THE FUTURE OF RURAL HEALTH SUMMIT

Report on a Special Convening Held November 19-20, 2024

Partnering Organizations

National Rural Health Association

RUPRI RURAL POLICY RESEARCH INSTITUTE

westhealth

Acknowledgements: The lead authors of this document included: Keith Mueller (RUPRI), Kevin Bennett and Carrie Cochran-McClain (NRHA), and JT Douglas (West Health Institute). Additional authors were Eli Steenhoek and Lauren Lavin.

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INTRODUCTION

This document synthesizes facilitated discussions held over two days involving more than forty experts in rural health services delivery and finance. The goal of this Future of Rural Health Summit was to identify the needs of the rural health communities, build on existing strengths, and develop a cohesive approach to improving the health of rural Americans through policy. This report outlines the guiding principles that were established as the foundation for discussion throughout the Summit, the themes that emerged for improving rural healthcare, as well as actionable policy opportunities identified by these experts. It serves as a roadmap for addressing the needs of evolving rural healthcare systems and creating thriving rural communities.

Impetus for the Summit grew out of a desire to update and improve the visionary work of three partnering organizations:

- The Rural Policy Research Institute and its Rural Health Panel seeking to update and refine work based on its framework for a High-Performing Rural Health System[1]
- The National Rural Health Association and its Policy Congress updating previous and ongoing work focused on the future of rural health[2,3]
- West Health Institute and its collaborative White Paper: "Reimagining Rural Healthcare—Before It's Too Late"[4]

Those organizations formed a Steering Committee drawn from their organizations and elsewhere to develop the agenda and invitation list for the Summit. Members of the Committee are:

- Keith Mueller, Director of RURPI and Chair of its Health Panel
- Jennifer Lundblad, member of the RUPRI Health Panel
- Alana Knudson, member of the RURPI Health Panel
- Kevin J. Bennett, NRHA President 2024

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[1] Coburn A et al (2022) High-Performing Rural Health System. *Policy Brief*. Rural Policy Research Institute. January. https://rupri.org/wp-content/uploads/High-Performing-Rural-Health-System-Update-01.07.22.pdf.
[2] National Rural Health Association (2013) The Future of Rural Health. https://www.ruralhealth.us/getmedia/714ab360-fae1-400b-8f8d-0490c2c96bb3/FutureofRuralHealthFeb-2013.pdf.
[3] National Rural Health Association (2022) The Future of Rural Health: Shared Rural Health Values. Unpublished working document.
[4] West Health, Intermountain Health, Gates Ventures, Microsoft: Reimagining Rural Healthcare – Before It's Too Late (2024). https://content.presspage.com/uploads/2804/05dd57e6-ee19-453d-a709-3171854d4726/intermountainhealth-ruralhealthwhitepaper.pdf?10000
https://www.modernhealthcare.com/opinion/rural-healthcare-telehealth-payment-technology

- Brock Slabach, NRHA Chief Operation Officer
- Carrie Cochran-McClain, NRHA Chief Policy Officer
- JT Douglas, Director of Strategy with West Health Foundation
- Ralph Llewellyn, Partner, Eide Bailly LLP

The Summit was held November 19-20 in the Hyatt Regency Hotel, Crystal City, Virginia. Forty-two experts in rural health services and policy participated in facilitated discussions and four workgroups. Note takers from RUPRI and NRHA staffed each work group and the general sessions. The agenda for the Summit is appended to this report, as is the list of Summit participants represented by these affiliations:

- Rural hospitals
- Rural clinics, including Federally Qualified Health Centers and Rural Health Clinics
- Health services researchers, including the rural health research centers supported by the Federal Office of Rural Health Policy
- All members of the RUPRI Health Panel
- Policy experts, including state offices of rural health
- Consulting expertise
- Practicing clinicians

The purpose of the Summit was to produce a blueprint for the ideal future of rural health-one that would ensure the optimum health of all rural residents, and to provide analysis and recommendations the three partnering organizations could use in their ongoing work.

GUIDING PRINCIPLES

Guiding principles identified early in the Summit were essential to creating clarity in purpose as well as motivating direction in solutions offered.

The committee identified an overarching goal for this work, to serve as a North Star that would guide discussions:

> A future for rural people and places in which rural health services are affordable and accessible for rural residents through a sustainable health system that delivers high quality, high value services. A high-performing rural health system informed by the needs of each unique rural community and population groups will improve community health and well-being.
>
> The Summit agenda further elaborated on this North Star by defining a system: A system includes organizations providing services across the continuum, addressing health-related social needs, and providing high-quality, coordinated, and integrated clinical care.

The agenda also provided an operating principle the committee deemed vital:

> Preserve what we have until we have clarity in specific steps to achieve the goal for the future.

Through use of a word cloud to generate more focused ideas, participants produced these additional directives for our North Star:

- A focus on supporting economically viable and thriving rural communities
- Community development policy and health policy should have a symbiotic relationship
- A rural health system should be designed to promote health and well-being
- Preserve what we have to assure access to affordable, high-quality services

VISION STATEMENT

The following vision statement was developed during the Summit:

> A national framework adapted to diverse rural settings that includes aligned financial incentives and a minimum floor of essential services, plus necessary and vital community services relevant to the community's or regional needs (e.g., regional centers of excellence), that move beyond the walls of the hospital to include social, public health, and economic factors.

OVERARCHING THEMES

Led by the guiding principles, four key themes emerged:

1. Community focus
2. Importance of messaging
3. Building from current assets
4. Addressing critical gaps

In order to create thriving rural communities that in turn have accessible and affordable healthcare systems, there needs to be a broader focus on community, especially outside of the healthcare system providing clinical care. When conveying this to stakeholders in rural communities and beyond, it became apparent that messaging needs to be consistent and look beyond the community. The final two themes address potential actions, reminding stakeholders to build upon the assets already present in rural communities while still addressing the gaps identified through evidence-based needs assessments.

1. A Community Focus

What is a "community focus?"

> Community health is one of the four pillars of the RUPRI High Performing Rural Health System (HPRHS). Discussions during the Summit gravitated to the term *thriving, healthy rural communities* to describe a future that recognizes the inter-connections of healthy populations. Health was defined using terms related to physical and mental health, and healthy communities defined in terms of maintaining essential infrastructure (e.g., roads, broadband connectivity), community identity (e.g., cultural assets), economic stability (e.g., attracting and retaining jobs), and educational opportunities (e.g., K-12 schools, advanced training).
>
> Participants emphasized the contributions of a health system (broadly defined to include addressing health-related social needs) to activities that maintain thriving communities. Similarly, participants recognized that holistic approaches to assuring

opportunities for achieving optimum health among all community residents requires maintaining other dimensions of a healthy community such as adequate housing, transportation, employment opportunities, and affordable nutritious food.

Who are the community leaders to engage in sustaining the thriving community?

A coalition of multiple key stakeholders in the community is necessary to work collaboratively to achieve all elements of a strategy that aims to sustain community well-being. The local health system, including hospitals, clinics, public health agencies, and community-based services organizations, should anchor a coalition focused on meeting the comprehensive health needs of its residents. Others in the coalition will include local businesses/employers, civic officials, and community residents.

How should a community coalition address the goal of sustaining a thriving community?

Throughout the two-day Summit participants emphasized the importance of the community developing its own metrics, based on needs assessments. A guiding phrase during the Summit was "measure what we value, not value what we measure." Metrics must be driven by communities to capture all elements of what makes the community thrive, and key indicators that assess progress towards that goal. Health-related social needs metrics should be developed (many possibilities are available) and used in needs assessments and strategic planning.

2. Message matters

How should messages about rural health be framed?

The consensus of Summit participants was that messages about health needs and related activities need to be *forward-looking,* emphasizing how rural health systems can be transformed into models of assuring sustainable value to local residents. Such messaging should include the key principles outlined in this blueprint, particularly the importance of holistic community involvement.

What are the appropriate foci for messages about rural health?

Messages should articulate the importance of vibrant, healthy rural communities to a broader geography because of the community's importance to the state, region, and nation. For example, messages could focus on the role of rural areas in critical national interests, including national security. With rural communities providing much of the nation's natural resources, it is vital to emphasize how important it is to have thriving communities to continue these vital supplies.

What are critical parameters for the messages?

Messages must be consistent and inclusive with all stakeholders regardless of roles in health services, coalescing in the same community-based message. The message should be consistent across time and geographic setting. As the work towards thriving communities evolves, messaging should describe changes for transparency, as well as communicate progress towards the communities' goals.

3. Building from current assets

What local assets form the foundation for sustainable, affordable local services and contribute to a thriving community?

Rural communities have a substantial, if not varied, stable of health-related resources that are currently serving their residents. It is important to recognize these assets, their contributions, and what they have to offer for the future.

Each community should undertake a resource inventory to capture these assets and determine their potential contributions to the *future of the community*. This would include current assets, future assets, and gaps in such resources.

The emphasis on the future may mean some historically important assets are not the building blocks of the future, at least in their current configuration. With a goal of coordinating health and health-related assets, the need to build capacity from existing infrastructure is essential for driving increased access to care.

How are assets defined and assessed?

Assets are those resources, including natural resources, that contribute to sustaining local population and community well-being. Participants discussed specific assets (to be delineated later in this report) that characterize the strengths of the community. This may include tangible assets (e.g., physical healthcare facilities) and less tangible assets (e.g., cultural assets and human capital, including leadership in health care).

Participants recognized that there is often a mismatch in rural communities between existing assets (both tangible and intangible) and meeting the needs of the community. Efforts to improve delivery and health-related needs need to not only consider the assets, but what gaps need to be filled to meet those needs.

4. Address gaps

What evidence should be used to assess gaps in health services?

In addition to the asset inventory discussed above, gaps in delivery, services, outcomes, and other health related concepts should be addressed as well. In order to do this, an inventory among these gaps needs to be undertaken. Existing work does

often identify many of these gaps, but communities must decide what other issues they will measure in order to address through this process.

Participants identified the Community Health Needs Assessment (CHNAs) process required for non-profit hospitals a model that could be used in all communities to identify priority needs based on data such as leading causes of mortality and morbidity. While the current requirement focuses on hospitals, CHNAs can be applied to the spectrum of services needed to address health needs, including roles for public health agencies and CBOs in addressing health-related social needs (HRSNs).

How should the evidence be used?

Any assessments, such as CHNAs should employ processes that incorporate comprehensive community input, both in assessing needs and in developing strategies to meet those needs. Doing so through the local coalitions described in the first theme increases the likelihood of progress in meeting needs and strengthening the local health system.

These assessments will also provide the framework for identifying metrics that will indicate success and progress. All such metrics must be able to be tied back to either identified gaps, interventions implemented, or indicators that improvement is being made. Ongoing calibration of such metrics is also vital to this process.

Summary

These four themes provide directives to guide actions in both policy and to sustain existing essential rural-based health services. They further develop plans and actions steps as the processes that enhance services through sustainable models of service delivery.

Posed as questions, these can be used as guardrails for any efforts undertaken by rural communities that are designed for changes in policy and in delivery of health services:

1. Is it in the best interest of all rural communities, or a subset of communities based on key characteristics?
2. What is the message regarding the impact of the proposed work?
3. How does a strategy build from current assets in rural communities?
4. Does it fill existing gaps in access to and affordability of services for rural residents where they live?

Answering these questions requires weaving critical elements together into a cohesive policy framework.

BUILDING A FRAMEWORK WITH SPECIFIC ELEMENTS AND ACTION STEPS

Elements

1. Address the full continuum of care.

What do we mean by "continuum of care?"

> Continuum of care refers to all services helping individuals realize their optimum health status, from pre-birth through palliative (end-of-life) care. The ideal health system in every rural community is one that secures access to high quality care for all its residents throughout that continuum.

Is there an approach that considers the range of services needed to address the continuum of care in a cohesive manner?

> Summit participants recommended using the core elements of primary care as originally put forth by Barbara Starfield[5] as principles defining the pillars of primary care practice:
>
> - First-contact care
> - Continuity of care
> - Comprehensive care
> - Coordination of care
>
> Local primary care teams would be responsible for the full continuum by delivering essential services locally and coordinating care with providers not locally based.
>
> Essential local services should include the following:
>
> - Primary care
> - Basic OB care
> - Behavioral health services
> - Chronic disease management
> - Select specialty care – at a minimum access to specialty care via telehealth
> - Oral healthcare
> - Pharmacy
> - Emergency Services and EMS
> - Long term services and support
> - Public health

[5] Starfield B. *Primary Care: Concept, Evaluation, and Policy*. New York, NY: Oxford University Press. 1992.

- Home-based services

What services across the continuum, for which ease of access is critical but not practicable within local communities, can instead be offered regionally?

Summit participants were particularly sensitive to the need to keep many services based in local rural communities; but recognized that it was more feasible to include such services within rural regions rather than specific rural communities.

Examples may include some of those listed above, including select specialty care, basic OB care requiring specialists other than primary care clinicians, and ER service and EMS. Services of special note not always thought as essential community-specific are long-term care (long term support and services (LTSS)) and public health. Both expand elements of care beyond clinical care to include community health activities of public agencies and human services provided by community-based organizations and area agencies on aging. A focus on clinical care is a long-standing policy legacy that should continue, but achieving objectives in *health* requires a broader definition of essential services.

2. <u>Embrace Social Determinants of Health (SDOH) and Health Related Social Needs (HRSN) as indicators to drive policies and programs addressing the full spectrum of health care services.</u>

Why are indicators of SDOH and HRSN important to considerations for the future of rural health?

Measuring and tracking SDOH will help ensure the future of rural health is inclusive of services that address all health-related needs. Those include contributors to resources for healthy living such as access to affordable nutritious food, adequate housing (e.g., adequate plumbing, clean water, lead abatement), childcare, and transportation services. Measuring and tracking HRSN integrates clinical care and social services to both address health needs and lower costs by avoiding unnecessary high-cost clinical services (e.g., rehospitalizations, avoidable hospitalizations for chronic conditions).

How should health services in rural places be designed to address SDOH and HRSN?

A strong theme in comments and recommendations from Summit participants was the critical role of public health policies and actions as foundational to individual and community health. Given the intersection of public health services that help secure and maintain health, Summit participants discussed the need to create incentives for public agencies and hospitals to collaborate to support actions that reduce individual burdens and improve quality of life.

Participants also recognized that existing providers and facilities were not necessarily equipped to address these needs. This lack of capacity is a need that need that must be addressed for SDOH and HSRN to be incorporated and addressed across this continuum.

3. Use the framework of the High Performing Rural Health System (HPRHS) to guide specific actions.

As a reminder, what is the overall vision, as agreed to by the Summit participants?

A national framework adapted to diverse rural settings that includes aligned financial incentives and a minimum floor of essential services, plus necessary and vital community services relevant to the community's or regional needs (e.g., regional centers of excellence), that move beyond the walls of the hospital to include social, public health, and economic factors.

The vision reflected discussions by separate breakout groups, the basis of which was an opening vision offered by the Steering Committee and taken from the RUPRI Health Panel's document describing the HPRHS.

How should the HPRHS guide policy and action?

Members of the RUPRI Health Panel participated in the Summit and provided both context and a commitment to update the HPRHS in 2025, including more exploration of specific applications (publications since the original presentation of the framework have focused on topics such as access, behavioral health, and public health).

Similarly, the NRHA Policy Congress will continue to develop a framework that includes position and policy recommendations to guide the development of public policies consistent with the recommendations from the Summit.

Discussions of the HPRHS during the Summit suggested operationalizing the base and pillars of the framework as follows:

- **Equity**: Summit participants discussed this foundational base of the framework as a principle of engaging all populations within rural communities in discussions of policy and practice interventions intended to improve and sustain individual and community health. A key phrase was repeated often during the Summit: "not about us without us." A parallel phrase was "no population left behind." Both phrases summarize an extensive discussion of ensuring the health needs of everyone in the

community are addressed. This includes recognizing cultural differences through SDOH.

- **Access**: Earlier sections describing the continuum of care emphasized that access in a rural context means assuring the presence of essential services in local communities. Further, Summit participants returned often to the need to assure access throughout the entire continuum of care, including addressing SDOH/HRSN.
- **Affordability**: Summit participants repeatedly homed in on a theme that rural health care services are grounded in the foundation of primary care, which in turn makes the system more affordable to both the consumer and the payor. Participants discussed the need to develop new metrics that support a multi-pronged approach to rural health over time. These would include payment design creating incentives to encourage optimal use of medical and other services focused on maintaining health in ways that lower costs by avoiding use of high-cost services.
- **Quality**: Summit participants proposed that evidence-based quality metrics must be agreed to across key stakeholders, including payors, providers, and geographies. The metrics must be both measures of community health and encounter-specific measures that account for the particular circumstances of rural populations, communities, and providers.
- **Community health**: A consistent theme during the Summit was that "community" be considered as two levels of geography:
    - For activities addressing individual health needs, the focus would be on local communities (a city/town and surrounding territory) and their resources.
    - For initiatives that encompass larger portions of the continuum of care, a larger definition of a regional community would need to be utilized to purposes of strategies to assure sustainable service delivery

Action Steps

Summit participants engaged in general discussions of what actions would be needed to prepare for implementation of specific policy and program recommendations. As the discussion unfolded, a sequence of actions was described that could be conceived as a road to the desired future. Figure 1 in the Appendix presents this in summary form. Specific actions are described in the text that follows.

1. Designing a decision-making structure suitable sustaining a model incorporating both regionally centralized (hub) specialty services and locally-based (spoke) primary services

Who should be included in local or regional decision-making, setting the course for the future of rural health?

An easy buzz-phrase answer is to say, "engage the community." Who sits in the decision-making structure to guarantee the entire community is engaged is also key, remembering the earlier edict "nothing about us without us." Further, how are appropriate persons and stakeholders engaged at both the local community and regional levels such that service delivery decisions, including where regional services are provided, account for community needs and preferences?

A specific suggestion from participants is to create leadership pipelines and support (including funding) for representation from groups throughout the community to realize their full potential as leaders. This approach requires an open decision-making process in which multiple perspectives from within the community are assured a voice, and a program to train individuals for those roles.

How should local and regional decisions related to the goal of a thriving community be made?

A decision-making process incorporating multiple perspectives (from different sectors such as housing, education, and health; and from different population strata) requires facilitation and guardrails. Summit participants discussed creating governing councils in communities and/or regions that would include voices for different program sectors and population groups. An early step could be fewer formal meetings led by a trusted facilitator to generate collaboration. On an ongoing basis the council would need a trusted facilitator for all discussions; local culture could drive specific decisions about formal structure.

Summit participants placed priority on developing regional strategies that were coined Regional Centers of Excellence. A structure of local community councils to identify needs, coordinate activities and resources that would then communicate with these larger regional centers of excellence to further identify needs larger community whole could prove to be very effective.

Having a specific emphasis on leadership development, as discussed above, would be vital for this structural communication as well. Summit participants identified this as a need that rural communities would require further development.

2. Determine local needs and actions – an ongoing process taking advantage of changes in health care organization and delivery

How should local and regional decision-makers set an agenda for action?

As discussed earlier in this report, a process using community health needs assessments (CHNAs, as is required for non-profit hospitals and local public health departments) could form a basis for identifying local priorities. Strategies should evolve in parallel with changes in health care organization and finance. For example, if the local hospital enters a joint-venture, merger, or affiliation with larger regional systems, additional resources may be available to support local strategic developments. Those may include sources for investment in community-based service organizations and new developments in clinical care. Community providers should take full advantage of telehealth to adapt which services can be offered locally.

Further, a broad coalition, inclusive of key stakeholders identified through careful design of a local/regional decision-making structure, may be well positioned to take advantage of opportunities and to deal with challenges to the local health system (e.g., mergers resulting in some services no longer being offered locally).

Specific Policies and Actions Supporting the Rural Health System

As the Summit continued, discussions became more specific about elements needed in policy and program actions. Topics included merging funding sources to support the rural infrastructure of clinical and public health services, shaping payment policies to meet rural needs, recruiting and retaining a health care workforce, and using technology to benefit the health of residents and communities.

1. Blended Funds Flow

How can multiple funding sources be used to support sustainable health services?

The vision and principles guiding the future of rural health encompass multiple activities supporting the health of individuals and communities. Therefore, Summit participants emphasized the need to utilize a variety of funding streams in support of rural health. Examples of such diverse public funding sources include USDA rural development programs that support community facilities, specific funds available for expanding access to high-speed broadband, support for local human services agencies and organizations (e.g., Area Agencies on Aging), and programs supporting community development through other federal departments and agencies (e.g., Commerce, Housing and Urban Development).

Private sources of funding, especially through local, regional, and state-based foundations, are available to help with specific projects. Knowledge of those private sources may be obtained through Grantmakers in Health, and the Rural Health Public-Private Partnership. More broadly, the Rural Health Information Hub includes a guidebook for local use. These diverse funds would also aid communities in addressing the social needs of their residents, which are traditionally not addressed via health financing mechanisms.

As payment continues to evolve (explored in the next subsection), possibilities will arise to combine funding from multiple specific payments to advance local rural health services consistent with the strategies developed by local and regional coalitions. The mechanics of blending the funding are to find means of combining them in integrated budgets supporting community-based strategies and activities.

How should success in obtaining and directing funds be measured?

Summit participants agreed on a simple, but powerful statement: get health expenditures to the right place at the right time.

A *process indicator* would be that discrete sources, such USDA facility community loan guarantees or philanthropic grants, were acquired and used to achieve objectives derived from deliberations of a community coalition. An *outcome indicator* would be effects on health-related measures agreed to by the coalition.

2. Payment Policies

Are there specific elements to current payment policies that might inhibit achieving the vision for the future of rural health services?

Summit participants agreed on current issues that must be resolved to ensure the continued presence of essential services in rural communities:

- Existing payment policies targeting the needs of rural providers should be preserved until a new payment system is developed that provides sufficient income for them to continue.
- Sequestration in Medicare payment should be repealed, at a minimum for at-risk rural hospitals, but also more broadly.
- Allow changes to the Rural Emergency Hospital program to facilitate appropriate participation as a means of sustaining essential services (emergency services, primary care, post-acute care).

What should be considered as alternatives to current payment methodologies?

Several ideas were offered during breakouts and the closing general sessions that could be directions for future payment policy changes:

- Consider a utility-based model of public support for the delivery of healthcare services, treating those services as a public good.
- Consider a global budget model.
- Utilize opportunities for collaboration with private insurers.
- Waive, or redefine, long term budget neutrality and cost-savings requirements to infuse dollars in rural settings that have had historical underinvestment.
- Revisit HHS approach to rural payment delivery reform.

What are special considerations for a new payment model?

- Provide a road map to transitioning out of the current infrastructure in some rural places, including funding to convert existing assets.
- Payment should encourage desired investment in infrastructure, resources, and services that lead to desired outcomes related to health status, through incentives linked to measurable outcomes.
- Hold private insurers (including managed care companies and Medicare Advantage offerings) more accountable for rural incentives and penalties.
- Coordinate resources provided outside the four walls of healthcare facilities; meet the patient where they are to ensure the right time, right treatment, right place.
- Track long-term investments; "True" cost assessment of rural health.
- Assess how to address rural hospital and provider bypass: What are the incentive structures for the patients? Are they driving patients into/out of the local provider?
- Focus on long-term care service viability and regulatory reform.
- Allow payment for community-based organizations providing health-related services, either directly or as a recognized expense for healthcare organizations.

3. Workforce Considerations

Participants at the Summit highlighted workforce development as a key priority requiring a cross-cutting approach spanning training, distribution, retention, and new workforce models. Their suggestions are tailored to short-term needs and the long-term sustainability of rural healthcare systems.

What are the essential elements of a comprehensive strategy to implement now?

Training emerged as a critical element, with participants recommending:

- A multi-layered approach to rural health training beginning with public health integration into fellowship and internship programs. Focusing on community health, these programs will develop future rural health champions who understand clinical needs and broader population health challenges.
- Structured apprenticeships, including those centered on nurse practitioners, were identified as a practical pathway for expanding the rural healthcare workforce. These would include public health integration into fellowship and internship programs. Focusing on community health, these programs will develop future rural health champions who understand clinical needs and broader population health challenges.
- Mandatory clinical educational rotations into rural areas for all health professionals were strongly endorsed at the Summit; this includes incentivizing educational institutions that promote these rotations. Participants stressed that exposure to rural healthcare settings during training would increase the likelihood of professionals choosing to practice in rural communities.
- A long-term strategy of building a "grow your own" workforce starting in secondary schools was identified as necessary for long-term sustainability. Achieving this will call for partnerships between local school districts to establish exposure to careers in health care early in students' lives and a clear educational pathway to those careers. These partnerships should focus on identifying and nurturing local talent that is more likely to return to serve their communities after completing their education.
- Health care leadership development was recognized as a need, recommending that C-suite and management positions receive support comparable to clinical roles and access to loan repayment programs and National Health Service Corps opportunities. Leadership training should also be made available to leaders of other community-based organizations that impact the health of the community.

Participants proposed several innovative solutions for workforce *distribution*.

- A workforce "exchange" system, modeled after food banks, would match healthcare needs with available capacity across regions. The Summit also highlighted the need for rural debt mitigation strategies to help attract professionals to these regions. Such a program could be facilitated by the regional hub and spoke structure discussed above.
- Interstate compacts would enable partnerships across jurisdictional boundaries and streamline the credentialing processes.

- Support re-engaging the National Healthcare Workforce Commission to provide centralized planning and coordination for these distribution efforts.

Retention strategies focused on two approaches. First, establishing community mentoring systems would help integrate new professionals into rural communities while providing ongoing support. Mentoring could be especially important for retaining diverse healthcare professionals facing unique challenges. Second, developing strong leadership focused on organizational stability and a positive culture would create environments where healthcare professionals want to remain long-term.

How should a long-term approach be shaped?

The Summit outlined several workforce models to address current and future needs. Participants stressed that these models appropriately value and compensate non-licensed team members, such as community health workers (CHWs), medical assistants, and patient navigators, who work together to provide coordinated and patient-centered care. Redesigning team composition and function was suggested to meet the staffing needs, i.e., incorporating non-licensed team members. Participants also recommended implementing evaluation systems to assess workforce development programs' effectiveness and identify areas for improvement.

Finally, the role of artificial intelligence (AI) in supporting rural healthcare delivery was explored; through automating routine aspects of healthcare, AI could reduce the burden on clinical staff—which is particularly important in rural areas, given staffing challenges.

Success in implementing these recommendations requires sustained investment and collaboration among educational institutions, healthcare organizations, and policymakers.

4. <u>Use of technology and data</u>

The Summit discussions revealed technology and data as potential catalysts for the transformation of rural healthcare delivery. While these tools have enormous potential, participants stressed how, if implemented, they must enhance rather than replace existing care systems in rural communities.

What fundamental infrastructure needs help rural benefits from use of new technologies?

Participants discussed the need for *connectivity infrastructure* and provider-to-provider consultation and information sharing. They considered systems that would allow rural healthcare workers to receive on-demand assistance virtually from seasoned clinicians (e.g., Project Echo), thereby extending the reach of the existing workforce.

Technology conversations were underpinned by a fundamental requirement of reliable *broadband* access. Rural communities will not be able to utilize telehealth, data sharing, and other technological advances without high-speed internet access. Participants felt that closing the broadband gap should be a priority in rural healthcare infrastructure investment. This applies equally to facilities, providers, and residents alike.

What aspects of technology are of special importance to rural health services?

The topic of *telehealth* highlighted opportunities and challenges. Drawing on lessons learned from COVID-19, participants called for making pandemic-era telehealth provisions permanent. They also emphasized the necessity of sensible guardrails to ensure that telehealth utilization does not lead to increased bypass patterns, or the supplantation of local primary care providers, especially for commercially insured patients. The consensus was that telehealth must complement, not replace, local delivery of health care.

Cybersecurity is a priority concern as resources for exercising adequate protective measures are often not available at rural facilities due to exceedingly high costs. Participants proposed creating shared cybersecurity resources among rural health systems to improve cyber protection while controlling costs.

How can the use of available data from various sources help advance rural health systems to achieve the envisioned rural health landscape, facilitated by improved sophistication in data collection and analysis?

The use of *claims data analysis* to understand healthcare costs and utilization patterns was identified as a critical need. However, many rural providers struggle to derive actionable insights from their claims data due to time and resource constraints. Summit participants suggested building shared analytics tools that might assist more rural facilities with interpreting this relevant information and in using it to optimize and more effectively deliver care.

Discussion focused on the role of *public health data*, particularly around CHNAs. Though these assessments are currently mandatory for nonprofit hospitals, participants stated they are often not a catalyst for real action. Participants thus called for reconsidering CHNAs as community-driven efforts to understand, meet, and deliver local health needs rather than regulatory mandated checklists.

Participants observed that many rural facilities lack the capacity to use data to inform their decisions and are thus trying to build their efforts to collect, track, analyze, and act on data. This discussion highlighted three interrelated needs:

- Establishing effective data sharing and inoperability standards
- Leveraging data to engage community partnerships
- Developing data analytics to support rural providers

The ability to utilize such an expanded CHNA would rely on the payment changes, discussed above, to empower the community organizations to collaborate for all health needs, not just healthcare delivery needs.

What concerns and opportunities exist as it relates to artificial intelligence in rural settings?

The discussion of *artificial intelligence* revealed both substantial opportunities and important concerns. Summit participants recognized AI's potential to change rural healthcare delivery in handling documentation, streamlining workflows, extending the existing workforce, and supporting clinical decision-making allowing healthcare providers to focus on patient care and reducing provider burnout. There was discussion of developing solutions specifically for rural healthcare rather than retrofitting urban models with attention to making AI both cost-effective and appropriate for rural settings.

Participants recognized that many rural facilities operate with limited resources and cannot afford expensive AI systems designed for large organizations. Participants recommended developing cooperative purchasing programs and shared service models to make AI tools more affordable for rural providers.

Payer use of AI, especially as it relates to coverage determinations, and data transparency also emerged as a concern. Concerns were raised by Summitt participants that there could be an imbalance of information and analysis between large payor organizations and rural health care organizations, which could affect adjudication of coverage determinations, preauthorization decisions, and payment negotiations.

During the numerous conversation sessions, participants kept returning to the human dimension of care and what healthcare technology brings to the ecosystem to enhance the human experience.

Summary

Multiple courses of action are critical to achieving the Summit's vision for the future of rural health. Achieving this will demand sensitive attention to matters of equity, access, and community preferences. Recommended policy and program actions are all grounded in the framework that opened this report of the proceedings, which incorporates approaches to drive both public policies and private sector strategies. Critically, for the future of health in rural communities, a process for executing strategies that take advantage of various resources (funds flow), new payment approaches (value-based payment), workforce initiatives in recruitment and retention, and technology advances must be grounded in decisions made by community coalitions.

Domains for action, as discussed above, represent pathways that when combined will help guide local decision-makers to the thriving communities envisioned by Summit participants.

TRANSITIONING TO A SUSTAINABLE SYSTEM IN THRIVING RURAL COMMUNITIES

Preserve current access: Policy Actions

A guiding principle of the Summit was to ***preserve what we have until we have clarity in specific steps to achieve the goal for the future***.

One of the closing sessions of the Summit was thus devoted to a discussion of this principle and what short-term actions the participants believe would be helpful to sustain current services availability in rural communities, consistent with transitioning to a more secure future. Recommendations were offered in the areas of finance, workforce, infrastructure, and community-driven decision-making:

1. Financing Rural Health Services

    - Obtain capital to support rural hospitals and other providers to meet current building codes, cybersecurity requirements, and prepare for the system of the future.
    - Maintain, and enhance when needed, current payment rates and methodologies to stabilize providers and more adequately prepare them up to transform into new models. Refinement of current payment systems is essential.
    - Adequately fund Emergency Medical Services, which is strained and unsustainable in certain rural parts of the country.
    - Adequately fund public health in rural, including Centers for Disease Control & Prevention Office of Rural Public Health.
    - Address Medicare Advantage issues: identify and resolve challenges on financial impacts, provide beneficiary education, and utilization management practices.

2. Support workforce initiatives already underway

    - Invest in rural health workforce for current and future needs. Focus on developing a rural generalist workforce, inclusive of clinical and administrative roles (e.g., grow your own rural program).
    - Support for rural residency program capacity building and GME slot growth in rural areas (e.g., Rural Residency Planning and Development program in the Federal Office of Rural Health Policy).

3. Support current infrastructure, physical and organizational

    - Remove limitations to primary care access (e.g., payment limits for provider based rural health clinics).
    - Advance Rural Emergency Hospital (REH) legislative and regulatory improvements.

- Strengthen health information technology availability and use in rural health settings.

4. Undertake discussions and actions through local and regional coalitions of stakeholders in rural health

    - Engage in programs to overcome stigma among persons with behavioral health issues.
    - Assure access to providers of choice.
    - Prioritize immediate community needs.

Assure direct consumer marketing used by MA plans includes full information on array of covered services.

Transitioning to the Future of Rural Health Services

The final interactive session of the Summit included creating lists of steps needed to transition to the envisioned future of rural health. Domains covered include financing health services across the continuum, reorganizing services to assure optimum use of resources, and assuring access and delivery of high-quality care.

1. Transitioning health services finance

What do health care organizations need as assurances and financial incentives?

- Create an expectation for change by using a strategy to exit from existing payment modalities, accepting that some organizations unwilling to adapt to change will not be subsidized and therefore may give way to others willing to participate in new financing frameworks.
- Provide transition payments to help facilities interested in getting to value. The payments should support capacity building and collaboration.
- Fund Rural Health Clinics to provide more integrate services.
- Provide direct financial assistance to health systems serving underserved communities.
- Have clear strategies to communicate with federal policymakers about rural health and policies needed to protect access.
- Identify methods to finance healthcare providers' work and collaboration with social determinants of health and community-based organizations.

2. Actions to re-organize health services

Public policies across dimensions of finance, regulations, and program funding (grants and loans) can be much more strategic in facilitating changes that move the rural health system

to a more effective future. Additionally, actions by stakeholders other than policy makers and providers can help drive changes that result in thriving communities that promote health.

A particular area of interest is the evolution of health care networks, which may be local or regional; a consistent thread in the Summit favored thinking and acting regionally for rural America. This phrase resonated with participants: "***independence through interdependence.***"

What specific actions are to be taken by health care organizations, policy makers, and other stakeholders to more effectively organize the delivery of health services?

- Explore regionalization strategies (e.g., regional centers of excellence).
- Establish networks that can be purchasing coalitions and improve payer. negotiation/market power.
- Fund new network development grants targeted for seasoned networks that can become models for clinically integrated networks.
- Pay for collaboration to bring the full range of stakeholders into discussions about sustainable rural health systems.
- Assess state policies that inhibit making necessary changes to become the vision
- Create a state-level rural regulatory review committee.
- Identify an accepted list of rural essential services, and provide adequate support to maintain such services.
- Convene rural governing councils strategically and dismantle the silos that suppress collaboration; and where applicable, build bridges across existing silos – both within the community and with the larger region of which they are part.

In developing and implementing strategies to build a sustainable health system as a core component of a thriving rural community, what are necessary elements beyond the current clinical infrastructure?

- Build more clinical training sites in rural communities, across professions including nursing.
- Assess potential conveners, with the ability to create new entities if they don't exist.
- Strengthen public health infrastructure and encouraging cooperation with primary care providers.
- Provide mechanisms to fund and support the rural health leadership pipeline.
- Develop a more robust governance training program.

3. Assuring high-quality rural health services

Service providers meeting the needs of rural populations must be accountable for quality in the processes they deploy and the outcomes they achieve. This holds true across the entire continuum, regardless of the origin of the service (e.g., sub-specialty services provided by urban-based clinicians and facilities) or the type of service (e.g., clinical and behavioral health treatment, public health, human services supporting personal and community health).

What are specific actions that assure service quality for rural residents?

- Support hospitals with training and direct incentives to serve as preceptors.
- Engage with American Medical Association RVS Update Committee to obtain better values for primary care and cognitive billing codes.
- Partner with other federal departments who prioritize rural to invest in the global community budgets.
- Fund quality improvement (including use of relevant metrics) and SDOH by supporting adoption of EMRs and interoperability, clinical data sharing, analytics, and TA.
- Align quality metrics across payers and make them rural relevant.

CONCLUSION

The Summit wrapped up with reflections from the partnering organizations.

As stated in the introduction and at the onset of the Summit, each organization (RUPRI, NRHA, and West Health) will use the substance of the Summit in their future work, including further development of action steps and suggested strategies for local and regional coalitions. Policy recommendations will be developed and offered by NRHA. The RUPRI Panel will continue to refine the framework of the high performing rural health system and explore policy and program directions to strengthen the pillars. West Health will use insights from the Summit to inform the development of modern, scalable rural health innovations that are rooted in a community's needs, adaptable across diverse settings, and equipped to support people at every stage of life through integrated long-term services and supports.

All participating stakeholders have benefitted greatly from engaging in this thorough discussion to help guide their future actions.

The most important takeaway from the Summit is that actions constituting the pathways to a sustainable future will result from a combination of national and state public policy, decisions and actions of health systems, and decisions and actions of third-party private payers. Meanwhile, ***the vision statement is a glidepath, directing rural stakeholders to the future and a means of keeping eyes on the prize, while implementing immediate and short-term actions.***

Therefore, the Summit defined the *what* (the vision) and the why (themes), suggested the *how* (framework), provided *pathways* (actions) and *guardrails* (principle of protecting existing exiting critical assets as transitions occur), and *markers for progress* (transition actions).

Noteworthy Highlights

Several points of discussion warrant a final list of highlights:

1. ***The ultimate goal for the future of rural health is that the health system be maintained as a vital contribution to thriving rural communities.***
2. ***The ideal rural health system includes a set of essential services, relevant to the communities' or regional needs, that moves outside the walls of the hospital to include social, public health, and economic factors.***
3. ***The continuum of care includes clinical services addressing primary care, acute care needs, long-term care (long term supports and services), and public health services.***

APPENDIX

Figure 1

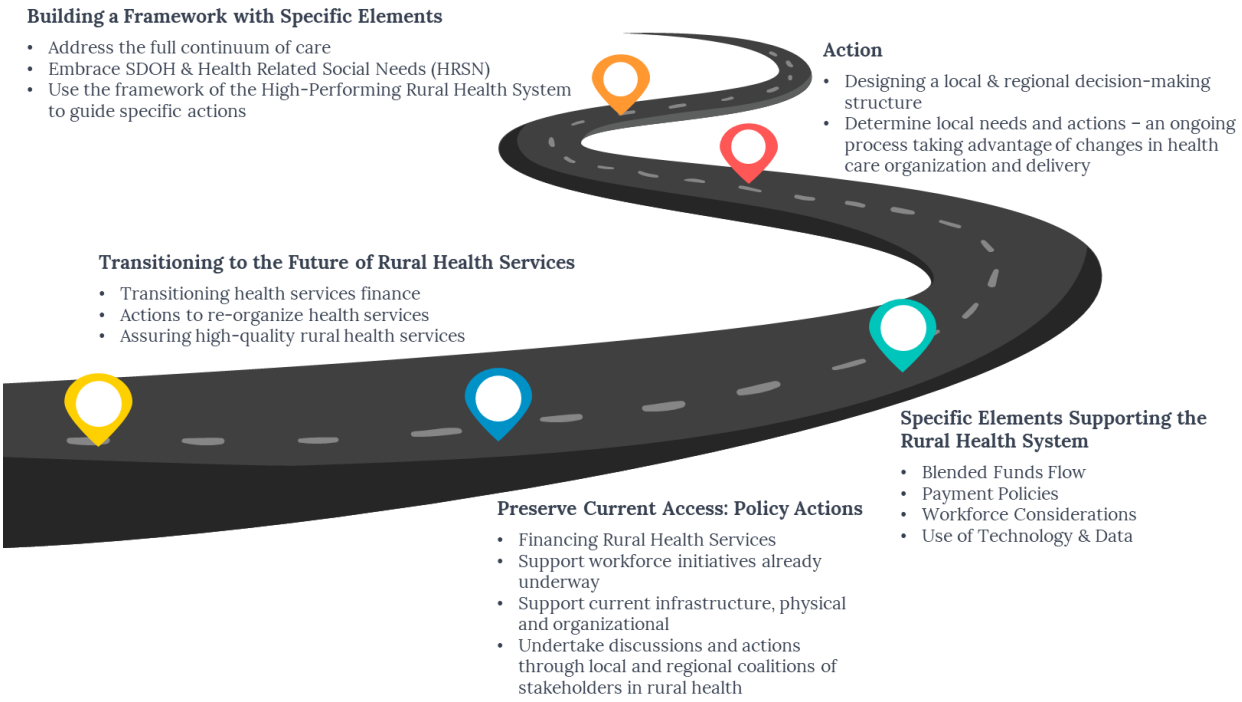

Figure 2

REPORT OF A SPECIAL CONVENING

Held November 19-20, 2024

THE FUTURE OF RURAL HEALTH

VISION

A national framework adapted to diverse rural settings that includes aligned financial incentives and a minimum floor of essential services, plus necessary and vital community services relevant to the community's or regional needs (e.g., regional centers of excellence), that move beyond the walls of the hospital to include social, public health, and economic factors.

THEMES

Community Focus

Thriving, healthy rural communities with infrastructure, jobs, and education

Message Matters

Rural health as a national priority; consistent messaging

Build From Assets

Strengthening local resources; supporting workforce and innovation

Address Gaps

Public health, workforce, and payment reform

ACTIONS

Financial & Payment Reform
Sustainable funding models, safety-net provider support

Strengthen Workforce
Rural rotations, loan repayment, leader development

Enhance Leadership & Collaboration
Rural governing councils, policy alignment

Improve Technology & Data
Broadband expansion, telehealth, AI-driven efficiency

National Rural Health Association

rupri RURAL POLICY RESEARCH INSTITUTE

westhealth institute