka System of

Levels of Strategic Affiliation⁸⁶



Care, reaching into the local community can be a powerful way to grow an innovative health care delivery system.⁹¹ Originally part of the Indian Health Service and controlled by a bureaucracy 5000 miles away, Southcentral struggled to serve its patients. In 1999 the Alaskan Native people chose to become customer-owners of the health care system and re-designed the system to meet their unique needs, building a system based on relationships.

Considerations

Strategic alliances and partnerships have great potential to strengthen rural hospitals and change the trajectory of rural health care by building stronger networks, preventing closures and helping to preserve local availability of care. However, given the critical role of rural hospitals in the health and economy of local communities, participating organizations must carefully consider and select appropriate partnerships.

Some considerations in the selection process might include distance to an affiliate or partner health care system and transportation challenges for rural residents to get to partner institutions for specialty care. In addition, as a major employer as well as health care provider, rural hospitals need to consider possible effects on staff, including dissatisfaction or resistance to new policies and procedures and the possibility of reassignment or layoffs to increase efficiency. However, successful partnerships in rural areas across the country point to the potentially life- and job-saving nature of well-designed alliances.

Leadership Transformation

Background

While many of the problems involving rural health care involve technological limitations and financial challenges, many potential solutions are close at hand, too, in the form of passionate, transformative leaders.

Rural health care leaders often embody many of the same qualities found in rural communities as a whole, including:

- Strong sense of community and civic pride
- Ability to leverage diverse relationships for mutual benefit



- Resilience
- Resourcefulness
- Full of purpose

These leaders are often used to innovating out of necessity and doing more with fewer resources. They are skilled at strategically developing both local and far-flung partnerships and working across many communities and organizations to achieve their goals.

But at times, rural leaders may feel isolated. Given the relentless financial and logistical challenges rural hospitals face, leaders can be prone to burnout. They may also feel stretched too thin to welcome the new perspectives and innovations rural health facilities must embrace in order to survive.

The Task Force believes that rural communities need an investment in transformational leadership development for health care leaders. It is their position that visionary leaders are critical to innovation and sustained change in rural health care. Transformational leaders do more than just chart a path forward. They encourage and motivate others to think creatively and work together to mold a successful future for their organizations.

Toward this goal, rural hospitals can better leverage already-existing leadership training resources. The Task Force hopes more opportunities to expand scholarships and rural CEO preparation/mentoring programs will emerge in the near future. Looking farther ahead, the Task Force would like to see increased opportunities to standardize leadership training programs and incorporate change management principles, to create a steady stream

of incoming rural leaders with strong visions and the skills to execute those visions.

Solutions

Rural hospitals should explore existing leadership resources, including state hospital associations and professional organizations to help develop necessary skills for rural leaders. The AHA's annual Leadership Summit offers many such learning opportunities.⁹² The Institute for Healthcare Improvement and the American College of Healthcare Executives are two of many other professional organizations that also offer robust health care leadership training resources.^{93,94} While the COVID-19 pandemic has strained rural hospitals nearly to the breaking point, the migration of conferences and training sessions to an online format means these offerings may be more accessible to rural leaders in 2021 and perhaps beyond.

Additionally, rural institutions should explore pipeline programs with local educational institutions. These programs, which start as early as high school, help build training tracks for students to gain the necessary skills and education to become future leaders in their rural communities. One well-known example is the Health Careers Institute at Dartmouth, a summer program for high school students located in rural northern New Hampshire.⁹⁵

The resources offered by Area Health Education Centers (AHECs) may help rural hospitals find pipeline programs with which to engage.⁹⁶ These state and local programs are committed to expanding the health care workforce, especially in underserved communities. They also maximize diversity and facilitate distribution of health care

professionals. AHECs offer innovative, hands-on health careers curricula for high school and college students. During the 2019-2020 school year, AHECs placed 17,000 health careers students in rural and other underserved communities.

Advanced Education Opportunities

There are also opportunities to expand scholarships and rural CEO preparation/mentoring programs, in which individuals who demonstrate leadership skills are targeted earlier in their education or career (including high school, college or entry-level jobs) to develop pathways for future leaders.

Many leading universities throughout the U.S. offer innovative health care-related, advanced-degree programs. One notable example is the Master of Health Care Delivery Science (MHCDs) at Dartmouth College, which combines features of traditional MBA and MPH programs, with courses taught by faculty from Dartmouth's medical and business schools.⁹⁷ This low-residency program is offered mostly online and has recently been compressed from 18 to 12 months to encourage more working adults to enroll.

The Master of Science in Health Care Transformation offered by the University of Texas at Austin is a one-year, 30-credit-hour program. It specifically focuses on the principles of transformational leadership executives need to create lasting change by reorganizing health care around patients' needs.⁹⁸ Housed in the Austin McCombs School of Business, this program also involves faculty from the School of Medicine for a well-rounded perspective. It combines in-person and online coursework.

There has also been increased interest in growing the knowledge base of rural hospital leadership. For example, in 2018 the State of Georgia passed legislation that requires rural hospital executives and board members to complete training modules within one year of their initial appointment.⁹⁹ Each leader must also complete refresher training every two years thereafter. The Georgia Rural Health Innovation Center created the curriculum — which includes ethics, fiduciary responsibility and strategic planning — and monitors compliance. Although the roll-out was met with resistance by some health care organizations, many Georgia leaders have now come to embrace these requirements.





One Task Force member based in Georgia shared that some board members self-selected by resigning from the board when the requirement went into effect. These board members were replaced by more responsive trustees who are open to innovation. If his observations play out on a larger scale, the training requirement can raise the bar for rural hospital leaders who can pilot institutions to greater innovation and accomplishments.

The Task Force believes that the Georgia model shows promise and should be explored in other states. At the very least, if states mandated board and staff training but left the implementation and customization to individual institutions, local knowledge would advance considerably.

Standardized Training and Education

The Task Force believes the opportunity exists to further standardize educational and training programs so there is a steady stream of incoming visionary rural leaders. Local, state and federal incentive programs should be better coordinated to prevent duplication. Programs could offer free tuition for health care executives who are willing to serve in rural communities for a set number of years.

Some medical schools are already doing this for future clinicians. For example, the University of Alabama at Birmingham offers a five-year Rural Medicine Program that includes two years of clinical rotations at the University of Alabama at Huntsville Regional Medical and rural rotations and coursework.¹⁰⁰ Graduates agree to practice in an underserved area of the state.

The Task Force believes that this approach would also be successful in creating skilled rural executive leaders. Just as Alabama has tried to increase the supply of rural

clinicians, the state has also sought to boost rural health care by creating the Alabama Rural Health Collective (ARHC).¹⁰¹ The ARHC provides technical assistance to eligible hospitals on key topics like in a variety of areas, including compliance, purchasing, quality, strategic planning, provider recruitment and third-party partnerships. Another crucial ARHC offering is its RV-based mobile clinical simulation lab that travels the state to train clinical and administrative staff on ways to improve quality and the patient experience.

Alabama has cemented its commitment to rural health care by developing the rural health care administrative fellowship available as part of the UAB master's in health administration program.¹⁰² The fellowship offers a comprehensive, multidisciplinary experience which consists of exposure to multiple areas and a diverse set of projects at a host rural hospital. This one-year program includes a competitive salary and benefits package from the host hospital and relocation assistance may be available.

The Task Force hopes that more such programs will become available to rural leaders over time. A network of standardized rural administrative fellowships could gradually transform standards of excellence in rural health care administration. Additionally, the Task Force believes that more states could offer incentives to both clinical and administrative leaders to focus on rural health care.

Considerations

Just as individual leaders have been instrumental in keeping rural hospitals afloat for so long, they offer great potential to help hospitals continue to adapt to changing conditions. But leaders' abilities to inspire change are limited when they themselves have settled into routine or find themselves resisting innovation due to a scarcity mindset. While legislative mandates can create resistance among board members and costs of training can be prohibitive in some situations, the Task Force feels these challenges can be overcome with forward and innovative thinking.

The Task Force believes that successful deployment of their recommendations is inextricably bound to a comprehensive effort – with allocated resources – to develop visionary leaders to drive the change that rural hospitals will need to thrive going forward.

Maternal Health

Background

Rural hospitals face significant financial and operational challenges as they struggle to provide maternity care to their communities. Despite being considered an essential service, rural OB units and service lines are being shut down throughout the United States. However, not offering an OB service line does not mean there will no longer be pregnancies and births in a community. It just means that women will have to travel farther to get the care they need, perhaps rendering them less likely to keep their prenatal appointments.

A 2017 *Health Affairs* study found that more than half of all rural U.S. counties lack hospital obstetric services, despite the fact that more than 28 million women of reproductive age lived in rural counties.¹⁰³ 9% of rural counties experienced the loss of all hospital obstetric services during the 10-year study period (2004-2014).

Many factors explain these closures, with the high cost of operations first and foremost. Additionally, the decentralized nature of rural populations means that any given rural hospital is likely to have relatively low volume for this service line relative to its cost structure. Other reasons for closures include:

- Difficulty recruiting and retaining obstetricians/gynecologists
- Inadequate patient access
- Effects of the social determinants of health, including health disparities (especially in women of color and immigrant women), education levels and access to transportation.

But underlying these concerns is the relatively high rate of maternal death during pregnancy, birth and the postpartum period among women in the U.S. in general and in rural areas particularly. The Commonwealth Fund reports that women in the U.S. are the most likely to die from complications related to pregnancy or childbirth among developed countries.¹⁰⁴ In 2018, there were 17 maternal deaths for every 100,000 live births in the U.S. — a ratio more than double that of most other high-

income countries. Rates of severe maternal morbidity and mortality compared are nearly 10% higher for rural U.S. residents compared to urban residents.¹⁰⁵ Among several key causes, these reports identify two that are especially common in rural areas: an inadequate supply of appropriate health care providers and a lack of maternal social supports.

According to the Centers for Disease Control and Prevention (CDC), 700 women per year die in the U.S. as a result of pregnancy or delivery complications, with American Indian/Alaska Native and Black women at substantially higher risk than white women.¹⁰⁶ More than 60% of pregnancy-related deaths occur in the time between delivery and one year postpartum. Additionally, 2 out of 3 maternal deaths were determined to be preventable. A recent study by the CDC also found that in Arizona, Native American women are dying of pregnancy-related causes at rate four times higher than white women.^{107,108}

The infant mortality rate among American Indian and Alaska Native populations remains alarmingly high. American Indian and Alaska native infants are nearly twice as likely to die by their first birthday as non-Hispanic infants. Between 2005 and 2014, this was the only racial or ethnic group that did not experience a decline in infant mortality.¹⁰⁹

For all of these reasons, the Task Force advocates for solutions that develop new care models to leverage the role of family medicine physicians and other qualified care providers to deliver routine maternal care. Additionally, the Task Force would also endorse the development of new payment models over time that reflect and reward this philosophy.

Solutions

In particular, the Task Force believes that the increased national awareness about the magnitude of the problem of pregnancy-related maternal deaths in the U.S. provides an opportunity to expand models and best practices that hold promise.

The Task Force would like to see expanded support for the Alliance for Innovation on Maternal Health (AIM) safety bundles.¹¹⁰ AIM is a national partnership funded by the Health Resources and Services Administration's

(HRSA) Maternal and Child Health Bureau. It includes provider, public health and consumer groups that work at the state level to develop maternal safety bundles that include evidence-based practices.

These standardized maternal safety bundles have been shown to improve quality, safety and outcomes, including reduced rates of maternal mortality and severe maternal morbidity. Rural hospitals have benefited from participating in statewide collaborations, for example in California and Texas, around AIM maternal safety bundles.

Additionally, the Task Force endorses the expansion of three innovative models: expanded doula care in rural areas, the Pioneer Baby model and the CenteringPregnancy program.

Expand Doula Care in Rural Areas

Birth doulas are nonmedical personnel whose only focus during labor and childbirth is providing continuous emotional support to the mother. Studies have shown that using doulas can improve outcomes for mothers and infants, especially for women at risk of adverse outcomes, including African American and Hispanic women, and those living in rural areas.¹¹¹ Doulas have demonstrated a reduction in labor time, reduction of mother's anxiety, improvements in mother-baby bonding and improved breastfeeding success. A 2017 Cochrane systematic review, generally considered the highest standard of evidence, found improved outcomes for women and infants including shorter labors and decreased numbers of caesarean and instrumental vaginal births.¹¹²

Barriers to entry to becoming a doula are low, making the occupation well-suited to persons who live in rural areas and need additional work opportunities within their communities. Formal medical training is not required, although off-duty and retired nurses may find doula work to be a good part-time occupation. Several organizations provide voluntary certification programs for doulas.

As an example, Healthy Start Inc. serves both Allegheny and Westmoreland Counties in Pennsylvania — which includes both urban and rural areas. During the pandemic, the organization expanded accessibility of free doula support through virtual technology.¹¹³ Extending this type of program nationally could help support pregnant women and improve maternal health outcomes in rural areas.

The widespread adoption of doula services to support rural laboring mothers still faces systemic challenges. With no licensure requirement or federal regulation in place to determine competencies, payers to date have not covered doula services, despite their strong record of quality improvements. This lack of insurance coverage and reimbursement for doula services can be challenging, making the work less financially viable for the practitioners unless it is supported by a health care system or private grant programs. Despite these challenges, some rural hospitals are responding to workforce challenges by engaging doulas, and the U.S. House of Representatives recently passed H.R. 4996, legislation that would pay for doula services. The Task Force encourages payers to reimburse for doula services.

Pioneer Baby Program

Launched six years ago at Kearny County Hospital (KCH) in Lakin, Kansas, the Pioneer Baby program focuses on improving pregnancy and birth outcomes among mothers with gestational diabetes. These women and their infants face an increased risk of both short- and long-term outcomes. A key feature of the program is a collaborative network, which includes public health organizations, medical schools and a federally qualified health center (FQHC). The program's success has helped ease the hospital's financial pressures associated with its maternity unit.

The Pioneer Baby initiative has four phases:

- **Phase 1:** Assess institutional needs and set clinical, quality or financial goals.
- **Phase 2:** Bring specialized care to the region to co-manage high-risk patients.



- **Phase 3:** Measure both clinical and financial results.
- **Phase 4:** Seek grant support from federal and local funders.

While this first application for the Pioneer Baby model focuses specifically on women with gestational diabetes, the Task Force believes this model can be applied more broadly to other pregnancy-related conditions.

CenteringPregnancy Program

Created by the March of Dimes, the CenteringPregnancy program brings together women due to give birth at the same time for group prenatal care appointments that last 90 minutes or more.¹¹⁷ The additional time with providers allows patients to become more engaged and better informed and ask more in-depth questions. It also allows mothers to make friends and benefit from the support of other group members.

While bringing together a group of pregnant women of similar gestational age in rural communities is challenging, the American College of Obstetricians and Gynecologists (ACOG) reports that early research shows that group appointments offer several benefits, including reduced preterm births, increased rates of breastfeeding, decreased emergency department visits, improved patient satisfaction and improved knowledge of childbirth, family planning and postpartum depression.¹¹⁸ CenteringPregnancy is a proven model that could bring great benefit to rural maternal care, if applied broadly throughout rural communities.

Considerations

In addition to what can be done in the near to mid-term, significant changes are needed to achieve widespread rural maternal health improvements in the future.

A key strategy to improve maternal care outcomes is to build the capacity of nurses, family physicians and health care providers to address maternity-related issues earlier, even before women become pregnant. While working to improve outcomes for women with gestational diabetes and their babies is crucial, for example, even greater benefit to mothers and babies would come from reaching women earlier so that they start their pregnancies on a healthier footing.

Changing Woman Initiative

Changing Woman Initiative is a nonprofit Native women's health collective with the mission "to renew cultural birth knowledge to empower and reclaim indigenous sovereignty of women's medicine and life way teachings to promote reproductive wellness, healing through holistic approaches and to strengthen women's bonds to family and community."¹¹⁴ It focuses on creating a community based wellness model based on cultural teachings and belief systems using indigenous midwives and doulas, in order to improve maternal health outcomes for indigenous populations. Today there are only 14 Native American certified midwives across the country.¹¹⁵

The Changing Woman Initiative is currently planning to develop the nation's first Native birthing facility in New Mexico that will integrate ancient tribal birthing practices and break down barriers to receiving proper maternal care: limited transportation, food insecurity, lack of awareness of prenatal care and high costs. The birthing center provides an example of a women's health model that can be expanded for tribal communities nationwide.¹¹⁶

In order to reach women earlier in the life cycle, more upfront interventions are needed in the form of preventive programs and wellness care. As the Pioneer Baby model demonstrates, targeting creative fundraising and grants to obtain funding for specific high-impact positions — like maternal-child nurses who can develop holistic relationships with women of reproductive age in their communities — is a viable strategy. Pursuing grant funding for purchasing costly equipment and technology that enhances collaboration between local providers and out-of-town specialists should also be considered.

In general, rural hospitals often find it difficult to fully staff their obstetric and family medicine services, demonstrating the need for innovative recruitment and retention strategies. Administrators can explore partnerships with regional medical schools to create rotation opportunities at their institutions for medical trainees in family medicine and obstetrics.



There is also an urgent need for medical schools, health care administrators and rural hospitals to support the practice of full scope family medicine. The number of family physicians who provide maternity care has declined steeply in recent years, and even fewer practice surgical obstetrics. Although 21% of new family medicine graduates in 2016 reported an intention to include obstetric delivery in their scope of practice, only 7% of family physicians were actually doing so in that same year, according to the *Journal of the American Board of Family Medicine*.¹¹⁹ Family medicine programs should incorporate maternity care into the vital training that family physicians receive during medical school and residency.

CMMI Pilot Project Focused on a Rural Maternal Health Model

CMMI should further disseminate state innovations and best practices. For example, the Task Force recommends expanding the Pioneer Baby model with further field testing as part of the proposed CMMI Rural Design Center (see [page 38](#)). If a CMMI pilot were successful, that would provide the vehicle needed to bring the model to scale throughout the rural U.S.

In September 2020, the House unanimously passed the following bills that now are under consideration by the Senate. These bills support the idea of expanding maternal health protections:

- **H.R. 4995.** The AHA supports passage of Maternal Health Quality Improvement Act (H.R. 4995) which aims to improve outcomes in rural and underserved areas by increasing access to maternity care, helping

providers implement best practices. H.R. 4995 also provides funds to extend postpartum Medicaid coverage and helping to address racial and ethnic inequities.

- **H.R. 4996.** The AHA supports the Helping Medicaid Offer Maternity Services Act (H.R. 4996), which specifically addresses Medicaid coverage of doula care. It also encourages states to extend Medicaid and Children's Health Insurance Program coverage for pregnant and postpartum women from the current 60 days to one year after birth. The AHA also urges CMS to consider ways to increase coverage for maternal care through its waiver authority.

In addition, another bill has been introduced to specifically address health disparities and inequities in maternal health:

- **H.R. 6142.** AHA strongly supports the Black Maternal Health Momnibus Act (**H.R. 6142/S. 3424**), which would invest in community-based organizations, support care coordination and collect data on maternal mortality and morbidity in minority and underserved populations. The bill also would provide funding to diversify the maternal and perinatal nursing workforce to reflect the patient population served, create a perinatal care alternative payment model demonstration project and protect the health of pregnant incarcerated individuals. The AHA urges CMS to consider ways to use CMMI demonstration authority to explore how community-based organizations can improve maternal mortality and morbidity.

Develop New Maternal Health Payment Models

Looking even further ahead, the Task Force supports the creation of innovative payment models to support maternal health. As rural hospitals strengthen their maternal health service lines via the recommendations outlined above, payers can develop flexible payment models tied to quality outcomes that enable family physicians to expand their maternity services. Doing so would encourage the resurgence of full scope family medicine and create environments in which value-based reimbursement becomes feasible.

Rural Philanthropy

Background

Rural hospitals are anchor institutions in their communities as principal health care providers, major employers and key economic drivers in their regions. Despite these strengths, rural hospitals are also vulnerable. Providing care to geographically isolated and dispersed populations holds many challenges. Low patient volumes increase per-patient costs of care delivery and heavy reliance on government-funded programs like Medicare and Medicaid translates into lower reimbursement rates. For these and other reasons, many rural hospitals have operated on razor thin margins for years and the current pandemic has further exacerbated that financial strain.

Many rural organizations look to grants or donations to fill the revenue gap or augment state and federal funding. But applying for grants or soliciting donations is time-consuming with no guarantee of success. Allocating resources to devote to researching, applying for and administering grant programs is also difficult. Without dedicated staff who focus on alternative or creative funding opportunities, rural health care administrators may not be aware of resources available on the state or federal level to help them apply for and receive grants and other funding. Even if they apply for grants, hospitals may find they are competing with other organizations in their own communities for the same funds.

At the same time, funders often do not have a clear understanding of rural health or make the connection between their philanthropic goals and rural health care's

needs. For example, COVID-19 has disproportionately impacted communities of color, and many funders have earmarked funds to address this. However, they may not associate rural hospitals with these goals, even though many do serve the target populations.¹²⁰ Developing relationships with leaders — including hospital executives — in rural areas can help funders gain a better understanding of shifting demographics in rural communities and the critical role rural hospitals can play in improving outcomes for immigrant populations, people of color and other marginalized groups.

Health care and health outcomes intersect with a wide range of policy issues. Funders focused on economic or social issues, conservation or technology may not think of rural hospitals as partners — and vice versa — even though monetary issues, housing, education, nutrition, the environment and access to technology are all social determinants of health that play a major role in a rural community's health outcomes.

Taking a more strategic approach to grants and philanthropic relationships, rethinking affiliations, tapping into available resources and working cooperatively with other community organizations may help hospitals and their communities develop innovative programs to improve health outcomes and realize financial goals more effectively.

Overview

Integrating philanthropy into a hospital's strategic plan should be a part of a long-term trajectory to promote investments in the health of a community. Forming long-term partnerships with funders and building relationships over time can lead to more funding opportunities and more secure financial footing for rural hospitals. These relationships are more likely to result from a series of conversations over time rather than a one-time application for a specific grant opportunity.

Hospital CEOs and administrators can and should take a lead role in these relationships — for example, by inviting potential funders to present their work or tour the hospital or community. But it does not have to fall solely on staff. Hospital trustees and advisory board members may have the time, resources and social or business networks needed to explore and forge relationships with potential funders.¹²¹



Resources to Help Identify Funding Opportunities

Resources are available to help identify funding opportunities:

- The USDA Rural Development has a variety of programs to support economic development and essential services — including health care — in rural communities.¹²² USDA staff representatives for every state help communities access these programs.¹²³
- The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services offers a variety of resources for rural providers, including A Guide for Rural Health Care Collaboration and Coordination that discusses funding opportunities.¹²⁴
- The Rural Health Information Hub, supported by HRSA, offers a comprehensive toolkit of emerging practices and resources for building philanthropic relationships.¹²⁵
- The Federal Register lists all available federal grants and other funding opportunities, including those offered by the Department of Health and Human Services.¹²⁶ Most states have similar lists of grant opportunities from state agencies.

The Foundation Center has a directory of grant-making organizations and agencies to help identify potential funders, many of which do not have websites. The website offers some basic information for free, with additional resources available for subscribers. The database may also be available through some public and institutional libraries.¹²⁷

Considerations

Hospitals should look at the wide spectrum of funders, including small, local foundations. Larger funders and government funders often are looking to build relationships in communities to improve health care and other social needs in rural areas. They need liaisons

to identify communities in need of funding, and small funders often play that role. For example, during the pandemic, small funders have made connections between rural hospitals and state/federal officials and helped them access state and federal resources to address the situation.

Another largely untapped resource is local community colleges and regional universities. Faculty, students and alumni can all play roles in identifying funding opportunities, applying for grants, building programs and fostering new types of community collaborations to achieve mutual goals.

Other commercial businesses and organizations may be able to advocate for rural hospitals, assist in the design and implementation of new programs and help make necessary connections with funders. Hospitals should rethink and re-envision existing relationships with local businesses, facilities and organizations serving the same community — turning service relationships into strategic relationships. Referral relationships, economic relationships and even competitive relationships can evolve into collaborations around mutual interests. This type of community cooperation and strategic planning is often exactly what funders want to see because it increases the chance of success and impact.

CONCLUSION

The COVID-19 pandemic has taxed the U.S. health care system beyond anything it has ever experienced in modern history. A particular burden has fallen on rural hospitals, shining a light on weaknesses that have long existed in our rural health care system. Fortuitously, this light also illuminates the path to a future where we address these weaknesses by pursuing not just temporary fixes or minor tweaks, but whole scale transformations. Ideas that might have sounded radical before the pandemic, now seem like simple common sense.

These transformations will require time, money and focus that are all likely to be in short supply while the crisis continues. But the Task Force is certain that by adopting the measures set forth in this report — and consistently

building on them — we can reimagine the future of rural health care.

Working together on local, state and federal levels, we can transform rural health care into being what it always could and should have been: a powerful force not only for addressing the medical needs of our rural patients, but for achieving optimal health in rural communities.

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Advancing Health in America

Chicago Office:

155 N. Wacker Drive, Suite 400
Chicago, IL 60606
312.422.3000

Washington Office:

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001
202.638.1100



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