

# Bright Spots

## Case Studies in Innovative Rural Healthcare



TEXAS A&M HEALTH  
A&M Rural and Community  
Health Institute

Robert Wood Johnson Foundation 

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This work was planned to include site visits to each Bright Spot to facilitate in-depth interviews and the richer perspective gained from boots on the ground. Due to the COVID-19 pandemic, travel was restricted, and each of our Bright Spots was fully engaged with caring for their community. The vast majority of this work was obtained from Zoom and conference calls amidst the struggles of the pandemic. We thank the leaders and healthcare teams at each of our Bright Spots for the work they do every day to help healthcare in rural America shine brighter.

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## Foreword

The Texas A&M Rural and Community Health Institute (ARCHI) comprises a team of dedicated researchers working to understand how to help rural communities achieve equitable access to healthcare. We have been honored to work with our funding partners, each a leader in healthcare systems improvement, to identify, understand, and disseminate the lessons of some of the most innovative health organizations in the nation.

This work, funded by the Episcopal Health Foundation, the Robert Wood Johnson Foundation, and the TLL Temple Foundation, has its foundation in the importance of improving the health and wellbeing of the communities they serve. Rural communities contain nearly 20% of the population of the United States but are often left out of the discussion on improving health systems. With the rapid and continuous change that defines the US healthcare delivery system, the perspectives of rural communities must be given a voice to guide policy and change. Through academic/philanthropic partnerships, success stories can be told of communities and organizations that have risen to meet the challenges, and through those stories, lessons can be learned, applied and adapted.

From the experiences gained working with these funders, ARCHI sought funding to create the Center for Optimizing Rural Health (CORH). Under a grant from Health Resources and Services Administration, CORH was created to aid rural communities in meeting the challenges of maintaining access to healthcare by providing technical assistance to vulnerable rural hospitals. This report stands as part of our larger mission to leverage academic knowledge and expertise to help rural communities through strengthening healthcare organizations.

We build this work around two ideas: *positive deviance* and the *community of solution*. For researchers, both these ideas, in turn, become frameworks for solving domain-specific problems utilizing strategies and concepts from within the domain.

The term *positive deviance* has been applied to describe innovative organizations that make positive changes from the norm<sup>1</sup>. In many contexts, these would be called positively disrupting organizations that disrupt the norm and, in doing so, create a new path forward. Healthcare literature is rife with examples of these kinds of organizations. But because most research teams are in urban areas or affiliated with large medical centers, these stories are often through the lens of urban care. The term *community of solution* is an older term, which first found prominence after the 1967 Folsom Report.<sup>2</sup> In the report, the term was used to describe communities that

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<sup>1</sup> Pascale, Richard, Sternin, Jerry, and Sternin, Monique. (2010). *The Power of Positive Deviance: How Unlikely Innovators Solve the World's Toughest Problems*. Boston, Mass: Harvard Business Review Press.

<sup>2</sup> Griswold, Kim S., Lesko, Sarah E., and Westfall, John M. (2013). Communities of Solution: Partnerships for Population Health. *Journal of the American Board of Family Medicine*, 26(3), 232-238. <https://doi.org/10.3122/jabfm.2013.03.130102>

tackled "problem sheds," the locus of the specific issue faced by the community, through an all-encompassing holistic approach. In this report, we consider entities that fall into both categories; rural communities that have taken up the mantle of their care and healthcare organizations that have fundamentally innovated for the better.

Factual reports on rural health correctly state the challenges facing rural communities. These communities are older, poorer, possess a higher prevalence of chronic illness, and are overall more prone to unhealthy behavior. But solely focusing on those facts ignores the diversity and experience working to meet these challenges.

Our work is constantly inspired by the insight of the organizations that somehow manage to not only survive but thrive under conditions uncondusive to success. Every community has members that are recognized as exemplary. Whether their communities are poorer than most, they have limited financial or organizational resources, or they have faced challenges that would have sunk many other providers, the *positive-deviants* in this report continue to provide inspirational care. They have driven innovation in developing their workforce, engaging with their broader community, defining areas of improvement, and optimizing their people to work in unique and beneficial ways for the communities they serve.

By highlighting these success stories, we hope the lessons herein can be used to strengthen the safety net for all people living in rural communities. The wish of the ARCHI team and our funders is to see these lessons become sources of inspiration for healthcare systems around the country. Through learning together and from each other, health systems become stronger and more capable of handling the ever-increasing challenges of providing medical care.

## **Executive Summary**

Rural hospitals are closing at an increasing rate, endangering the health of nearly 20% of our population. Solutions are urgently needed to maintain access to healthcare in these areas. The goal of this study was to find commonalities among facilities and communities that demonstrated positive deviance in rural healthcare and then share those elements that have contributed to success.

Bright Spots, the positive deviants identified among rural health practices, were identified utilizing the combined experience and tools available to the Texas A&M Rural and Community Health Institute. The eight Bright Spots featured in this report were selected to ensure a broad range of innovations in Texas and across the nation.

### **Bright Spots – Positive Deviants among Rural Health Institutions**

- Audubon County Memorial Hospital: Thriving as an independent hospital after leaving a system.
- Columbus Community Hospital: Advocating for more accessible care for Texas mothers.
- Hill Country Memorial Hospital: Creating a culture of excellence where patients and staff thrive.
- Kearny County Hospital: Building a mission culture to best serve a diverse community.
- Sakakawea Medical Center and Coal Country Clinics: Collaborating rather than competing to meet community needs.
- Southcentral Foundation: Defining a culture to achieve multiple aspects of wellness.
- Titus Regional Medical Center: Engaging the community to redefine the role of a hospital.
- Trinity Memorial Hospital District Board: Adapting leadership to learn from past mistakes and maintain local healthcare.

## Bright Spot Commonalities

- Multiple sources of leadership are vital to a rural healthcare organization.
  - Institutions were successful when they development resources, a knowledge base, and fostered mentorship for their leadership team. Emerging leaders were especially critical for new ideas but required support and guidance.
  - Support resources are needed for both recruiting and retaining leaders.
  - Leaders fundamentally drive the culture of the institution and should be trained in management.
  
- Culture defines the parameters of success; Bright Spots all possessed cultures of innovation and excellence.
  - Cultures can be changed and cultivated with deliberate planning.
  - A culture change takes time and persistent effort; all institutions were most successful in creating plans for sustainability and continuity.
    - Institutions all highlighted the necessity of succession as key drivers of success in leadership transitions.
  
- Data are needed to inform leadership, demonstrate impact of culture change, and communicate with rural communities.
  - Rural healthcare facilities struggle with the tyranny of small numbers, making evaluation more difficult but no less critical.
  - Proper data utilization demands constant adjustment in processes and strategic decisions, moving in a direction not necessarily arriving at a destination.
    - Organizations were most successful when starting small with using data to meet basic requirements and advance towards integrating data into all workflows to support priority setting, change management, and organizational planning/funding.
  
- A spirit of inquiry and upstream thinking allows leaders to be open to new ideas in a proactive manner.
  - All Bright Spots highlighted the importance of constantly improving. Resting on success does not grow culture, continually seek ideas to improve healthcare in your community.
  - Use data to identify problems. Think upstream to find solutions to prevent these problems. Then use more data to measure success and remember to search for better ways.



## Introduction

### **Background**

The story of rural healthcare seems bleak. The challenges facing rural communities and rural healthcare are many, varied, inextricably intertwined, and the subject of a great amount of scholarship. Rural America recalls two contradicting but not unrealistic images. The conjured rural imagery is often that of a bygone era: the American farmer, Main Street filled with antique cars, and pastures packed with lazing cows. But maybe more readily recalled are those images of decay: Main Street shuttered, roads and bridges in disrepair, and run-down homes. Neither of these descriptions captures the true image of a diverse, often vibrant, or unfortunately just as often hurting, modern rural America where a part of the nation raises children, works jobs, and lives. The purpose of this report is two-fold: to relay the stories of successful modern rural American communities and institutions in overcoming the healthcare access problems they faced and provide a spark of inspiration to the hundreds of other communities faced with similar challenges. Through telling these stories, we hope to show the way to a brighter tomorrow for rural America, brightening the story of rural health.

Improving healthcare delivery systems can be thought of as two complementary methods: first, through ever more structured methods, healthcare stakeholders try to identify failings within care systems; second, stakeholders work to foster and measure positive change in a particular system. Current efforts in confronting the “rural gap” have centered on “Find and Fix” approaches, where researchers and healthcare leaders seek to identify and address shortfalls in the landscape of healthcare delivery. This paradigm is important for the continued development of medical delivery but comes up short in two important ways. First, the discoveries of these quality improvement missions are often ‘siloes,’ found only in pockets of best practices without wide-scale adoption. Commonly, the quality of medical care falls along a wide spectrum with rural hospitals, limited by a lack of resources and the unique characteristics of rural communities, coming out on the wrong end. Much has been written on the highly dimensional reasons for this situation<sup>3</sup>. Even as healthcare organizations are charged with providing the best possible care to their service population, they are enmeshed in a daily struggle for continued operation, leaving them without the time or energy to search out or develop new strategies. Second, by focusing solely on deficit areas, the full range of the rural organizations are ignored. For every organization gridlocked by challenges, there exists an organization that has managed to adapt and overcome.

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<sup>3</sup> Bolin, Jane N., Bellamy, Gail R., Ferdinand, Alva O., Voung, Ann M., Kash, Brita A., Schluzer, Avery, and Helduser, Janet W. (2015). *Rural Healthy People 2020. New Decade, Same Challenges*. College Station, Texas: Texas A&M Health Science Center School of Public Health, Southwest Rural Health Research Center.

Over the last forty years, there has been a recognition that rural health is in crisis. Previous work by this research team explored this crisis in two contexts. Earlier, we were asked to develop a road map for Texas rural healthcare.<sup>4</sup> In partnership with the Episcopal Health Foundation, [we developed a view of steps-forward for the crisis in Texas](#). Using our expertise as a diverse team of researchers and healthcare practitioners, we pushed back against the common narrative that the choices of rural communities are binary decisions, where either the community’s hospital remains open and the community maintains access to care, or the hospital closes, and the community joins the growing list of healthcare deserts. Our “[menu of alternatives](#)” approach reflected the multiple ways communities continue to be able to overcome the challenges of location as reflected in the current academic literature. A year later, in an expanded partnership with Episcopal Health, the T.L.L. Temple Foundation, and the Robert Wood Johnson Foundation, we sought to create a set of blueprints for rural communities moving forward into the next era of medical care.<sup>5</sup> That report was developed through interactions with healthcare providers across the state of Texas. In it, we explored a cross-section of rural providers who faced the challenge of maintaining healthcare access despite harsh economic realities. Those reports reflected the reality as seen from ‘on the ground’ rural workers, emblematic of larger problems.

Many mechanisms cause rural hospitals to close and wreak damage on the community. The recognition that rural America is facing challenges has developed slowly. Over the last twenty years, hospitals, which formed the bedrock of healthcare in rural areas, have been closing at an ever-escalating rate, with more hospitals in danger every passing year<sup>6</sup>. The United States currently has 1,805 rural hospitals. The Cecil G. Sheps Center for Health Services Research at the University of North Carolina reports that of those nearly two thousand rural hospitals, close to one thousand are at risk of closing.<sup>7</sup> The loss of healthcare access fundamentally changes the prospects of a community. When a rural town’s hospital closes, the people of the town face a myriad of decisions: to stay or go, where to see a physician, and where to take their sick children. The outcome of these decisions can spell economic ruin for a town with an exodus to more health-accessible areas, leaving those who cannot or will not leave to fend for themselves. With the loss of

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<sup>4</sup> Texas A&M University Rural & Community Health Institute (ARCHI). (2017). What’s next? Practical suggestions for rural communities facing a hospital closure. Retrieved from <https://www.rchitexas.org/>

<sup>5</sup> Texas A&M University Rural and Community Health Institute (ARCHI). (2018). *Optimizing Rural Health: A Community Healthcare Blueprint*. Retrieved from <https://architexas.org/ruralhealth/activities.html>

<sup>6</sup> Kaufman, Brystana G., Thomas, Sharita R., Randolph, Randy K., Perry, Julie R., Thompson, Kristie W., Holmes, George W., & Pink, George H.. (2020). The Rising Rate of Rural Hospital Closures. *Journal of Rural Health*. 32(1), 35-43. doi:10.1111/jrh.12128

<sup>7</sup>The Cecil G. Sheps Center for Health Services Research. Retrieved July 14, 2021, from <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

the hospital, rural residents face higher mortality rates,<sup>8</sup> the loss of what typically is a large employer in the county, and increased travel times for emergency care. These factors combine to create an untenable situation where negative economic, social, and health factors blend to damage a rural community.

Hospitals in rural areas close for a variety of reasons. Most often, financial drivers lead to hospitals being unable to cover operating costs, a fact reflected by the majority of rural hospitals having less than 30 days cash on hand and so are unable to respond to any stress. This lack of financial reserves accelerated the closure of rural hospitals during the 2020 COVID-19 pandemic. A relatively small number of changes causes these stresses. Each of them comes with a specific set of struggles that healthcare providers must adjust for, leading to overall more expensive and intensive care. The *demographics* of rural areas are defined by a shrinking number of inhabitants and an older and poorer population. Paradoxically, even as the populations they serve require more care, many rural providers also experience lower volumes because patients may *bypass* their local facility due to perceptions of quality. This situation often leads to facilities caring primarily for the most vulnerable populations who do not have the recourse to leave. All of these reasons have been exacerbated in recent years by the overall transition of U.S. healthcare to increasingly specialized care that rural institutions often do not have the means to support. Valiant efforts by federal policy and programs have made progress in alleviating these challenges, providing quality improvement opportunities, and protecting rural institutions. However, those efforts have not been enough to reverse the trend in many communities.<sup>9,10</sup>

Predicting the future of healthcare is impossible, even more so in attempting to predict rural health. As this report is being written, the extent of the COVID-19 pandemic has yet to play out. With a wide variety of political and healthcare leaders calling for systematic changes to the U.S. health system, we cannot speculate what the health landscape will look like. We are hopeful that many of the systemic issues laid bare by the pandemic, namely the inequality of access and outcomes, will achieve some momentum towards resolution.<sup>11</sup> From our experience with rural stakeholders, we also foresee a growing interest in telehealth solutions, an interest that reached a fever pitch during the pandemic lockdowns and is likely to remain unabated post-pandemic.

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<sup>8</sup> Gujral, Kritee and Basu, Anirban. (2020). *Impact of Rural and Urban Hospital Closures on Inpatient Mortality* (Issue date of August 2019, Revision Date June 2020). NBER Working Paper No. w26182. Available at National Bureau of Economic Research. <https://www.nber.org/papers/w26182>

<sup>9</sup> See for example the FLEX Program. Retrieved July 14, 2021, from <https://www.ruralcenter.org/tasc/flex>

<sup>10</sup> Comprehensive list of Federal Office of Rural Health Policy initiatives. <https://www.hrsa.gov/sites/default/files/ruralhealth/resources/newapplicantresourceguide.pdf>. Retrieved 06/05/2020

<sup>11</sup> Henning-Smith, Carrie, Tuttle, Mariana, and Kozhimannil, Katy. B. (2020). Unequal Distribution of COVID-19 Risk among Rural Residents by Race and Ethnicity. *The Journal of Rural Health*, 37(1), 224-226. <https://doi.org/10.1111/jrh.12463>

Instead of trying to predict the larger trends or build or develop radically new solutions to old problems, this report shines a light on current innovations. The COVID-19 pandemic revealed the wisdom of using solutions already known to work as our highlighted Bright Spots continued to shine during the tumultuous year of 2020. The systems in place that elevated them to Bright Spot status allowed them to adapt to changes that nobody had anticipated. The findings reported herein reflect both the years of experience with rural communities brought by the research team, a dynamically evolving understanding of the totality of struggles facing health providers, and the insights from these Bright Spot organizations that are signposts on the road to a better health system. Several key issues critical to improving rural healthcare are explored, including health system leadership, community engagement and support, addressing inequity, and others. However, it cannot be overemphasized that the changing healthcare delivery environment is having a tremendous impact upon care rendered in rural America. While it is beyond the purview of this report to change or criticize the United States healthcare delivery environment, the changing landscape with accompanying regulations and legislation must be considered as solutions are sought for maintaining access to care for those who live outside the greater metropolitan areas. The findings of this report can help guide not only healthcare leaders but also the decision-makers who create and shape health policy.

## **Research Approach**

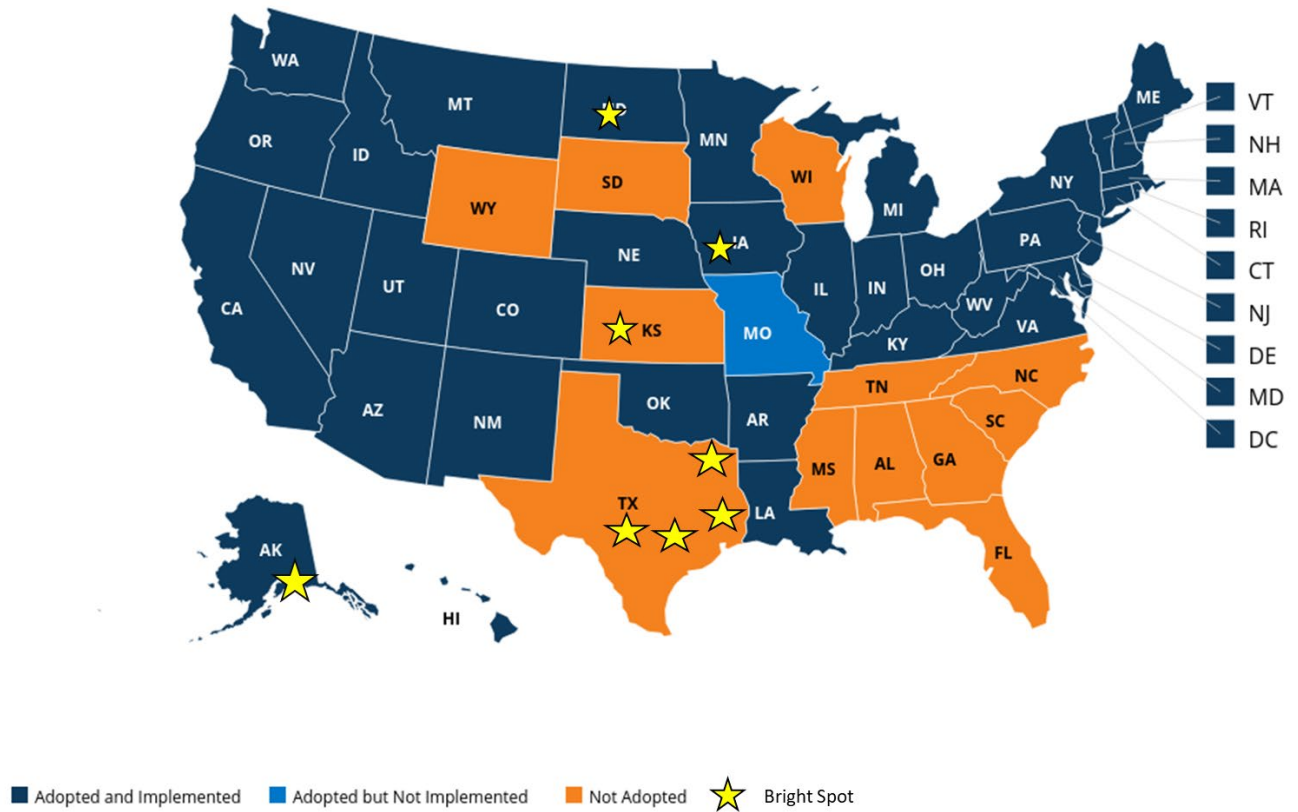
ARCHI proposed to highlight nine rural hospitals for this Bright Spots report. The Episcopal Health Foundation (EHF) and T.L. L. Temple Foundation are based in Texas. Between these two organizations, they funded four of the nine Bright Spot locations with a requirement that they are from Texas. The Robert Wood Johnson Foundation (RWJF) was the third funder and has a national presence as they work to improve America's health and wellbeing. Five of the nine Bright Spots were funded by RWJF and located outside of Texas. The Funders pulled together several rural stakeholders to help create suggestions for innovations to highlight. These stakeholders were from HRSA and CMS. At a meeting between the ARCHI team, RWJF, EHF, T.L.L. Temple, HRSA, and CMS, it was suggested that Bright Spots include: an obstetrics example; a facility in a low resource space; a CMS innovation model; a Tribal Health example; innovative payment models; and representation from states that did and did not accept Medicaid expansion as these represented areas of focus for policymakers.

The ARCHI team reviewed grey literature and reached out to their extensive network of contacts as well as national rural stakeholders to compile a list of potential Bright Spots. The potential spots were narrowed down into 19 strong possibilities to match the requested highlights most closely. Through consultation with the funding agencies, the ARCHI teams winnowed the list of 19 possibilities down to the final 9 Bright Spots. These were chosen to highlight a range of

innovations and areas of policy. The intent was to showcase each Bright Spot as a case study, a common format in the medical literature. Case studies provide a record of an individual circumstance, which, while not generalizable, serves to inform by example and offers insight to policymakers and stakeholders on how some rural communities have confronted challenges. Originally, the deep dive into developing each case study involved desk top research as well as travel to the nine locations to observe and interview key leaders. Plans were significantly altered once the Public Health Emergency was declared as the result of COVID-19. Travel was not an option, and while the Bright Spots were gracious and generous, the truth of the situation was that they were fully engaged with caring for their community during this unprecedented time. Conference calls and virtual sessions were utilized to conduct interviews in place of in-person interactions. While functional for information exchange, these modalities lack the richness that comes from walking the halls of a facility, striking up ad-hoc conversations, and establishing trust with candid conversations over a meal. COVID-19 was a limitation on this research, and yet it provided the unexpected benefit of showcasing how Bright Spots perform under unanticipated stressors. Unfortunately, due to COVID-19 travel restrictions and the strain of providing care for their community during the pandemic, one of the nine chosen Bright Spots was unable to participate virtually, and so only eight Bright Spots are included in this report.

These case studies are the results of semi-structured interviews conducted by the ARCHI team throughout 2019 and 2020. Questions were chosen based on a particular Bright Spot's history and the reasons it was selected as a Bright Spot. We allowed the discussion to diverge from the questions giving each Bright Spot the ability to expand on old or offer new reflections. See [Appendix 1](#) for the Interview Guide.

## Status of State Action on the Medicaid Expansion Decision



SOURCE: Kaiser Family Foundation, kff.org

Figure 1: Map showcasing geographic spread of Bright Spots and Medicaid expansion status (from the Kaiser Family Foundation<sup>12</sup>)

<sup>12</sup> Kaiser Family Foundation. (2021). Status of State Medicaid Expansion Decisions: Interactive Map. Retrieved July 11, 2021, from <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

## **Bright Spots**

This section provides brief biographical sketches of the organizations the ARCHI team identified as best practices sites. aka “Bright Spots.” These short bios are intended to set the stage so that a reader might find a Bright Spot that sounds like their facility or perhaps sounds like the type of facility the reader is striving towards. The hyperlinks at the end of the biographical sketch can be utilized to jump to the sections only related to that particular Bright Spot for a targeted reading approach. The reader also can read this report in its entirety and explore all eight Bright Spot innovations. The hyperlinks and their taglines are intended as teasers to encourage the audience to continue reading in one of the two proposed paths.

The selection process made use of the combined knowledge, contacts, and experience of the research team. This should not be thought of as a systematically exhaustive list of innovative organizations within the United States; instead, this list was winnowed from larger lists of scores of dynamically disrupting organizations from around the country, any of which could deserve a place in this report. We are aware that we cannot cover the full spectra of rural challenges and innovations. To be relevant to many people, Bright Spots were intentionally selected to feature different patient populations and different funding support while still addressing common struggles. Through this report, we hope to show a wide variety of organizations and innovations to inspire healthcare leaders and policymakers around the country. Only by looking at the brightest corners can we hope to meet the challenges of rural health.

This list contains many different types of organizations reflecting the wide variety of interested parties within the sphere of rural healthcare. Primarily comprised of hospitals, ranging in size from large to small, the list also contains one healthcare system and one municipality. Each has acted in innovative ways to overcome the gap in access to healthcare. Each highlights strategies the research team sees as generalizable to other localities and the organizations that serve them.

### **Audubon County Memorial Hospital & Clinics: Breaking Away to Come Together**

Audubon Medical Center is a 17-bed critical access hospital located in Audubon, Iowa. The town of Audubon, the seat of Audubon County, is home to around 2,500

residents with a total county population of nearly 5,600 people<sup>13</sup>. The town is located an hour and a half from the cities of Omaha, Nebraska to the west and Des Moines, Iowa to the east.

Audubon County comes ahead of analogous rural counties for many important population-level determinants of health, comprised of environmental, biological, and social factors. At near the national average of 11%, the county's poverty rate is significantly lower than comparable rural averages of 16%.<sup>14</sup> Like many parts of rural America, the county's people are ethnically homogenous, with the vast majority (96%) White. The median income is nearly \$10,000 lower than the national average. The population of Audubon has decreased 10% over the last ten years, a significantly higher rate than the rural average. Its population is older, with more than 50% over 65 years old. This has left the hospital, while in a relatively prosperous area, at least in comparison to most rural areas, with the challenges of a shrinking patient base and an older population that requires more care overall. Given this data, Audubon Hospital does not seem a likely candidate for being recognized for innovation, but its story models what rural healthcare can become through strong leadership and collaboration.

The story simple; it starts with Audubon bucking the prevailing trends of consolidation and systematization that have governed rural health over the last thirty years. Research has pointed to increasing pressure on rural hospitals to affiliate, particularly with large systems. A Chartis Center for Rural Health study found that system affiliation decreases the likelihood of hospital closure by 47%.<sup>15</sup> While many larger hospitals around the country have joined health systems to enjoy the increased specialist access and economies of scale provided by that affiliation, Audubon struck out on its own.

Previously part of a larger system, the board of trustees of Audubon became frustrated by the cost of the management fee related to the value provided by the system and the diminishing local control. There was an imbalance of referrals going to the system but not much benefit returning to the hospital. There were also demands on the hospital to conform to the needs of the entire system that were not always consistent with the needs of the hospital.

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<sup>13</sup> United States Census: Quick Facts.

<https://www.census.gov/quickfacts/fact/table/auduboncountyiowa,US/PST120218#qf-flag-D>

<sup>14</sup> United States Department of Agriculture. (2018). *Rural American at a Glance: 2018 Edition*. <https://www.ers.usda.gov/webdocs/publications/90556/eib-200.pdf>

<sup>15</sup> The Chartis Group. (2020). *The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability*. Retrieved July 14, 2021, from [https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH\\_Vulnerability-Research\\_FINAL-02.14.20.pdf](https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FINAL-02.14.20.pdf)



At the direction of the Audubon board of trustees, the CEO of Audubon hospital at the time, Suzanne Cooner, began looking for options to end the substantial management agreement. After years of being told that the proposed plan to leave the system was impossible and systemization was the only way forward, Audubon broke away from the larger system and found independent success by working with a homegrown network of collaborating hospitals and clinics. The success of the Audubon hospital has been recognized by being named one of the Top 100 Critical Access Hospitals in the United States by the Chartis Center for rural health seven times in the past decade. The National Rural Healthcare Association (NRHA) also recognized Audubon County Memorial Hospital as one of the nation's 2017 Top 20 Critical Access Hospitals.

A significant piece of that success has come from a strong, independent leader in Cooner. The realization that her Critical Access Hospital needed to join a larger hospital to meet CMS regulatory requirements to provide emergency services that are not within a small hospital's capability, physician peer review, and quality improvement spurred her to begin looking for a hospital interested in collaborating. Over time, she found a partner in a large network hospital in Iowa to send critical referrals and to provide medical staff education and access to additional specialists. Audubon's CEO visits the partner hospital each year to discuss the arrangement between Audubon and the larger facility. She leaves with joint decisions and recommendations from the better-equipped system. Administration members from the larger facility visit Audubon at least annually to review strategic plans, quality initiatives and discuss any challenges the smaller hospital faces. The partnership that has been developed has been very beneficial to both organizations and is based on mutual respect and trust.

And while the partnership with a larger hospital addressed some of her concerns, there were still opportunities to be developed. Ms. Cooner developed a collaborative network with a dozen other independent hospitals who share lessons learned at conferences, information to assist one another in improving third-party contracts, and insights into the constantly changing regulations that seriously impact small hospitals. The collaboration is young, but Cooner watches other networks and collaborations to identify ways that this group of hospitals can maintain their independence while garnering some of the benefits of joining a group.

Learn more about this breakaway success:

[Leadership Planning](#)

[Optimizing External Partnerships](#)

### Complimentary Collaborators in Colorado: **Western Healthcare Alliance**

In 1989, a small group of independent rural hospitals met to discuss how to keep local control while maintaining access to healthcare in Colorado. They determined there was power in numbers and worked to develop shared solutions such as group purchasing, policy discussions, and recruitment efforts under a 501(c)(3) organizational structure. All members are a rural healthcare entity in either Colorado or Utah. Those seeking membership must submit an application, and then the board can vote them into the group. By the mid-1990s, the Western Healthcare Alliance (WHA) had grown to 20 members and created Healthcare Management, LLC, which now provides A-Z revenue cycle solutions to its members via 90 employees.

In 2015, WHA launched a population health initiative by creating Community Care Alliance, LLC. It serves to help members transition from fee-for-service to value-based care payment models and address population health needs to lower health costs. The Community Care Alliance has an ACO to coordinate high-quality care for their Medicare patients by ensuring patients get the right care at the right time while avoiding unnecessary duplication of services. The ACO was a bright spot in their own right during COVID as they came together to share PPE, policies, solutions, and communication plans. It was so effective; they extended the invitation to their discussions to nonmembers in order to create a regional network across Colorado. They had about 180 rural stakeholders engaged in local solutions during the pandemic. You can read more about the discussions that occurred in Colorado in [“Re-imagining Leadership: A pathway for Rural Health to Thrive in a COVID-19 World.”](#)

Members also collaborate for solutions via peer networks. WHA facilitates 15 different peer groups because they know we are stronger together. The HR peer group had the brilliant idea to address a growing leadership crisis by creating a Leadership Academy. This Academy is different by design to meet rural needs. A core curriculum addresses hot topics such as Peer Today, Boss Tomorrow and How to Build Trust. New material is added as issues arise, such as resiliency during the COVID pandemic. Originally crafted as a 6-hour in-person workshop followed by a mentor program and a peer-to-peer pairing, the Academy pivoted to a series of one-hour interactive sessions delivered over several weeks. Needless to say, there is a waiting list for this amazing resource, and it is also available to non-WHA members.

Today, WHA is 31 members strong and encompasses hospice, clinics, hospitals, and even a behavioral health specialty hospital. WHA purchased the building that houses Healthcare Management, LLC employees and leases out the space they do not need to generate revenue in that manner as well. They are constantly working on how to gain the benefits of a system while retaining independence. Angelina Salazar, the Chief Executive Officer, is exploring efficiencies in compliance audits, CEO succession planning, and other necessities. It is possible that they may also have their own Medicaid Advantage Plan that is responsive to rural needs and possible by leveraging their collective volume to create the perfect solution.



### **A different Perspective: Patterson Health Center: Rightsizing by the Community**

Two struggling critical access hospitals ten miles apart merged into one centrally located, beautiful, state of the art facility. The prevailing trend for struggling rural hospitals across the United States is to watch their patient census dwindle to the point necessitating a hospital closure. How did Patterson Health Center defy the trend? The new facility was made possible by a generous donation from The Patterson Family Foundation, but Neal Patterson required that the two facilities agree on a plan that provided a more sustainable and innovative environment for rural healthcare. Sustainability was addressed by unifying the two communities around keeping healthcare available locally by combining two hospital districts. Then the staff of the hospitals in Anthony and Harper, Kansas came together to transform rural healthcare at the Patterson Health Center. Patterson Health Center is right-sized at 16 inpatient beds complemented by a large emergency room to support the Level IV Trauma center. This right-size reflects a decrease in the total number of hospital beds available from before but is the number needed to meet the needs of the two communities. Community input and care is evident even in the interior decorating details. Art on the walls comes from local artists and depicts scenes of life on the Great Plains. The art is accentuated by color palette selections. Waiting areas are painted soothing blue while the physical therapy area is red for high energy activities. The new hospital district also received a USDA (United States Department of Agriculture) loan for innovative technology upgrades so they could take advantage of unique service delivery models and new service line enhancements. Patterson Health Center is a unique public private partnership working to provide for the health of rural Kansans.

### **Columbus Community Hospital: Advocacy for what will actually work in rural healthcare**

Columbus Community Hospital is a 40-bed hospital located in Columbus, Texas, halfway between two large cities, Houston and San Antonio. The overall poverty rate is 10.07% which is roughly the national average, and the median age is 39.9 years. Thirty-six hundred residents call Columbus, Texas home, and it has seen a 1.45% growth rate since the 2010 census.<sup>16</sup> The city of Columbus may only span 3 miles, but the catchment area is much larger due to the closings of many other rural hospitals nearby. In a 45-mile radius, Columbus Community Hospital is the only hospital providing obstetrics (OB) care. Rurality necessitates that Columbus provides this service to mothers and their babies, and the leadership and staff of

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<sup>16</sup> *World Population Review*. (2021). Columbus Texas, Population 2021. <https://worldpopulationreview.com/us-cities/columbus-tx-population>

this hospital committed to providing the highest quality OB care that is humanly possible. A culture of quality that produces safe patient outcomes is reflected by recognized awards such as being named a Top 100 Rural Hospital by the Chartis Center for Rural Health. Not once but repeatedly, Columbus has made the Top 100 list, including 2019, 2020, and 2021. NRHA recognized Columbus Community Hospital as a Top 20 Rural and Community Hospital in February 2021. CCH is especially proud of this recognition because they are an independent hospital, not managed by a larger system.

Providing maternity and newborn care has become increasingly rare in rural America, and the emerging OB deserts result in rising maternal and newborn morbidity and mortality.<sup>17</sup> Legislators in Austin decided that to address maternal and infant morbidity and mortality, they would legislate a staffing level that they perceived would fix the problem. They implemented a new requirement that if a rural hospital were going to offer maternity care services, the hospital would need to be staffed 24/7 with a board-certified OB/GYN specialist. However, that legislation did not consider that most maternity and newborn care in rural areas is not provided by OB/GYN specialists but by family physicians, largely due to shortages of these specialists in rural areas. A 2020 March of Dimes report on maternity care deserts shows that in 2017, 514,000 babies were born in rural areas, while only 8% of obstetric providers practice in rural areas. There are simply not enough OB/GYN specialists to do what the legislation proposed, so care must be provided by family physicians.<sup>18</sup> In fact, for as long as residents of Columbus could remember, family physicians had delivered their babies, guided the entire family through health concerns, and been a source of comfort at the end of life. Requiring an OB/GYN specialist would have meant that not only the residents of Columbus, but those for many miles around, would no longer have access to care; they would need to go to much larger cities to find the services they needed.

Leading the charge to address this oversight, Dr. Thomas Mueller, the Medical Director at Columbus Community Hospital, stressed the importance of remaining active in professional organizations. These organizations can be lifelines for rural providers, keeping them up to date on proposed rulings as well as providing networking opportunities with similarly aligned organizations. Leadership from Columbus Community Hospital alongside ACOG (American College of Obstetricians and Gynecologists), AAFP (American Academy of Family Physicians), TMA (Texas Medical Association), and TAFP (Texas Academy of Family Physicians) educated legislators on what works for rural and how to balance what works with high-quality standards. The coalition of organizations and physicians like Thomas Mueller preserved access to care for women who live in

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<sup>17</sup> March of Dimes. (2020). *Nowhere to Go: Maternity Care Deserts Across the U.S.* Retrieved July 14, 2021, from <https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx>

<sup>18</sup> Marsa, Linda. (2018, November 15). *Labor Pains: The OB-GYN Shortage*. AAMC. <https://www.aamc.org/news-insights/labor-pains-ob-gyn-shortage>

areas served by small rural facilities and simultaneously educated the legislature. As a result, family physicians with appropriate training can continue to provide 24/7 obstetrics and newborn care as they had been doing so well.

Learn more about this rural policy advocate:

[Optimizing Rural Maternity Care](#)

### **The City of Trinity, Texas: A Community Down but Not Out**

Trinity, Texas, lies in the Piney Woods of East Texas, about 90 miles to the northeast of Houston. The city hit its highest population mark in 2010 and has seen a dwindling population base ever since.<sup>19</sup> The remaining residents have a median age of 34.9 years, an average household income of \$35,238, and a poverty rate of 33.35%. The city reflects the truth of many rural areas around the country over the last two decades. Situated too far from a major medical center for comfortable transfers or regular primary care visits, the population of Trinity needed community-based provider care. Originally a hospital was built in 1949 with community aid and funds from the Hill-Burton Act. The community came together in an inspirational way: the largest employers in town had their employees pledge one day a month of salary to build the hospital. Citizens drove personal trucks to other hospitals to pick up used beds and hospital equipment to stock the new facility. Until the formation of a hospital district in 1985, the hospital was only supported by direct community engagement. Unfortunately, neither that zeal nor the addition of a local supporting tax was enough. In 2017, the health system that operated Trinity's local hospital pulled out of its management agreement leaving the town without experienced leadership. After an exhaustive search, the hospital's board could not find a partner willing or able to take on the hospital's management; like so many others in east Texas, the hospital closed quickly thereafter on July 31<sup>st</sup>, 2017.

As the Board was providing leadership to the community regarding developing options for access to local care, they evaluated the preceding years. In frank discussions with ARCHI, the Board indicated that during those years when the large system operated the facility, the Board asked few questions, assumed that the information provided regularly was the information needed to be hospital advocates, and ultimately the board found itself facing closure. In the months leading up to closure and preceding the opening of the clinic, the Board educated its members so that they would not again find themselves in a position of having to "take their word for it."

Immediately upon the departure of the previous system, the hospital district entered into an agreement with another national health system to open a clinic in the

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<sup>19</sup> *World Population Review* (2021). Trinity, Texas, Population 2021. <https://worldpopulationreview.com/us-cities/trinity-tx-population>

previously used building. Within another year, the district contracted with a Federally Qualified Health Clinic (FQHC). The commitment of the board was to create/maintain access to care instead of insisting that a hospital was the only possible solution. This commitment allowed the town to maintain access to primary care even as they continue to work towards a brighter tomorrow for the town.

Though they “settled” for establishing a clinic, they never lost sight of the community’s investment in a hospital and the ultimate desire to offer a higher level of care than a clinic. So, they maintained the hospital facility to be prepared for the future. During the early days of the COVID-19 crisis, Trinity’s hospital was chosen by the Texas National Guard as a potential site to reopen as a COVID hospital to alleviate the then-stressed medical system. The National Guard commended Trinity on taking care of the building, parts of which were still in use as a clinic and advised the board that the hospital was ready to reopen with minimal repairs, an extraordinary achievement considering many closed rural hospitals fall into disrepair. While the National Guard did not ultimately open any COVID hospitals in Texas, the level of maintenance did not go unnoticed and left future options open with less infrastructure stress.

In the future, the Trinity Board is exploring, with its partners, reopening the hospital as a 4-5 bed *micro hospital* designed to meet the community’s specific needs. While talks and planning are still underway, many within the community have recognized the need for emergency and radiology services to return for Trinity to attract business and new residents. The city contracted ambulance service is handling emergency needs at the moment, but Trinity has maintained the FAA license for the helipad, which is used often and is exploring having a helicopter stationed in Trinity. The story of Trinity tells how adaptive community-based leadership can maintain healthcare within an area and how leaders can learn from past mistakes to revitalize dying institutions with a similar story to Palacios, Texas.<sup>20</sup>

Learn more about how the Trinity Memorial Hospital District Board is making a comeback:

[Optimizing Leadership](#)

[Optimizing External Partnerships](#)

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<sup>20</sup> Episcopal Health Foundation. (2021). *Palacios Community Medical Center*. Retrieved September 14, 2020, from [https://www.episcopalhealth.org/grant\\_partner/palacios-community-medical-center/](https://www.episcopalhealth.org/grant_partner/palacios-community-medical-center/)

## Complementary Site: **The City of Palacios, Texas**

The combination of philanthropic organizations with community effort can have great effects on the nature of healthcare delivery within an area. Here, we highlight a notable instance of collaboration between the Episcopal Health Foundation and the city of Palacios. Located on the southern coast of Texas, this small community of around 4,000 rests nearly two hours from the nearest cities (Houston to the northeast and Corpus Christi to southwest) and provides a quiet paradise for birders and fishermen. Palacios is the third-largest shrimping port in Texas and has self-proclaimed itself as the “Shrimp Capital of Texas”.

Palacios, within Matagorda County, is in a Health Professional Shortage Area and is classified as a Medically Underserved Area. Residents are fortunate to have the Palacios Community Medical Center, a 17-bed Critical Access Hospital that has been serving the needs of the community since 2001. The Medical Center includes a 24 bed Emergency department, primary care clinic, and swing bed program. Ancillary services such as radiology, laboratory, wound care, and physical therapy can also be accessed at the Palacios Community Medical Center (PCMC). The Episcopal Health Foundation has provided monetary support to the PCMC rural health clinic three times since 2017. Due to difficult financial times for all rural facilities, in 2018 PCMC took the move to align with El Campo Memorial Hospital, a 49-bed hospital located 38 miles away.

PCMC does not stand alone in addressing the span of health needs of Palacios. A comprehensive population initiative approach is supported by the Palacios Wellness Council. The Wellness Council of the Palacios Community Conversation strives to identify and remove barriers to access mental health services and to assist with the integration and collaboration of health services within and around the Palacios community. The Episcopal Health Foundation (EHF) has helped support some of the council’s efforts by providing technical support services and expertise. EHF provided direct support during the COVID-19 pandemic by hosting and facilitating Zoom sessions that were open to the community of Palacios to talk about COVID concerns and where to find resources.

Palacios is an example of a rural community connecting with a local, rural minded, philanthropy. Funding as well as the sharing of ideas that comes from these connections can be a beneficial step for other rural communities struggling to keep healthcare local.



## Hill Country Memorial: Creating a Culture of Quality and Excellence

Fredericksburg is in the beautiful hill country region of Texas. Originally founded by German immigrants, the city is now known for its peaches, German food, and wineries. Fredericksburg residents have a median age of 47.2 years and an overall poverty rate of 9.8%. Hill Country Memorial is a community health system with an 84-bed community hospital located in Fredericksburg that also operates with four clinics in neighboring counties. HCM began as a small hospital in 1971.<sup>21</sup> The population of Fredericksburg has grown by 11.93% since 2010. Reflecting their growing community's need for healthcare, the original hospital also grew over the years by expanding its physical location and opening a series of clinics to provide primary care. Over the last decade, Hill Country has been nationally recognized for its dedication to quality and positive health outcomes. Its most recent award was being named as a Top 20 Rural Hospital by the National Rural Health Association in February of 2021. HCM views these awards as external validation of what they live every day. "We think you'll find HCM to be a bit different than the rest. Because we aren't just hospitals and clinics.... We're how healthcare is supposed to feel."<sup>22</sup>

Another national recognition came from the Baldrige Program, the nation's public-private partnership dedicated to performance excellence.<sup>23</sup> Originally created to help American businesses compete in the global economy, it is now the highest level of recognition for performance excellence. In addition to the extensive assessment by the Baldrige Board of Examiners, the labor-intensive application process ensures that those recognized are true role models of excellence in practice. HCM was the winner of the Malcom Baldrige award in 2014. Since the healthcare sector of the Baldrige award was established in 1999, there have only been 29 award recipients. Yet, only ten years earlier this achievement would have seemed impossible for HCM. A series of clinical failures culminated in a highly publicized death in the Fredericksburg community. Acting as a well-run responsive organization, the hospital's management decided that change was necessary and motivated leaders began an organizational overhaul. This overhaul created HCM's Always culture to ensure that the highest quality care is delivered most cost-effectively.

The then and current CEO implemented operational management measures based on lean principles (going so far as to hire an ex-Toyota engineer to lead their quality

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<sup>21</sup> *World Population Review*. (2021). Fredericksburg, Texas, Population 2021. <https://worldpopulationreview.com/us-cities/fredericksburg-tx-population>

<sup>22</sup> Hill Country Memorial. (2021). *Who we are*. <https://www.hillcountrymemorial.org/about/who-we-are/history/>

<sup>23</sup> Baldrige Performance Excellence Program. (2021). *About Baldrige*. <https://www.nist.gov/baldrige/how-baldrige-works/about-baldrige>

team). This implementation led to rapid changes within the organization in all areas of interest: clinical quality measures were up; financial viability has increased; and workers and patients were on average much more satisfied with their care. The featured focus is how the Always Culture has sustained excellence. HCM's Journey of Remarkability did not end in 2014; they regularly perform self-assessments with an eye towards improvement. In 2020, CareChex by Quantros ranked HCM among the best in the nation for medical excellence and patient safety.<sup>24</sup> The CareChex awards are based on a review of patient complications, readmissions, mortality, AHRQ patient safety indicators, and inpatient quality indicators. The data set does not include any self-reported or survey data to rate quality objectively. The writing on the wall in their learning center says it all, "improving us for the sake of others." This knowledge-sharing approach is encouraged by the Baldrige Program. Award recipients have a profile on the NIST Baldrige Award website.<sup>25</sup> This profile includes their success story and contact information so that others might reach out to learn more about their best management practices. The profiles are intended to facilitate mentoring and role modeling. It was precisely these acts of mentoring and role modeling of remarkable quality that placed HCM on the list of Bright Spots. The ARCHI research team had heard from hospitals in Texas about the exceptional quality at Hill Country Memorial. This information was affirmed by the list of Texas innovators submitted by the Texas Organization of Rural and Community Hospitals (TORCH).

Learn more about Hill Country Memorial's Journey of Remarkability:

[Optimizing Leadership](#)

[Optimizing Cultural Transformation](#)

[Optimizing Data Utilization](#)

## **Kearny County Hospital: Building a Mission Culture**

Located in the southwestern corner of Kansas, Kearny County is a rural area with a declining population of around four thousand. Residents of Kearny County have a median age of 34.7 years, average earnings of \$37,628, and a 19.61% overall poverty rate.<sup>26</sup> Nearly half of that population resides within the county seat, Lakin, the site of Kearny County Hospital (KCH). This Critical Access Hospital (CAH) has

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<sup>24</sup> Hill Country Memorial. (2021). *Hill Country Memorial Ranked among the Nations Best for Medical Excellence and Patient Safety*. <https://www.hillcountrymemorial.org/5525-2/>

<sup>25</sup> Baldrige Performance Excellence Program. (2021). *Baldrige Award Recipients Listing*. <https://www.nist.gov/baldrige/award-recipients>

<sup>26</sup> *World Population Review*. (2021). Kearney Count, Kansas Population 2021. <https://worldpopulationreview.com/us-counties/ks/kearny-county-population>

gone from a troubled area facing provider shortages to a bright spot that services a twenty-county region and a population of almost fifteen thousand people.

What prompted KCH to change? Ten years ago, CEO Benjamin Anderson looked at the data and discovered they were turning away 50 new patients a week from the clinics because the clinic was understaffed. These primary care patients were then forced to seek care in the emergency department. The clinics even had a policy to only provide care for in-county residents in an attempt to keep up with needs. However, faced with a shortage of physicians and physician assistants, KCH adopted a new focus that has propelled it into being a thriving, growing practice with seven physicians, 13 clinic nurses and a PA. The main driver of the program, CEO Benjamin Anderson, describes four types of physicians who will traditionally practice in rural health settings: physicians rurally born and raised, immigrant physicians, troubled physicians, and “missionary” physicians. While two of the first three serve well in rural areas, they do not yet have the numbers to fix the provider shortage facing rural areas. The key insight of Kearny County Hospital’s leadership was recognizing these divisions among their potential provider workforce, and their innovation was targeting the demographic that would best serve their community, those self-described ‘missionary’ physicians.

With recruitment on the rise, Kearny was able to focus on identifying and meeting a variety of community health needs. They have launched multiple initiatives centered on different aspects of care. Kearny adopted a value-based medical ethic that focuses on holistic patient wellbeing; this was the product of consultations by Dartmouth College faculty centered on crafting “a new care culture.” Anderson earned a Master's in healthcare delivery science at the Tuck School of Business at Dartmouth College and had retained connections to his faculty even as a CEO. More concretely, two initiatives have increased Kearny’s presence in two critical areas: undocumented and refugee care and OB/GYN services. Using money from partnerships with Tyson Beef, the largest employer in the region, and the United Methodist Church Foundation, Kearny has created a team to provide care for factory workers (most of whom are Black, Hispanic, or foreign-born).

The story of Kearny is one of cultural transformation to create an institution that cares for its community with limited resources. KCH has a wealth of excellent providers across multiple language groups, practicing full-scope family medicine, allowing families to say close to home for health.

Learn how a small herd of unicorns can set the standard for rural health:

[Optimizing Leadership](#)

[Optimizing Culture Transformation](#)

[Addressing Inequity](#)

[Optimizing Rural Maternity Care](#)

## **Southcentral Foundation’s Nuka System of Care: Defining a New Culture**

Southcentral Foundation (SCF) is one of the largest healthcare organizations in Alaska, with a service area of roughly 150,000 square miles and 65,000 patients. The entire state of Alaska has a population of only 733,391 people as of April 1, 2020. In addition to an expansive service area, SCF maintains a wide assortment of care options for the people it serves.<sup>27</sup> These services range from primary care provided by integrated care teams to community health efforts to behavioral health work with a total workforce of over 2,300 individuals. Since its inception, SCF has reported remarkable growth, expanding from a \$3 million to an almost \$300 million enterprise focused on all aspects of healthcare. Throughout the last twenty years, the SCF has implemented a series of transformational organizational measures that have made it one of the country’s most highly regarded health organizations. A two-time winner of the Baldrige award for quality, SCF provides a unique set of tools for understanding the improvement of rural healthcare systems. SCF’s whole healthcare system is named Nuka System of Care. Nuka is an Alaska Native word used for strong, giant structures and living things that pairs perfectly with the goal of SCF to achieve physical, mental, emotional, and spiritual wellness for Alaska Native people.

Before the inception of the Southcentral Foundation, Alaska Native Health was the responsibility of state and federal governments. With the passage of the Indian Self-Determination and Education Assistance Act, this system was transformed into one that focused on Native self-determination and ownership of health outcomes. From this transformative moment, SCF was born and used the principles outlined to become one of Alaska’s largest and most effective healthcare providers. Self-determination and personal ownership of health outcomes have become the hallmark of this system. These ideas created an integrated model of care centered on patients as “customer-owners” who were part of both the management of their own healthcare decisions as well as the system that provided them care. Southcentral Foundation has 15 listening posts, including community advisory boards and direct customer-owner feedback to facilitate customer-driven healthcare. SCF re-imagined healthcare from a population health perspective and changed how healthcare was delivered by transitioning from the traditional view of hospitals as the main and sometimes the only point of access to care to create a healthcare system to achieve physical, mental, and emotional health, and spiritual wellness. SCF has been recognized as a Patient-Centered Medical Home.

Now, SCF takes its direction from multiple advisory or management groups of Alaska Native stakeholders; an emphasis is placed on having customer-owners as team members at all levels of the organization. Changing the narrative and nomenclature around the term patient provides a lens to understand the institutional

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<sup>27</sup> United States Census Quick Facts. (2021). *Alaska*. <https://www.census.gov/quickfacts/AK>

changes of SCF as each is organized on principles of patient ownership. Nowhere are these ideas more evident than in their Core Concepts, spelling WELLNESS.

Work together in relationship to learn and grow

Encourage understanding

Listen with an open mind

Laugh and enjoy humor throughout the day

Notice the dignity and value of ourselves and others

Engage others with compassion

Share our stories and our hearts

Strive to honor and respect ourselves and others

Each of these outlines a tangible commitment to developing holistic patient-based care for their 65,000 customer-owners.

<b>Oregon Care Redesign Principles Adopted from Southcentral Foundation</b>
<ol style="list-style-type: none"><li>1. <i>Patient-Driven Care</i>: Involving patients in the design and evaluation of care that takes into account patients' values, preferences, and needs.</li><li>2. <i>Team-Based Care</i>: Using teams to make care more efficient and ensure that all team members are practicing to the highest level of their credentials.</li><li>3. <i>Proactive Panel Health Improvement</i>: Assigning a panel of patients to a team of providers that proactively determines and meets preventive care needs.</li><li>4. <i>Integrated Behavioral Health</i>: Incorporating a behavioral health practitioner into the team to identify barriers to self-care and screen for and treat mood and behavioral issues.</li><li>5. <i>Barrier-Free Access</i>: Removing barriers that stand in the way of prompt and appropriate care, such as language, culture, attitude, time, and place.</li></ol>

Figure 2: Oregon CCO Redesign Principles Derived from Nuka Model of Care. Adapted from The Commonwealth Fund<sup>28</sup>

<sup>28</sup> Klein, Sarah. and Mearthy, Douglas. (2010). *CareOregon: Transforming the Role of a Medicaid Health Plan from Payer to Partner*. The Commonwealth Fund. Retrieved 5/20/2020 from <https://www.commonwealthfund.org/publications/case-study/2010/jul/careoregon-transforming-role-medicaid-health-plan-payer-partner>

Learn more about SCF's relationship-based, customer-owned approach to transforming healthcare, improving outcomes, and reducing costs: See similar approaches with Cherokee Indian Hospital and the State of Oregon's Coordinated Care Organization.<sup>29</sup>

[Optimizing Leadership](#)

[Optimizing Cultural Transformation](#)

[Optimizing Data Utilization](#)

[Optimizing External Partnerships](#)

#### **Replication Site: State of Oregon Coordinated Care Organizations**

After sending a team to visit the Southcentral Foundation, the state of Oregon began by creating a coordinated care organization in the Nuka model. As of 2020, there are now over a dozen such organizations each serving their patients with integrated multi-disciplinary care which highlights the potential of the Nuka model for a predominately Medicare/Medicaid population. A criticism of the Nuka model is that it will only work in a tribal community, but Oregon offers some proof that the model will also work in a contained patient population such as Medicare/Medicaid or Veterans healthcare. CareOregon® is a nonprofit Medicaid health plan that serves 128,000 people. They have two innovative programs, Care Support that follows a multidisciplinary case management service approach and Primary Care Renewal that is built upon SCF principles. The Primary Care Renewal Model has been particularly successful. Utilizing the Nuka blueprint centered on self-determination and wellness, the Oregon Coordinated Care Organizations offered performance incentive payments for clinics to participate in the pilot. Working with consultants from Southcentral Foundation and the state office, all clinics were able to see significant clinical improvements in their patient cohort. In one year, there was a 7% increase in blood pressure (BP) and A1C control with the best performing clinics exceeding national benchmarks. Other significant clinical changes were a 10.8% increase in A1C testing, a 7.6% increase with A1C below a goal of 8, and a 7.6% increase in BP controlled below 140/90. Additionally, there was a 3.4% increase in PAP tests, a 12.2% increase in up-to-date child vaccinations, and a three-fold increase in patients screened for depression. Research has shown the sound investment preventive health can have on an individual's chronic disease management as well as pocketbook. Reaching goals in disease states as predominant as hypertension and diabetes improves the health, reduces overall cost, and reduces mortality risk for this patient population.

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<sup>29</sup> Klein, Sarah. and MCarthy, Douglas. (2010). *CareOregon: Transforming the Role of a Medicaid Health Plan from Payer to Partner*. The Commonwealth Fund. Retrieved 5/20/2020 from <https://www.commonwealthfund.org/publications/case-study/2010/jul/careoregon-transforming-role-medicaid-health-plan-payer-partner>

### Replication Site: **Cherokee Indian Hospital**

Cherokee Indian Hospital (CIH) is a 20-bed critical access hospital and clinic located on the Cherokee Indian Reservation in North Carolina that serves approximately 14,000 Native Americans. Controlling per capita costs, to responsibly manage the Tribe's resources, are a priority and so they turned to Southcentral Foundation to learn the Nuka way. Through education and consultation services, SCF partnered with CIH on a transformation plan. The leadership from the Cherokee Indian Hospital Authority adapted the Nuka way to fit their unique culture. They eliminated private physician offices to collocate care team members into one primary care area. CIH has six of these teams (physician, nurse, dietician, behavioral health therapist, and pharmacist) responsible for no more than 1000 patients. CIH has the "Right Way" training program to teach all employees the relationship-based culture. CIH incorporated their culture into the building of their new facility with an emphasis on Cherokee history, arts, crafts, as well as the healing aspects of the Cherokee culture. By considering the mind, body, and spirit of the Tribe, CIH offers a system-wide approach to healing.

### **Sakakawea Medical Center & Coal Country Clinics: Working Together to Help the Community**

The Sakakawea Medical Center (SMC) is a 13-bed critical access hospital and a 34-bed licensed basic care facility located in Hazen, North Dakota, that boasts roughly sixteen medical practitioners with six MD/DOs and ten other professionals of varying certification along with one-hundred non-clinical employees. SMC is a community-owned, non-profit hospital governed by a volunteer board of directors. The Coal Country Community Health Center (CCCHC) is an FQHC located in Beulah, North Dakota, a roughly ten-minute drive away from Sakakawea, with approximately one-hundred thirty employees. Both facilities are in Mercer County, which has shown a 6% population decline since 2010. The residents of Mercer County are predominately White (88.7%), with a median age of 39.8 years, an average income of \$45,046, and an overall poverty rate of 10.26%.<sup>30</sup>

Traditionally, these two practices competed for resources and clientele. Less than a decade ago, this competition reached the point that both were facing financial instability due to limited resources and clients. To combat this mounting pressure, the organizations decided that a collaborative approach would better serve their

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<sup>30</sup> *World Population Review*. (2021). Hazen, North Dakota, Population 2021. <https://worldpopulationreview.com/us-cities/hazen-nd-population>

communities. The CAH and the FQHC aligned around the common purpose of local, quality care. Leaders from SMC and CCCHC worked to establish trust and promote the idea of a unified health system. This journey towards collaboration was not easy; it took time and effort. Now organized under a single CEO, these two practices have jointly worked to promote wellbeing in their corner of western North Dakota. Together they serve Dunn, Mercer, and Oliver counties, which span more than 3,900 square miles. This joint mission has transformed the organizations substantially. Financial stability has been realized as evidenced by increased days of cash on hand. Clinical efficiencies have been realized as well. While the two organizations remain separate with separate boards and employment contracts, under the new agreement, they often work together. Collaboratively, they work on various projects: community health assessments and strategic planning, as well as offering seamless care transition between their two practices, yielding an increased specialized service capacity.

With the two largest healthcare providers coming to terms, meaningful collaboration with other local providers has flourished, leading to greater continuity and quality of care between the many providers. The National Rural Health Organization awarded Sakakawea Medical Center and its partner Coal Country Community Health Center the Outstanding Rural Health Organization award in 2015.

Their vision is to be the preeminent providers of innovative and collaborative healthcare services. In an industry where collaboration is the exception, not the rule, learn more about this dynamic duo:

[Optimizing Leadership](#)

[Optimizing External Partnerships](#)



### Complementary Site: **Cary Medical Center and Pines Health Service**

Cary Memorial Hospital opened its doors in 1924 to serve the community of Caribou, Maine. Caribou continued to grow and in 1978 Cary Medical Center replaced the original hospital but continued the mission of patient-centered quality care. Pines Health Service was designated as a Federally Qualified Health Center (FQHC) in 2007 with locations in Caribou, Presque Isle, Washburn, Fort Fairfield, and Van Buren. These two entities, the FQHC and the hospital, opted to collaborate rather than compete to better serve their rural community. It did not take long to see the results of this relationship as they received the 2009-2010 Directors Award from the Maine Immunization Program in recognition of their phenomenal H1N1 and seasonal flu vaccination program.

Caribou, Maine is the most northeastern city within the United States and has a population of about 8,000 people today. Cary Medical Center is a 65-bed acute care hospital known for its award-winning healthcare. They have a goal to be the leading healthcare organization in providing high quality, affordable, and accessible care. Well on their way, they have been recognized in Maine and nationally for quality care, patient safety, and customer service. In collaboration with Pines Health Service they offer a wide array of services including general surgery, pediatrics, 24-hour emergency medicine, obstetrics and gynecology, orthopedics, physical and emotional therapy, family medicine, sports medicine, cardiac and pulmonary rehab, internal medicine, urology, radiology, pathology, and other specialty clinics. Continuity of care is facilitated between the two entities by having providers with privileges at both locations. The unique collaboration between Cary and Pines is an ideal training environment for the next generation of rural providers. Medical students from Tufts University School of Medicine are already taking advantage of the wide range of specialties while being exposed to the challenges and rewards of rural medicine.

### **Titus Regional Hospital: Standing Ground in a Tough Situation**

Northeast Texas has its challenges. More than half of the residents in this 35-county region live in rural areas. Relative to Texas overall, the people in Northeast Texas are older, have a lower median household income, and have higher mortality rates due to heart disease, cancer, stroke, chronic lower respiratory diseases, and unintentional injury.<sup>31</sup> Titus county residents earn an average of \$31,715/year and have a poverty rate of 17.68%.<sup>32</sup> Titus Regional Medical Center (TRMC) serves a

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<sup>31</sup> The University of Texas System. (2016). *The Health Status of Northeast Texas*. <https://utsystem.edu/sites/default/files/news/assets/northeasttx-health-status-report-2016.pdf>

<sup>32</sup> *World Population Review*. (2021). Titus County, Texas Population 2021. <https://worldpopulationreview.com/us-counties/tx/titus-county-population>

community in which 31% of the adults are uninsured. This is a population that needs access to healthcare and yet has experienced the closure of four hospitals in the last six years. It certainly looks like a tough situation, but the leadership at Titus Regional Medical Center feels their location is a huge asset. Taking advantage of rural positives, Titus recruits physicians who want to live on the lake and belong to the community of Mount Pleasant. The community website summarizes, “While Mount Pleasant is located right-off I-30 and an easy drive to the Dallas-Fort Metroplex, Shreveport, and Little Rock, there’s no reason to leave this community.”<sup>33</sup>

The leadership team at TRMC never thought about closing their hospital. For them, it was personal because in rural communities, “we are in this together.” They saw what happened to the communities when hospitals closed around them and made a strategic choice to stay open. At the time, the number one cause of deaths and transfers was cardiac in nature. TRMC used its cash reserves to build a catheterization lab and cardiac center. They estimated it would take them a year to break even on the inpatient side, but the expense was strategic because they could grow those services by reducing cardiac transfers. The outpatient volume growth took longer to break even financially. TRMC focused on primary care and cardiac care in 2014; then, they focused on stroke care excellence in 2015. TRMC used 1115 waiver funds to extend hours and days of operation for one primary care clinic and create the stroke center. The 1115 Medicaid waiver is the section of the Social Security Act that allows the federal government to approve waivers for demonstration projects that expand access to care and specialty care in rural areas. Self-generated funds were then used to expand the hours of access for three additional clinics that are part of TRMC. The quality and growth of these service lines allowed them to build and add urology, orthopedics, critical care, and pain management. This is not a magic bullet for everyone, but these service lines were what their community needed, and so they right-sized and right-timed their offerings to match. Titus embraced the idea that with the poor health outcomes in their region, they had to think differently; they had to think more about social determinants of health and frame themselves as a community health program. Titus Regional Medical Center (TRMC) is an 80-bed hospital that increased to 108 beds during the COVID pandemic.

The story of Titus is of a hospital that has successfully engaged with its community to redefine the role of a hospital. Titus has always had an events-based community engagement approach and used these events to improve community health. They hosted health fairs, lunch & learns, and CPR classes in addition to having a presence at local fairs and festivals. This engagement was critical during the COVID-19 pandemic when Mount Pleasant was a hotspot and information needed to be shared, but it was also crucial six years before when surrounding hospitals were

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<sup>33</sup> Mount Pleasant Texas. (2021). <https://www.mpcity.net/>

closing. Titus was consistent with messaging that they were open and able to serve the region. The outreach to the surrounding communities stressed the word *Regional* in TRMC and that they were no longer called Titus County Hospital. TRMC leadership met with community leaders and healthcare stakeholders in the surrounding communities to understand their unique needs and worked to ensure those needs were met. It was not a one-size-fits-all approach; each community had a distinct voice in the conversation. With 51 employed providers and an active medical staff totaling 98, TRMC is the only independent health system in Northeast Texas. To remain open and independent, Titus has overcome a traditionally challenging set of demographics for hospital finances.

Learn how Titus Regional Medical Center makes sure that Healthier Tomorrows start here:

[Optimizing Leadership](#)

[Optimizing Cultural Transformation](#)

[Optimizing Data Utilization](#)

[Addressing Inequity](#)

[Optimizing Rural Maternity Care](#)

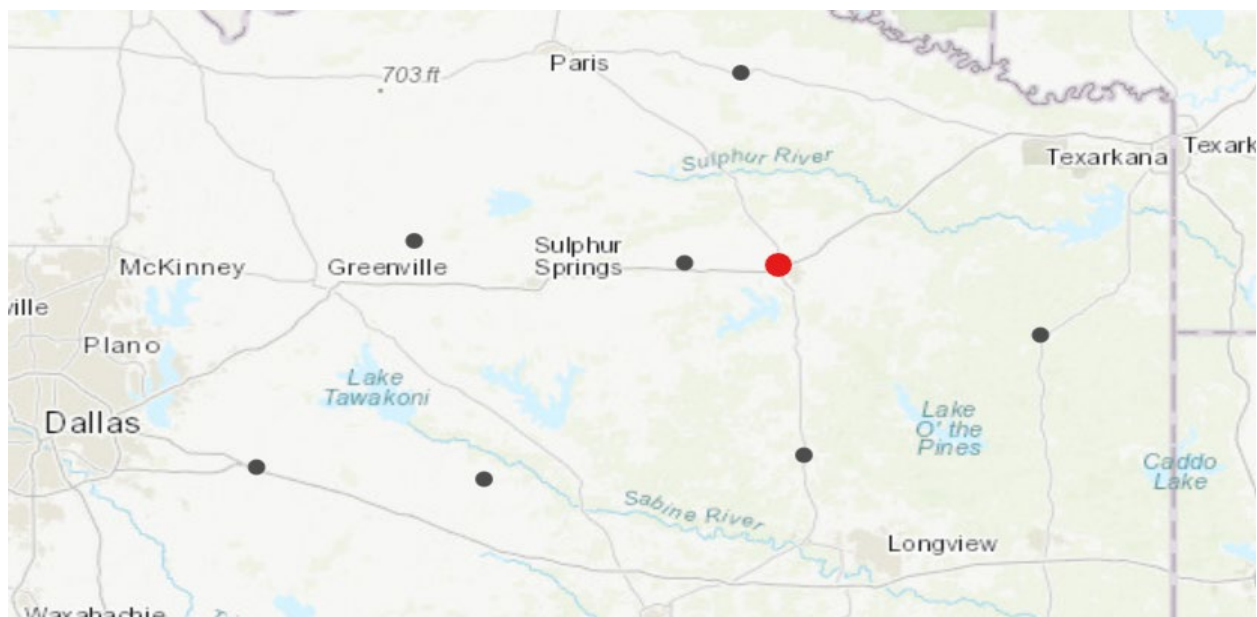


Figure 3: Hospital Closures near the Titus Regional Hospital; the red circle is Titus Regional Medical Center; the black circles are closed rural hospitals. Image adapted from the University of North Carolina Cecil G. Sheps Center.<sup>34</sup>

<sup>34</sup> The Cecil G. Sheps Center for Health Services Research. *181 Rural Hospital Closures since January 2001*. Retrieved May 8, 2020, from <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

## Optimizing Leadership

In all of the Bright Spots, leadership shines through as the most essential ingredient for success. Echoes of inspiring leadership are seen in every other aspect covered in this report.

Dynamic leadership is one of the defining characteristics of successful healthcare organizations; this is especially true for rural organizations. The constant state of flux for rural healthcare requires adaptive leaders able to execute their vision by coordinating diverse teams of stakeholders. A narrative exists that rural places lack leadership and capacity, yet the most striking characteristics of our Bright Spots were their leaders and leadership teams. Leadership can be found in many roles of rural healthcare organizations, most commonly in C-suite positions and in various positions like the hospital's board.

Leadership has been called “the most observed but least understood phenomenon in the world.”<sup>35</sup> While the subject of leadership has been the focus of much academic and operational study, it remains hard to define and even harder to develop in organizations. For organizations increasingly on the brink, solid leadership can be the difference between remaining open and succumbing to closure. According to Alan Morgan, Chief Executive of the National Rural Health Association, “Leadership is the single highest predictor of rural hospital success, and today’s CEOs in many of these communities are leaving their positions too often.”<sup>36</sup> Therefore, optimizing leadership should be a priority for every rural facility as it continues to provide the care needed by its service population.

Leaders not only define the success of an organization; they establish the mission, the values, and the culture of the organization. Indeed, many of the ideas discussed in this section and beyond were generated, fought for, and implemented by an organization's leadership. In our view, the most important facet of a leader's duty to their organization is predicting or safeguarding against uncertainty so that organizations can continue fulfilling their purpose. Given the nature of healthcare, constantly undergoing paradigm shifts either due to changing payment systems or advances in technology, organizations must be agile in adapting to change. Challenges to change can come from many parts of an organization, usually through normal organizational inertia, necessitating a central, communicable vision from the highest part of the organization.

Writing a definitive manual defining “how to be a leader” would prove impossible in any field, but almost none more so than healthcare. Many leadership manuals talk about the individual characteristics that define great, or even just adequate,

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<sup>35</sup> Burns, James MacGregor. (1979). *Leadership*. Harper & Row.

<sup>36</sup> KU School of Medicine-Wichita. (2015, September 16). *Improved Health of rural Kansas Moms and Babies is Program's goal*. <https://wichita.kumc.edu/newsroom/pioneer-baby-091615.html>

leadership; indeed, this report contains many examples of aspirational leadership personalities. While these are the leaders that rural organizations need and deserve, waiting for one (or many) to appear is akin to waiting for lightning to strike. One focus of this report is identifying reproducible policies and learnable skills that give organizations the ability to potentially develop a leadership cadre without waiting for the lightning strike. We forgo an in-depth conversation of the theories of healthcare leadership.<sup>37, 38</sup> While these provide a grounding for the study of leadership, and many of the insights here fall in line with them, they are often divorced from the realities faced by rural organizations. This reality often requires leaders to “wear multiple hats,” performing duties that two or three specialized staff would perform in larger organizations.

Not only do rural organizations face the task of discovering or developing leaders, but they also often face the prospect of that leader leaving with little notice. High turnover is a problem for many rural healthcare organizations. “With CEO turnover rates exceeding twenty percent in many communities, this means that one in five CEOs are leaving their positions regularly.”<sup>39</sup> Organizations need to consider how *new* leadership will ‘take the reins’ and how to do so in such a way that the organization is never left rudderless, without a clear vision moving forward.

Healthcare organizations should identify current and potential qualified individuals to helm leadership teams and then invest in developing them to prepare them to take on rural organizations’ challenges. As we hope to show in this section, overcoming this daunting task is possible for any organization. The strategies by which organizations have sought to bridge the leadership gap are as diverse as the organizations themselves.

## **Developing Leaders**

This section details how different organizations have established internal leadership capacity to serve their community better. Succession planning from within can be challenging because many rural facilities require staff to fulfill multiple organizational roles due to the small pool of employees, often without dedicated time to train or mentor. Many of the Bright Spots had a single leader out of the classical mold with a strong personality and clear vision. Most seemed to appear like lightning, coming out of the chance to steer the organization. But each leader, encountered by the research team was determined to see their organization’s progress continue after their tenure. Each had a similar goal of *developing* the leadership potential of their organization.

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<sup>37</sup> Healey, Bernard J. (2018). *Principles of Healthcare Leadership*. Chicago, Illinois: Health Administration Press.

<sup>38</sup> Hartley, Jean and Benington, John. (2010). *Leadership for Healthcare*. Bristol: Policy Press.

<sup>39</sup> Bridewell, Mellie and Matt Shahan. *Rural Hospital CEO Turnover*. National Rural Health Association Paper [https://www.ruralhealthweb.org/NRHA/media/Emerge\\_NRHA/Advocacy/Policy/documents/2020-NRHA-Policy-Documents-Rural-Hospital-CEO-Turnover.pdf](https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy/documents/2020-NRHA-Policy-Documents-Rural-Hospital-CEO-Turnover.pdf). Accessed: 12/13/2020

Southcentral Foundation looks internally to its current staff to develop the next generation of leaders, an approach deeply embedded into its organizational culture. While many organizations take a top-down approach where a leadership team or CEO leads all organizational change, Southcentral Foundation has pioneered a flat decision-making approach, in which all members of its organization, from the front office manager all the way to its provider staff and CEO, act as decision-makers and are constantly given an opportunity for more responsibility and professional growth. The commitment to employees is driven by the purposeful goal of mutual respect between every customer-owner and employee. Southcentral Foundation fosters each team member to feel connected to the mission of the larger organization through Core Concepts.

From the time an employee is hired until the time they leave Southcentral Foundation, employee training is available that will lead them up the organizational ladder. Training may take the form of workforce development learnings or academic leave to get a college degree or professional certification such as nursing or pharmacy training. The organization supports employees on each step of their career progression and, importantly, provides an outlet for continued growth within the organization. The centralized career pipeline provides a steady stream of qualified professionals at each level of the organization. The key insight of this approach spurs a focus on even the most entry-level employees. Southcentral Foundation averages 76.9 hours of education in the first year of employment as opposed to the industry standard of 22 hours. Under this framework, training is an investment in the future of all employees and the entire organization; both have a vested interest in the other past a paycheck or fulfillment of a role.

Professional paths are divided into administrative and clinical tracks with natural crossover points between the two, reflecting complimentary organizational needs from the initial hire. The clinical track follows a typical progression of personnel based on licensure. The administrative track follows either a management path or an organizational improvement path depending on professional interest. Southcentral Foundation's approach highlights that individualization of career trajectories is possible even within a system of graduated responsibility. By developing this system, every employee has become an involved stakeholder, and the organization has created a dedicated pipeline of internal individuals for organizational roles and a succession plan that is robust against any particular individual leaving.

Two examples highlight the reasons and benefits for this dedication. First, the story of their past President and CEO, Katherine Gottlieb, exemplifies the Nuka path to excellence. Gottlieb started her career in 1987 as a receptionist with Southcentral Foundation and, throughout her career, led its growth into one of the most dynamic healthcare organizations in the country. When Gottlieb left in August of 2020, April Kyle, an MBA, stepped right in as Interim President/CEO. Kyle is an SCF customer-owner who began her career at SCF in 2003 in the Human Resources Department and, before becoming President and CEO, most recently served as Vice

President of SCF's Behavioral Services division. Second, the onboarding events illustrate early career commitment. Members of Southcentral Foundation have spoken widely on the transformative impact of this practice on the organization. Every onboarding event instills a powerful sense of organizational spirit and understanding of the employee's place within the mission of the organization.

Hill Country Memorial has a support structure that includes coaching, mentoring, and training to develop its leadership team. Leadership team members participate in graduate education with the help of tuition reimbursement from HCM. Attendance at conferences and memberships in professional organizations are also encouraged to stay current with rural healthcare. An article on leadership best practices is read every week and discussed. A memorable article from July 2020 was on adaptability during a crisis. It served to remind the team that the real challenge is not to return to previous methods but to strive to improve thru adversity. Coaching to hone leadership and teamwork skills is highly encouraged. The vision of HCM is to Empower Others and Create Healthy. Starting with empowering her leadership team, the CEO is helping the team reach new heights by sharing information and time. When staff sees leadership living by the organization's core values and vision/mission statements, they know it is more than an empty slogan; it is a true reflection of the culture. This dedication was recognized when CEO Jayne Pope received the Harry S. Hertz Leadership Award in 2020. This award "recognizes role-model leaders that challenge, encourage, and empower others to achieve performance excellence."<sup>40</sup>

## **Recruiting Leaders**

For many rural organizations, the internal recruitment described above may be infeasible or, at least, a long-term improvement plan. However, recruiting from beyond an organization has the benefits of bringing in a fresh perspective, different experiences and avoids the common pitfall of nepotism that can erode confidence in leadership.<sup>41</sup> Recruiting talent to rural areas can be difficult and expensive. Unfortunately, the struggle does not end once a new employee has been hired, so retention efforts should begin immediately.

While it is not the focus of this work to delve into the myriad challenges and potential solutions for rural recruitment, sources like 3RNet's Recruiting for Retention online Academy offer detailed information on strategies to overcome these gaps. The greatest challenge of effective recruitment often lies in an organization's culture. "If you build it, they will come" may be a misquotation from

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<sup>40</sup> Al Faber, President and CEO of the Foundation for the Malcolm Baldrige National Quality Award. In press release <https://baldrigefoundation.org/news-resources/press-releases.html/article/2020/01/21/baldrige-foundation-announces-2020-leadership-award-recipients>

<sup>41</sup> Barto, Sarah. (May 17, 2018). *Preventing unnecessary CEO turnover in rural and critical access hospitals*. Rural Voices. National Rural Health Association. Retrieved from <https://www.ruralhealthweb.org/blogs/ruralhealthvoices/may-2018/preventing-unnecessary-ceo-turnover-in-rural-and-c>

the movie *Field of Dreams*, but it has application to healthcare. As described in detail in the section on culture, creating a culture and being known for that culture is a powerful recruitment tool. It may be that an organization is not ready for a culture change or has not decided in which direction to move. Though it is important for an organization to work to define its culture and begin to live its culture, in the meantime, exploring other programs and providing education are financially responsible ways to look at options. SCF offers several ways that external organizations can receive leadership training and guidance without requiring a cultural transformation to the Nuka System of Care model.

### **Mentoring Future Rural Leaders**

In early 2020, the National Rural Health Association created the Rural Hospital CEO Certification Program in response to the rural hospital CEO turnover study and hospital closure crisis.<sup>42</sup> Quickly the demand for mentorship and specific education outstripped the supply, and NRHA was unable to (and still cannot) accept all those who applied. Before the Rural CEO Certification, there was a lack of any targeted education available for rural health leadership. Those that found themselves thrust into leadership positions often sought a mentor to learn the ropes. In time, those seasoned leaders offered their own life lessons and hard-won successes to mentees. These formal and informal mentorships are a beautiful example of the self-sufficiency so prevalent amongst rural leaders. Mentorships still provide a valuable means to develop leaders, a fact reflected by many of our Bright Spots. As discussed in the stories below, identifying and relating to a mentor is as individual as the CEOs themselves. It is the process of learning from someone who is a guide, usually someone who has been through the same or similar process and can help identify possible challenges and potential solutions.

Benjamin Anderson first became CEO of a rural hospital at the age of 29, with no prior experience working in a hospital. At that time, Ashland Health Center in Ashland, Kansas, had only four days of cash on hand. He knew to ask thoughtful questions of the team inside the hospital and build relationships with successful leaders across the United States. Early on, he cold-called five CEOs of hospitals that had won the National Malcolm Baldrige Award and asked for mentoring. He traveled to each of their offices and met with them in person. When he was later CEO of Kearny County Hospital in Lakin, Kansas, the board paid a monthly stipend to the executive coach to encourage his ongoing professional development. The investment by the hospital in Anderson's professional development paid off with a massive primary care recruitment effort and measurable improvements in clinical outcomes, most specifically around maternal health equity. Later, members of the leadership team at Kearny County Hospital attended the Value Institute for Health & Care at The University of Texas at Austin. There, Anderson reconnected with a Dartmouth College faculty member, Elizabeth Teisberg, Ph.D., now the executive

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<sup>42</sup> National Rural Health Association. (2020). *What difference does leadership make?*  
<https://www.ruralhospitalceo.com/ceo-certification-program>



director of the Institute. Benjamin credits Teisberg as a key mentor in his leadership development as well. In time, Anderson recruited and mentored David Hofmeister, who has continued to steer the culture changes at Kearny County Hospital.

TRMC has relied on internal and external voices to help build the health system over the past few years. TRMC hired several experienced service line and quality-driven leaders from across the nation along with promotions from within to build the current leadership team. The TRMC leadership team also created dyads with physician leaders of the community to navigate decisions and strategies. The leadership team has turned to several external professionals for insight during their journey who became mentors for Terry Scoggin. One is a CEO who created a path that the leadership team envisioned for their own hospital, and the other is an industry leader with decades of experience perfecting the service line approach. Steve Summers was the CEO of Wise Health System in Decatur, Texas. Summers oversaw the name change from hospital to the system to better align the mission and direction of an all-encompassing healthcare service for the community. It took time to change to a system mentality, and Scoggin appreciated Summers's perspective at the end of a cultural transformation. Dan Zismer at Castling Partners is a consultant that Scoggin and the leadership team have worked with to provide expert professional advice.<sup>43</sup> A well-published author and established lecturer, Zismer helped the leadership team at Titus determine that they did indeed have the ability to stay independent. There is a dichotomy between Scoggin's two mentors, and yet the sum of their advice helped create a Bright Spot. Mentors come from a variety of places. Some support and counsel for a season, and some remain across an individual's career with insights appropriate for each different stage. Darrold Bertsch, CEO of Sakakawea Medical Center, summed it perfectly by stating that he found mentors in most situations. Every time Bertsch had the opportunity to advance, it was because somebody took a chance on him and provided mentoring. This held true from his first employment at a hospital in materials management at the age of 19 all the way to CEO. Now it is Bertsch's time to be a mentor for his replacement in a formal CEO transition mentorship approved by his Board of Directors.

When asked about mentors, Hill Country CEO Jayne Pope offered an interesting observation. Mentors are selected from a pool of people who have been down this particular road before. Mentors share experiences that you have in common because mentors are insiders. On the other hand, coaches are selected because they are outsiders and can identify gaps in leadership development, strengthen and refine skills, and hold you accountable for improvement. There is a role for CEO coaches as well as coaches for the entire leadership team. Investing in the leadership skills at a rural hospital will consistently improve the expertise of these crucial individuals. Realizing that executives have many demands and should not expect all needs to be met by one and only one mentor, organizations should encourage and sponsor their leaders in approaching and compensating sources of expertise. A professional executive coach can help in transitions to new leadership roles, while

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<sup>43</sup> Castling Partners. (2019). <https://elliott-zismer-2cj0.squarespace.com/daniel-k-zismer>

an extended network of colleagues can provide social support and stress relief. While there is great value in a rural hospital financially supporting formal coaching, limited finances need not restrict a new CEO or an aspiring leader from seeking assistance from the broad group of individuals willing to lend a hand without a fee. Developing a supportive community of peers can help with accountability, defining and celebrating successes, commiserating with and developing strategies to overcome struggles, and often yields invaluable mentorship opportunities. Everyday healthcare is a collaborative endeavor, and the same goes for leading healthcare organizations. Empowering leaders in creating networks of support and developing best practices will help individual institutions and the field as a whole.

### **Dynamic Engagement**

There are many definitions of a dynamic leader. Some define it as a person who sees problems and obstacles as invitations to grow or a person marked by usually productive activity. Certainly, in an arena characterized by continuous change, dynamic leadership is a positive characteristic.

Some leaders shine when engaging with their community. CEO Terry Scoggin of TRMC and his leadership team were the calm, competent voices in Mount Pleasant during the COVID-19 pandemic. Scoggin hosted weekly updates on Facebook to keep his community updated on best practices and steps the hospital was taking to keep everyone healthy and safe. At the beginning of COVID, Scoggin was not comfortable with marketing such as Facebook Live, but his marketing team, in conjunction with his leadership team, prepped and coached him to become the face of his organization. Getting out in front of the public and asking locally known and respected providers to explain emerging updates on COVID helped establish the TRMC team as the experts on COVID and key sources of information within the community. When information rapidly changed during the early pandemic, TRMC had a consistent and transparent presence that brought comfort to Mount Pleasant and the surrounding catchment area. They repositioned themselves as the leader of health information, which helped in the short term and will continue enabling TRMC to impact other populations such as people with chronic diseases like hypertension and diabetes. The TRMC team stepped up and provided high-quality care for all, both the insured and the large number of uninsured residents in the area. As stated earlier, the TRMC website says, "While Mount Pleasant is located right-off I-30 and an easy drive to the Dallas-Fort Metroplex, Shreveport, and Little Rock, there's no reason to leave this community."<sup>44</sup> They proved it during the tough days of the pandemic and are still proving it to be true.

As the pandemic progressed and Mount Pleasant became a COVID hotspot, TRMC was featured in a national news video feature to highlight the challenges being

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<sup>44</sup> Mount Pleasant Texas. (2021). <https://www.mpcity.net/>

faced by rural institutions.<sup>45</sup> The video on *Matter of Fact TV* was titled “Rural Hospitals on Life Support during the pandemic,” which, while sounding dire with a portrayal of TRMC being pushed to the limits, also highlighted to the community how TRMC was still able to provide excellent, quality care during times of crisis. Often these types of conversations are difficult; no patient wants their hospital to be in crisis. However, ensuring that the public knew the challenges but, more importantly, the dedication and resilience of the organization and staff allowed for clear community dialogue. More than that, Titus gives some credit to this national news spotlight for helping the facility obtain greater supplies of Remdesivir to treat their COVID patients (then thought to be a critically important treatment).

If dynamic leadership brings new ideas to help with changing times, then the TRMC leadership team exemplified this method with the COVID huddles implemented during the pandemic. The huddles consisted of a group of admitting physicians, ED providers, house supervisors, and administrators on call. All admissions to the COVID unit were run past the huddle group to determine if they were appropriate to admit to the COVID unit or if the patient should be sent to a higher level of ICU care from the emergency room. Discussing and outlining contingency plans allowed the team to be more agile and adapt faster to changing patient conditions. TeamSTEPPS data shows that as teams improve their communication and teamwork skills, there is an increase in adaptability and improved patient outcomes. Mount Pleasant was an early hotspot in Texas due to a meat processing plant, but even though they had hundreds of cases in the COVID unit, they lost very few patients. They had one of the lowest mortality rates in the state. While they were taking charge of the COVID narrative with consistent education and transparency, TRMC shared their outcomes. In the context of a COVID hotspot status, the low mortality rate emphasized what they had been saying, come here to TRMC because we will provide better care. Instead of being crushed by the additional strain of the pandemic, COVID allowed TRMC to accelerate staffing changes as input from the staff via these huddles created a sense of safety, ownership, and quality patient care. The huddle process was such a success that they will repurpose the group for post-pandemic situations.

Others define dynamic leadership as the ability to adjust in order to reach the people they are leading. Darrold Bertsch, the CEO at Sakakawea Medical Center and Coal Country Community Medical Center, has aspired to be such a leader. During his tenure as CEO, Bertsch, along with the respective Boards, aligned the CAH and the FQHC around the common purpose of providing quality patient care locally in his role as sole CEO of both institutions. He helped redirect their focus from a stance of competition to this unified goal. Before operating under a combined CEO, the hospital and FQHC competed for patients, market share, and

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<sup>45</sup> O’Brien, Soledad. (n.d.). *Rural Hospitals*. <https://matteroffact.tv/rural-hospitals-on-life-support-during-the-pandemic/>

workforce in a service area of 15,000 people. According to Bertsch, adjusting his coaching style to provide the needed leadership that brought both facilities together required humility, patience, and, most importantly, listening to both sets of stakeholders. Overemphasizing the importance of patience and communication skills is impossible. Both are essential in allowing a leader to transition from being a trailblazer to a quiet voice mediating a heated conversation. We have noted that rural healthcare leaders often are forced into multiple roles; relatedly, they are often forced to interact in different ways with different stakeholders. In recognition of his skill and its impact on healthcare, Darrold Bertsch was named one of Becker's Healthcare 60 rural hospital CEOs to know in 2020.

Part of what makes these organizations Bright Spots was constantly shining a light for others to see. In November of 2020, as the pandemic was at its height, TRMC held its first drive-thru flu vaccination clinic. Residents could stay in their vehicles and receive a flu shot, COVID screen, routine bloodwork, and blood pressure check. For many, this was the first time medical providers had screened them since the previous March. Two participants were even taken to the emergency room with hypertensive emergencies that may have gone unnoticed until they had progressed further. TRMC shared details on planning this event during a call with other critical access hospitals leading Henderson Health Care Services in Nebraska to replicate the event. Within a week, TRMC was fielding phone calls from hospitals across Texas and Oklahoma who wanted details on organizing their own drive-thru health fair. This case exemplifies how rural organizations can learn from the best practices of others and how disseminating information can only help healthcare across the country.

### **Leadership Planning**

Leaders are essential to establish workplace culture as well as clinical and operational initiatives. In time, all leaders will change. Succession planning is necessary for an organization to survive the departure of a leader, especially if that leader was the one who initiated a great change.

According to Suzanne Cooner, CEO of Audubon, developing post-leadership succession planning strategies is critical for rural hospitals. By affiliating with a larger organization, Audubon could negotiate an agreement to effectively mitigate an event that is potentially catastrophic for many organizations if there was a sudden and unplanned departure of the CEO. Preventing a leadership vacuum and allowing the board to be confident that the long-term goals of the strategic vision will be achieved during a transition period is critical to maintaining continuity of vision, maintaining staff morale, and handling upcoming challenges effectively. A succession plan also helps prioritize development opportunities for future leaders allowing boards to allocate these resources to the greatest benefit.

Another example of this foresight is in North Dakota. At Sakakawea Medical Center and Coal Country Community Health Center, the Board of Directors used their recruitment committee to immediately search for a CEO when Darrold Bertsch announced his retirement. Bertsch's dynamic leadership strengthened both organizations, and both wanted to continue sharing efficiencies and collaborating beyond his tenure as CEO. Both the hospital and FQHC also wanted several months of overlap between Bertsch and the new CEO, Brian Williams, to facilitate a seamless handoff between tenures. This transition period was especially important for both learning and feeling comfortable moving forward with a single vision and for staff to feel secure meeting their new CEO. While it may not be possible for all facilities to have a CEO in waiting as the Iowa hospital collaboration does, all organizations need to have a succession plan for key leadership positions.

Kearny County also intentionally planned a leadership transition. The CEO at the time of writing, David Hofmeister, interned with Benjamin Anderson at Kearny County Hospital 11 months before the Board selected him as CEO. Hofmeister came from an academic background where he had been a Dean leading a medium-size organization. They had a working relationship before David moving to KCH. He met Benjamin in 2015 while partnering on rural health projects and eventually hired on with KCH as Operations Officer. Hofmeister's time in academia provided him with various faculty connections to aid in coaching his leadership team. Hofmeister's choice of coach may seem unusual because he has a community marriage counselor working with his leadership team, but it made sense for him. Marriage counselors are used to working in low trust environments and helping people understand how to meet people where they are and useful skills in a pandemic like stress management. Hofmeister is an example of the expertise in higher education that can be potentially leveraged for qualified partners at a very reasonable cost, along with being a reminder to look for diverse community members for advice.

Hill Country Memorial has a formal succession plan for all senior leadership and other key positions. They adapted a succession approach from a 2010 Baldrige recipient, an excellent example of a Bright Spot learning from other higher-performing organizations. Like SCF, the hospital developed a career progression plan that aligns with individual employee plans, organizational capability, and facility capacity plans to supplement the succession plan. Internal promotions are tracked with a goal to ensure a balance of leadership developed from within and to bring external knowledge and experience into HCM. As Jayne Pope says, "the people keep the culture going," so both a succession plan and an internal development scheme are necessary for the hospital's continuity.

Now more leadership programs exist. One funder of this project, the Robert Wood Johnson Foundation, has partnered with Rural Development Initiatives to develop a

rural leadership network.<sup>46</sup> Another example of intentional leadership planning is the Veterans Administration Medical Centers, which are large enough to support succession planning structures. Associate Directors, who are the Chief Operating Officers and undergo formal training in this career trajectory, observe acting Directors and gain experience by acting as interim Acting Director when the need arises. They have the depth on the leadership team to have this process in place. Most rural hospitals must find creative ways to transition and train the next hospital leader. Different instruments are available for free or low cost to determine an individual's emotional intelligence and leadership style. 360-type evaluations help to showcase natural strengths as well as opportunities for improvement. All this information is useful to new leaders as they build their skills. A coach can help give a new leader the full picture and offer insight into blind spots possessed by all. Coaching is also valuable in learning to manage both clinical and non-clinical staff. Additionally, the American College of Healthcare Executives (ACHE) has an annual conference that typically offers CEO boot camps.<sup>47</sup> While ACHE is a membership organization, these boot camps are a short option that may be more obtainable than a master's program or formal coaching. ACHE offers online training to help leaders understand their role as CEO. ACHE chapters are ubiquitous across the country and can be utilized to create a network of other CEOs in a general area. Some CEOs have also found success in searching out retired hospital CEOs in their area; the Bright Spots leaders have generally noted this group as a ready and willing source of wisdom and mentorship.

## **Board Leadership**

Often among the most consequential leaders in a rural healthcare organization are the sitting board members. Board members decide a range of critical issues and strategies; to do so properly requires not only a willing board but one well versed in reimbursement rules, service line viability, rural health policy, as well as their own hospital and community tacit knowledge.<sup>48</sup> They also must work effectively to guide their hospital through the difficult landscape of rural healthcare today.

A seminal work on board leadership argues that an effective board uses three modes of governance to steer an organization. First, a board has a fiduciary responsibility for the legally required operations and expected in terms of oversight, compliance, and stewardship.<sup>49</sup> A common way of approaching this responsibility is asking the question – what is wrong at our facility. Second, a board has a set of strategic responsibilities to guide management and make recommendations regarding

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<sup>46</sup> Rural Development Initiatives. (2021). *Building Rural Communities through Leadership Development*. <https://rdiinc.org/ld-programs/>

<sup>47</sup> American College of Health Care Executives. (2021). *Our Story*. <https://www.ache.org/about-ache/our-story>

<sup>48</sup> AHA Trustee Services. (2021). *How Rural Trustees Can Meet Health Care Changes*. <https://trustees.aha.org/articles/1026-how-rural-trustees-can-meet-health-care-changes>

<sup>49</sup> Chait, Richard P., Ryan, William P., and Taylor, Barbara E. (2005). *Governance as Leadership: Reframing the work of Nonprofit Boards*. Hoboken, NJ: Wiley.

decisions about the direction of large amounts of resources, services, and programs. A board trying to meet this responsibility will ask what the plan is and understand the larger goals of the hospital and how to shape goals for the future. The third and often most challenging area of responsibility is generative. This domain engages board members in a deep inquiry asking the questions to determine root causes, generating operational alternatives, and coming up with new directions. A board engaging with these responsibilities must determine what questions need to be asked.

For various reasons, rural organizations are often challenged in maintaining boards that meet all these requirements. Due to inertia, ignorance of the full scope of responsibilities, or even lack of engagement, some organizations go for years with boards that only rubberstamp decisions and attend two meetings a year. Unfortunately, the ever-leaner landscape of rural healthcare does not leave boards that luxury any longer; boards must dynamically evolve with the changing times or be a contributor to hospital closure.

One example of an organization that rose to this challenge is Trinity Memorial Hospital District. Before losing its management contract, the board only acted in the fiduciary mode, as is often the case with hospital boards. Once the management company left, they had to shift to a strategic mode as well as a fiduciary mode. Now, they are also operating in the generative mode as they work with their community and external partners to launch a Health Resource Center.

Trinity learned the hard way how essential education is to the viability of a rural hospital. After the hospital closed, the Trinity Board was forced to recognize a gap in their knowledge. Onboarding events are also crucial for a hospital's Board of Directors or Trustees. Community members serve on these boards and are not employees of the hospital. An onboarding education should cover a board member's defined role, the scope of power, expectations of membership, and basic training on the challenges of rural healthcare. Much like the Southcentral Foundation workforce development training, continuing education for board members is an investment worth making. Trinity has found excellent support from external organizations like the Texas Organization of Rural & Community Hospitals and the Texas State Office of Rural Health. True to the common theme seen in these Bright Spots, the Trinity Board is open to new resources and is actively looking for connections to help on their self-improvement journey.

Acknowledging past mistakes, the Trinity Board admits some degree of laziness and misplaced trust with their previous management company. Instead of being actively involved in the hospital's strategic and operational decisions, the Board had handed off responsibility to a company with divergent interests. The Board was not aware of the problems because the management company, as a large system, solely reported averages but avoided specific data about Trinity, which hid the hospital's financial challenges. After the departure of the management company, the Board

learned from discussions with their auditors how to make their data actionable. The Board has stated that the most useful lessons they learned centered on what to ask for and how to display data and analyze data. The Board learned how to build better contracts which they employed when they contracted with Health Point for their Federally Qualified Health Center (FQHC). They learned that delayed reporting allowed the prior management company to hide trends leading the board to now meet monthly with the FQHC CEO. These lessons were hard-won, and now that board members are experienced having served long terms, Trinity benefits from their collective knowledge of lessons learned. Continuity rather than turnover is a key factor in retaining knowledge. However, like filling leadership positions, having an infusion of new members also brings new perspectives, new visions, new energy and can help defend against inertia. The lessons of Trinity can be summed up as:

1. Be able to tap into the resource of your community. Marrying the culture of a town to the strategic alignment of healthcare access is critical.
2. Identify the needs and wants of the community. This identification will involve discussion and compromise between what they want, what they need, and what they can support. Urgent Care could take care of about 85% of healthcare needs in Trinity County but would not be able to care for heart attacks, strokes, and trauma properly.
3. One rural town is not the same as another. Trinity is fortunate because of its relative proximity to Houston and the amount of investment moving into the area. Leveraging what makes a community unique is vital for an organization.
4. Search out experts. Trinity board members paid to have work done; they asked for experts to assess, spell out options, and help them learn.



## Optimizing Cultural Transformation

The culture of a healthcare organization defines it and sets it apart from other organizations. While a strict definition of organizational culture is impractical, we take the pragmatic view of many healthcare practitioners that culture is simply how things are done at a hospital or organization. Cultures can run the gamut from well-developed values that permeate the institutions with established practices and norms to new groups with ill-defined roles and responsibilities with gray areas where the underlying philosophies and values have not been defined. Many healthcare organizations are rigidly structured around certain defining operating principles; the best ones have defined a value proposition that underlies the policy structure. Often though, organizations fall short of their operational goals. This section considers organizations that overcame entrenched cultures to assemble new organizations centered on patient safety, care quality, and service.

A famous truism of business goes, “culture eats strategy for breakfast.” Meaning no matter how beneficial a new improvement strategy is, if it is unaligned with organizational culture, that strategy is doomed to failure. That does not mean that a hospital or system should not pursue a particular strategy but rather that an institution should know and understand its cultural parameters and redefine those parameters if they do not help move the organization in the desired direction.

Instead of providing a how-to-manual or “quick and easy” steps for optimizing culture, our goal is to detail the ways organizations have changed for the better. This broader view requires more thought and care in implementation, but organizational culture should be approached with thought and care. This section also takes a view of the necessity for *transformation in healthcare organizations*, which comes from the need to improve how healthcare is provided continuously. A useful analogy for the difference between changing and transforming is a butterfly. The metamorphosis of a butterfly is a transformation fundamentally altering the structure of the caterpillar. A butterfly is no better than a caterpillar but may be better to function given new challenges. In much the same way, healthcare organizations can and must fundamentally alter their makeup to transform as the healthcare industry changes.

Four of the eight featured Bright Spots reached a cultural turning point. This was when healthcare leadership determined that the way things were being done was not good enough to solve the imminent challenges. Many who reach this point decide to make changes that allow their culture to better address problems or promote new solutions. This section features cultural transformations when leaders forged an entirely new path for their organizations.

## **Nuka System of Care Transformation**

Nuka is the name given to the system of care that Southcentral Foundation has designed and deployed. Nuka is an Alaska Native word that means strong, giant structures and living things. Don Berwick, the Institute for Healthcare Improvement founder, said, “I think it’s (SCF) the leading example of healthcare redesign in the nation, maybe the world.<sup>50</sup>” Berwick has spoken numerous times and written about the cultural transformation of Southcentral Foundation. Much of Southcentral Foundation’s redesign has been described as a transformation in terms of the principles of Native self-determination. Before completely restructuring the care delivery organization, patients entered the healthcare system through the emergency room as is typical in many rural institutions resulting in long waits and disorganized care inherent in using the ER as a place of primary care. The hesitation to come to the hospital was rooted in years of mismanagement by the federal government leading to distrust by the community. Restructuring required a complete overhaul of the principles underlying the system. Southcentral Foundation’s vision is a “Native Community that enjoys physical, mental, emotional, and spiritual wellness.” Their mission is “Working together with the Native Community to achieve wellness through health and related services.”<sup>51</sup>

To foster buy-in of these principles, SCF requires Core Concepts training for all new employees. This training is much more than the typical HR onboarding training package where new employees might just sit in a room and click through mandatory PowerPoints. The Core Concepts training is a live engaged series of presentations and reflections and a very active set of activities. SCF leadership is present for each training and is actively involved in the entire duration of the three-day event. This level of engagement sets the tone that leadership believes in the culture, which is indeed the Nuka way. The Core Concepts course is essentially a communication workshop for all employees where they learn how to respectfully interact with customer-owners, co-workers, and leadership while also substantiating a common set of workplace values. Prominent in the training are Learning Circles. These circles are opportunities to connect and build relationships by sharing stories and listening to others. Learning Circles are also utilized to provide peer support for various physical, mental, emotional, and wellness subjects. The expectation is set that SCF employees utilize communication skills to excel in their relationship-based system of care. Core Concepts establishes open avenues of dialogue with leadership, and an open-door policy maintains effective information exchange.

The SCF cultural transformation was driven by listening to their customer-owner population. The people they serve wanted respectful and culturally appropriate healthcare without extended wait times. SCF found rapid success in promoting

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<sup>50</sup> Southcentral Foundation. (2017). *Progress Report*. [https://www.southcentralfoundation.com/wp-content/uploads/2017/01/Progress-Report\\_2016.pdf](https://www.southcentralfoundation.com/wp-content/uploads/2017/01/Progress-Report_2016.pdf)

<sup>51</sup> Southcentral Foundation. (2021). *History*. <https://www.southcentralfoundation.com/about-us/history-2/>

access to care by creating a primary care medical home with integrated care teams and empaneled patients, which have become the bedrock organization of SCF. Each interdisciplinary team has a primary care provider, nurse case manager, certified medical assistant, and case manager support. Other providers, such as pharmacists, dietitians, and behavioral health providers, can be added to the care team as they are needed. SCF found that nearly 50% of all primary care encounters have some behavioral health component, so it became essential to address all aspects of health during a visit. The team approach means that patients can be seen and helped but do not necessarily need to see the primary care provider. Patients are triaged to the most appropriate team members to meet their needs and see multiple team members during a visit. Empaneling ensures continuity of care and builds the relationship between the care team and the patient. At SCF, empaneling means about 1,100 patients/team and an open line of access to the team. Customer-owners in remote villages are also empaneled to a primary care team in Anchorage. A provider assigned to a particular village will visit a few times a year and is also available to connect via telehealth. If a patient needs to come to Anchorage to utilize the hospital, they are routed to their team members located in Anchorage, preserving the relationship and ensuring continuity of care, creating a braided stream. There are different paths, but the water is still going in the same direction, so there is leeway in how to work as a team.

The respectful and culturally appropriate care came about by changing the mindset from a paternalistic model of care into a relationship-centered partnership. SCF did away with white coats and made the U.S. Public Health Service Commissioned Corps uniforms optional for employees from the Indian Health Service. Outside of SCF, many primary care physicians divide their time between patient care, research, and working with medical students and residents to train the next generation of care providers. While research and teaching are worthy endeavors, they can interfere with a physician's ability to be available for patient care. SCF has its providers spending 100% of their effort in clinics or hospitals. This practice helps decrease waiting times, preserves the relationship with their empaneled patients, and allows for unique levels of access to care providers. With providers working to serve their community, customer-owners receive excellent care. Nuka reports 97% customer-owner satisfaction, 95% employee satisfaction and scoring between the 75-90<sup>th</sup> percentile in many HEDIS measures.

SCF created a relationship-building culture and now recruits providers who believe the same way. They have not had to use locums in years because they have excellent retention of providers, and they can build relationships with patients and the team, which all contribute to better communication. Better communication helps achieve the Nuka vision: a Native Community that enjoys physical, mental, emotional, and spiritual wellness.

SCF changed its recruitment process to see if an employee would like to live in Alaska and pivoted to focus on the Alaskan lifestyle. They invited the entire family to come for the interview to show how Alaska could be a good fit. SCF utilizes behavioral-based interviews to connect to workplace competencies and has found that doing so facilitates selecting the right individuals. Team-based interviews set the expectation that SCF has a distinct culture, and so the culture is integral to every part of the recruitment and retention process. SCF has a robust hiring process that requires time. The downside of this lengthy process is that hiring can be slow, but the benefit is that there is a good match with employees. The data show a lower turnover rate than the industry average, which supports the effectiveness of the process.

SCF also has an improvement culture, as evidenced by winning two Malcolm Baldrige National Quality awards. Southcentral Foundation is one of eight organizations that have achieved this double honor and is the only healthcare organization to have done so. “Hospitals that use the Baldrige process exhibit significantly higher rates of improvement in balanced organizational performance than non-Baldrige hospitals. Baldrige award hospitals are significantly more likely than their peers to win a Top 100 Hospitals national award and significantly more likely to display faster 5-year performance improvement.”<sup>52</sup>

The Nuka transformation is not easy. Stating an underlying philosophy of meeting patient needs while raising patient satisfaction requires the constant engagement of leadership, the inclusion of key stakeholders, and multiple iterations of change moving in the direction of the stated goals. Where there is no employee buy-in, sites will continuously have a tug-of-war regarding what is driving the process. Where there are competing requirements such as clinics involved in teaching learners, full access scheduling can appear nearly impossible. If the community, the Nuka equivalent of consumer-owners, does not value the new cultural underpinnings, transformation is unlikely. The extraordinary success of SCF’s Nuka transformation shows the importance of positive cultural change. Between the years 2007-2019, Nuka tracked 4,235 site visit requests worldwide from people eager to learn more. They are an international bright spot.

### **Hill Country Memorial’s Always Culture**

Hill Country Memorial’s (HCM) reputation has become synonymous with exceptional quality, procedural integrity, and patient satisfaction. This reputation is largely due to their Always culture, which means Always improving and evolving towards something better. The Always Culture aligns its Vision, Mission, and Strategic Plan to the IHI Triple Aim to ensure that the highest quality care can be delivered in the most cost-effective manner. HCM differentiates itself from other

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<sup>52</sup> Foster, David A. (2011). Comparison of Baldrige Award Applicants and Recipients with Peer Hospitals on a National Balanced Scorecard. <https://www.nist.gov/system/files/documents/baldrige/baldrige-hospital-research-paper.pdf>. Accessed June 8, 2020.

hospitals by leveraging its core values in every decision. Their Always culture makes the difference in remarkable patient outcomes, service, workforce engagement and satisfaction that contribute to positive long-term financial performance. The alignment diagram below shows how HCM captures stakeholder input, executes its mission by living its values, achieves strategic goals and uses coaching plans to ensure alignment at all workforce levels with organizational strategic direction.



Figure 4: Hill Country Memorial’s Always Culture Alignment<sup>53</sup>

The CEO who continued and helped deepen the transformation of HCM, Jayne Pope, would be the first to say that the transformation was not easy and required great dedication and buy-in from the HCM team, more akin to a marathon than a sprint for higher quality.<sup>54</sup> You cannot make an omelet without breaking eggs. HCM and SCF lost staff resistant to large-scale organizational change, but those who stayed have created a better system. It is such a paradigm shift from the practice of rural hospitals making difficult employment decisions because of the significant challenges associated with recruitment. HCM was committed to its vision of change and accepted the loss of some staff and even providers. HCM facilitated workforce buy-in by conducting listening sessions. These sessions allowed all staff to provide input and be engaged. There is a link between an engaged workforce and an engaged patient. HCM is committed to equipping each team member with what is needed to deliver Remarkable. Pope says Remarkable is measurable and defines it as being in the top decile, so she will be the first to acknowledge that she pushes

<sup>53</sup> Hill Country Memorial Award Application. Baldrige Foundation. [https://www.nist.gov/system/files/documents/2017/10/11/2014\\_Hill\\_Country\\_Memorial\\_Award\\_Application\\_Summary.pdf](https://www.nist.gov/system/files/documents/2017/10/11/2014_Hill_Country_Memorial_Award_Application_Summary.pdf). Accessed June 8, 2020.

<sup>54</sup> Pope, Jayne, E., Padula, Emily, and Wallace-Dooley, Debbye. (2015). Improving Ourselves for the Sake of Others: Our Baldrige Journey. *Frontiers in Health Service Management*, 32(1), 3-16. <https://pubmed.ncbi.nlm.nih.gov/26492731/>

the team hard. A values screening is done as part of the hiring process to align new hires with the Always Culture. It is important that the entire workforce feel ownership in the culture that defines Hill Country Memorial as empowered to make necessary changes rather than just renting a spot on the organizational chart to collect a paycheck.<sup>55</sup> Vision, mission, and values are communicated to the entire HCM team. Storytelling is used to connect to the heart and build relationships, while skill-building is utilized to integrate processes with culture. All leaders demonstrate a commitment to the culture by role modeling expected behaviors and aligning decisions with values.

HCM's cultural transformation came from a back-to-basics approach centered on improving quality and a stringent application of the Baldrige award core values and concepts.<sup>56</sup> Pope is emphatic to say this approach is not a "one-size-fits-all," but as we have seen, no part of rural health falls under that moniker. However, examining why and how HCM has leveraged these concepts can help elucidate how other organizations may change their practices.

Two questions are important to answer to understand HCM's quality: first is the concepts HCM finds essential to operating efficiently and how these concepts map to their everyday practices. HCM has followed two primary approaches to quality excellence – strategic breakthrough initiatives (SBI) and cascading goal process. SBIs are projects assigned to a team that will use a Plan-Do-Check-Act (PDCA) process to achieve a specific target within a short timeframe, usually three months. Each quarter, the leadership team reviews progress on strategic goals and assigns new SBI teams. Strategic goals are also integrated across HCM via the Cascading Goals process, whereby the strategy map for all of HCM is broken down into department goals and individual goals. The goals cascade down, but the progress feeds upwards so that team members can see how their daily work fits into the big picture of Hill Country Memorial. Progress is communicated quarterly via the individual Quarterly Coaching Plans and visible on Alignment boards posted in each department. The mapping of these two approaches is evident in the above Alignment of the Always culture diagram.

HCM is working on their 2022 Baldrige application. Each time HCM goes through the application steps, they identify gaps and make improvements. They also identify what is elevating and going well at HCM. There are seven categories/areas, known as the Baldrige Criteria for Performance Excellence.<sup>57</sup> HCM says the Baldrige application allows for reflection on their processes; it does not overlay their work or force any change; instead, it takes time to document areas of potential. The journey is worth the effort, and Jayne Pope encourages all hospitals to invest this

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<sup>55</sup> Tye, Joe and Schwab, Dick. (2009). *The Florence Prescription: From Accountability to Ownership: The Next Frontier for Patient Satisfaction, Workplace Productivity, and Employee Loyalty* (3<sup>rd</sup> ed.). Values Coach Inc.

<sup>56</sup> NIST. (2021). *Core Values and Concepts*. <https://www.nist.gov/baldrige/core-values-and-concepts>

<sup>57</sup> ASQ. (2021). *What is the Malcom Baldrige National Quality Award?* <https://asq.org/quality-resources/malcolm-baldrige-national-quality-award>

time because their hospital will be better for the experience. In her words, improving an organization is best done “by tackling one piece at a time, nobody eats an elephant in one bite.”

The COVID-19 pandemic had some silver linings for Hill Country Memorial. By driving home the necessity and value of adhering to their Baldrige excellence framework, the dire situation caused the staff of HCM to be relentless in their strategy of improvement. Kaizen events are a standard part of the HCM quality improvement framework and are traditionally done in person. Social distance requirements during the pandemic forced the Kaizen events to go online, where several unexpected efficiencies were realized. Post-COVID, a hybrid of virtual and in-person, may be the new normal. Changes that came about during COVID forced HCM to re-evaluate its communication effectiveness and strategies. They looked for ways to strengthen relationships, increase employee engagement, and maintain trust with their community, all while using a virtual presence. Another benefit was that so many educational opportunities were offered virtually and at a reduced cost. For an organization like HCM that invests in the education and development of its staff, these were advantageous opportunities.

### **Kearny Mission Culture**

The leadership team at Kearny County Hospital had a key takeaway while learning from the Value Institute at the University of Texas at Austin.<sup>58</sup> They had a six-question tool to drive their cultural transformation.

1. What ONE outcome do we wish to improve?
2. Who are our stakeholders?
3. Where are the opportunities to share?
4. Why isn't it already happening?
5. How will we measure success?
6. When do we expect to see progress?

The leadership team determined that they had a problem with maternal health and infant outcomes. The number of moms with gestational diabetes was 2x the national average which created risk for mom and long-term health impacts for the child. Kearny decided to focus on transforming maternal health in two ways. They wanted to recruit OB physicians to their rural hospital, and they wanted to amplify the system's focus on mom because if mom were well treated, she would recruit dad and all the children into primary care and wellness. The focus on wellness would help create a healthier community and allow the providers to develop a relationship with the entire family. Relationships speak to trust and quality of care. KCH saw a 60% increase in primary care paneled patients over five years!

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<sup>58</sup> Value Institute for Health and Care. (2021). *Transform Health Care*. <https://valueinstitute.utexas.edu/>

Benjamin Anderson, the past CEO of Kearny County Hospital, has a background in recruiting. He observed that physicians tend to come to rural areas for a few different reasons. Some people are looking for a rural/frontier lifestyle that is drastically different from the city, but they often did not stay because the reality of rural isolation does not match their idyllic dream. Then there are those who grew up rural and can land and thrive in a rural area. Anderson wanted to focus recruitment on those who would thrive. An added layer of complexity is the incredibly diverse population in rural Kansas. KCH serves more than 30 different nationalities. Many of these people are refugees looking to work in the meat packing industry. Anderson decided that of the thrive cohort, mission-minded was his target recruitment group. Physicians who serve internationally in marginalized countries are more willing to serve poor patients in rural America, where populations experiencing health disparities are like foreign countries. What does a mission-minded workforce look like? Dr. Drew Miller said it is when “from the top down, people are committed to serving each other and serving patients.”<sup>59</sup> To attract this type of physician, Kearny County Hospital is generous with vacation time so that the physicians can continue international missions, and KCH has benefitted from their recruitment success by eliminating the need to use locum tenens to staff the emergency room. These providers also like to work with like-minded, service-oriented staff. KCH has found that recruiting friends or more than one physician at a time helps maintain this culture.

KCH recommends developing a mission-focused culture within all organizations, administration, and boards before recruiting staff and providers. This establishes the culture and leadership commitment to this is how we do business at our hospital. A distinctive culture can be an invaluable recruiting tool. David Hofmeister, the current CEO at Kearny, says he has a small herd of unicorns, those incredibly rare but absolutely amazing team members. When asked how one would recruit a unicorn, Hofmeister said they find their way to Kearny on their own. An example that arose during the COVID pandemic is that the COVID team of physicians and mid-levels made the difficult decision that they would not deliver babies until the pandemic was over. Instead of initiating transfers and possibly damaging the relationships built over time, a non-COVID team stepped up and said they would continue to ensure quality births could happen at KCH. The mission mindset shines through, especially during hard times. However, while recruitment is eased by having a culture that calls people, it takes work and constant diligence to ensure that new staff is fully accepted into the established cultural framework.

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<sup>59</sup> Kozhimannil, Katy B., Henning-Smith, Carrie, Lahr, Megan, and Gilbertson, Mary. (2020). *Making it Work: Models of Success in Rural Maternity Care University of Minnesota Rural Health Research Center*. [https://rhrc.umn.edu/wp-content/uploads/2020/11/UMN-Models-of-Success\\_Case-Series\\_11.5.20.pdf](https://rhrc.umn.edu/wp-content/uploads/2020/11/UMN-Models-of-Success_Case-Series_11.5.20.pdf)



The cultural transformation at Kearny County hospital took about five years, from 2013 – 2018. The data that KCH have to show the transformation worked are that they expanded their primary care footprint by 18%, they received \$300,000 in grants which helped them expand OB services by 18% with the Pioneer Baby program, and they did all this expansion while decreasing their dependency on local tax revenues by 58%. KCH grew and is sustained by strategic service line expansion and a culture that appeals to at least one subset of “unicorns” to facilitate recruitment and retention of staff needed for this service line expansion.

### **Titus Wellness system culture**

Titus Regional Medical Center did not want to only come to mind when someone was sick, so they transformed into a system that exists to help individuals stay healthy. They changed the mentality of the hospital, its employees, and therefore the community as well. Titus employees refer to being in the system, and they mean a wellness system, not an ownership system. The change did not happen overnight, and even after five years, the leadership team feels there is still more to do to maintain this change in mindset. Additionally, the hospital leadership team sought mentorship and guidance from those who had already made such a transformation. There was also a significant effort put into communicating the idea to the community. Marketing is commonly used to inform people of new services, but it should also be utilized to engage the community in what a change means specifically for them. The concept of a wellness system is not the default assessment most people have when they see a hospital building. Titus embraced the opportunity to educate and build trust in the area and has emerged as a true regional leader in healthcare. The physicians at TRMC are respected in the community and act as wellness ambassadors. The physicians show faith and alignment with the leadership at Titus. A successful culture change takes the entire organization. The Board and hospital leaders need to be aligned so that the same message is communicated to all staff and indicates the complete buy-in by leadership. The established relationship as a wellness center allowed Titus to pivot during the COVID pandemic and respond rapidly to community needs. The community residents already saw their hospital as a place of wellness and trusted medical information, so they looked to the staff at Titus to keep them healthy and out of the hospital. During that last in-person townhall in 2020, a powerful indicator of unity was the recurrent expressions of “we are in this together.” It is unknown what the next assault on rural healthcare will be, but it is safe to say that everyone is stronger and safer if there is a relationship between the community and the hospital.

## Optimizing Data Utilization

One of the most consequential management thinkers of the 20<sup>th</sup> century, W. Edwards Deming, once said: “if you can’t measure it, you can’t manage it.”<sup>60</sup> To understand the efficacy of a process, all aspects of the process must be understood. Therefore, this chapter aims to convince reticent adopters on both the necessity and efficiency of data-driven decision-making and, second, to relay how these practices have been successful in rural settings. Typically, rural organizations cannot hope to match the amount of staffing available to larger health systems with established business intelligence teams. However, rural organizations cannot afford to ignore their data.

In terms of both its practice and management, healthcare has become a data-driven industry. The advent of evidence-based medicine fundamentally changed how medical practices were validated by integrating clinical knowledge and the best available clinical evidence. A similar evolution is happening in healthcare services management, with many larger healthcare organizations shown in movements towards centralized data warehouses. One estimate puts the future value of the healthcare analytics business at \$50 billion by 2024.<sup>61</sup> In line with Deming’s thoughts, data utilization and analysis can steer organizations to understand how to improve, grow, and overcome weaknesses.

Data drive many common organizational improvement strategies. Earlier in *Optimizing Cultural Transformation*, Hill County Memorial’s strategy for improvement was driven by insights generated from data. Another common approach is to perform a SWOT analysis. Standing for *strengths, weaknesses, opportunities, and threats*, this analysis harnesses data-driven techniques to develop organizational competencies. HCM has flipped this approach to TOWS to confront Threats first.

Benchmarking is among the most persistent challenges facing healthcare systems, constantly asking, “has what’s been implemented worked.” A seemingly simple question has consumed a large amount of effort by system leaders and healthcare providers. The crux of this section is how healthcare organizations can use data to understand the effectiveness of their practices and generate decision-making principles.

Working with rural organizations has deeply instilled a view in this research team that every organization can utilize their data for the better. At the beginning of 2020, ARCHI, in collaboration with the Texas Organization of Rural and

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<sup>60</sup> Orsini, Joyce Nilsson (Ed.) (2013). A System Must Be Managed. In *Essential Deming: Leadership Principles from the Father of Quality* (pp. 151-192). New York: McGraw-Hill Education.

<sup>61</sup> *Healthcare Analytics Market*. (2019). ResearchAndMarkets.com  
[https://www.researchandmarkets.com/research/zj49bn/global\\_healthcare?w=5](https://www.researchandmarkets.com/research/zj49bn/global_healthcare?w=5)

Community Hospitals, launched the DASH tool that allows for a central repository of financial and operational benchmarks to aggregate data among like rural hospitals. This benchmarking is done to both understand individual hospital performance and the performance of rural hospitals at large. It helps independent rural hospitals see how they are performing against peer hospitals to understand better which trends are market-driven versus those impacted by their direct actions. This type of benchmarking data is commonly provided to hospitals within a system but is difficult to acquire for independent entities outside a system.

### **Southcentral Foundation's Data Strategy**

In SCF's view, being data-driven is essential simply because procedural changes cannot be evaluated without understanding data. By relying on understanding the data, SCF has been able to show that their culture change has resulted in population health improvement. By benchmarking current vs. past performance, they have been able to see an improvement across multiple measures. Among others, SCF has noted a 44% decrease in ER visits in the five-years after its system transformation; a 63% decrease in hospital discharges during that same five-year period; HEDIS outcomes above the 75<sup>th</sup> percentile on many measures; reductions in employee turnover of 12-15%; 97% customer satisfaction; and 95% staff satisfaction. These measurements highlight the success of the cultural transformation and the utility of SCF data moving forward.

The effectiveness of these measures stems in large part from the ease with which customer-owners and staff can provide feedback. Kiosks and tablets are ubiquitous in care areas, so completing a survey is both quick and easy. Having survey data readily available and easily accessible for all stakeholders has resulted in more data and the identification of real-time process improvements. One clear example is performance improvement on the HEDIS measures. The results are tied to annual evaluations and performance reviews, motivating staff to perform highly and understand customer-owner feedback directly. Staff are empowered to improve: all staff has both online and offline tools to share the best ways to get things done so that those high-performing individuals can elevate others. More than that, data are not blinded on dashboards, so all staff can see all other staff's performance on these measures and communicate with each other on how to improve. This competition can be a powerful motivator and incentive for outstanding performance.

As part of their larger data initiative, SCF centralized all data measures in a single location dubbed the Data Mall and integrated data into workflows. The Data Mall is a homegrown system and started pulling data from the EMR as a backup option. They use the Baldrige approach: ADLI = Approach, Deployment, Learning, Integration. The data are run every week to get a snapshot of the results. A faster turnaround of data allows for faster responses. They have a crosswalk between HEDIS/GPRA/UDS (Healthcare Effectiveness Data and Information

Set/Government Performance and Results Act/Uniform Data System) and then work with data stewards to make sure they are reporting the right things to the right people. Data are only useful if it is in the hands of the correct people. SCF used data to prove that culture change worked. They originally had two groups, standard of care and the integrated team model. They contrasted patient outcomes after staff implemented the integrated team model to outcomes previous to the redesign. The comparative data confirmed that the new approach achieved better outcomes with less effort. If considering adopting an integrated team model, use SCF's data to prepare your leadership team for the change because when the transition happens, you will see a decrease in patient volumes with a corresponding decrease in collections, but overhead expenses will drop even faster, so your net revenue will increase. This is the same concept as what we see played out in brick-and-mortar malls vs. online Amazon and other shopping options. Drop overhead expenses, and you can offer more.

Every year leadership makes a performance development plan for all work groups aligned with SCF initiatives and is tied to corporate objectives and goals. This plan tells each employee how their effort supports the overall organization and is connected to the corporate goals. SCF may not have a Baldrige award every year, but leadership makes sure they are preparing to submit documentation towards this goal annually. They also do not have a five-year strategic plan because it is always evolving. Instead, they get a scorecard each quarter and can revisit the plan

### **Hill Country Memorial data transparency**

Hill Country Memorial optimizes data utilization to recruit, retain, increase patient volume, and maximize financial incentives for safety and quality. Decisions are data-driven and always in alignment with the vision, mission, and values.

HCM uses a disciplined structure to collect and share data. A copy of the strategy map, which includes the balanced score card, is available for the public on their website and can be viewed over the shoulder of CEO Jayne Pope if you are fortunate to have a Zoom session with her. This scorecard is presented to the hospital board as well as the entire organizational team. It allows them to look at key metrics and then take action. If things are going well, then people can be recognized for their achievements. Recognition approaches include True North Living our Values cards from senior leadership; annual award celebrations; public recognition via print and social media venues; and celebrations funded from department-level recognition budgets. If metrics are not going well, there is a drill down with a Kaizen event or a new strategic breakthrough initiative. The objectives are also subject to quality improvements. Recently, while discussing the harm index as a measure of health, the question was raised as to why they did not have a wellness index. So look for a wellness score to come soon that looks at the amount

of EAP (employee assistance program) utilization, FMLA, voluntary turnover, engagement survey results, and 401K contributions.



Figure 5: Hill Country Memorial Strategy Map from HCM Community Health Needs Plan<sup>62</sup>

The wellness index acknowledges a fact many employers overlook; lives do not stop when your employees cross your threshold. Success and happiness at home influence success and satisfaction at work. The wellness index is staff-driven, showing that key metrics can be a grassroots effort. Pope knows the strategy map has some hard to achieve benchmarks, but she will not lower the bar to score higher. She has a grocery store test. Her entire team should be able to hold their heads high while meeting neighbors at the grocery store. Having knowledge of HCM’s relentless pursuit of excellence equips them to be ambassadors in their own neighborhoods.

The data that HCM tracks for its scorecard are validated by sustained top-decile performance in Press Ganey results for inpatient, outpatient, emergency departments, and home health. Employee satisfaction scores and long-term retention speak to the impact of the scorecard’s people focus.

<sup>62</sup> Hill Country Memorial Hospital. (2019). *Implementation Plan*. <https://www.hillcountrymemorial.org/wp-content/uploads/2019/12/2019.CHNA-Gillespie-Blanco-Kendall-Counties-Hill-Country-Memorial-Implementation-Plan.pdf>

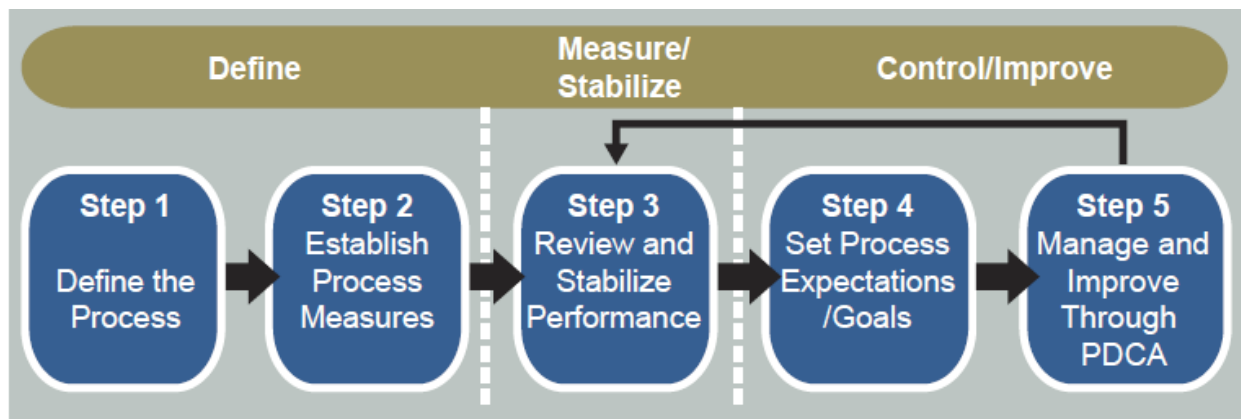


Figure 6: Hill Country Memorial Process-Based Map from HCM 2014 Baldrige Application <sup>63</sup>

### Titus's New Data Plan

Titus Regional Medical Center went live with EPIC EMR in November 2020 during another COVID surge. A relationship with Ochsner in Louisiana allowed TRMC to access the foundation of their medical record. EPIC will have the ability to create patient registries so TRMC can track quality measures and generate reports. The data tracking will enable them to participate more meaningfully in their ACO. It will also have a video embedded to facilitate telemedicine and track wearables that patients would wear at home and give providers a real-time sense of health status. Data = power. Part of the struggle with data is what to do with it. TRMC wants to harness its data to help with quality and safety reporting to advance its Quality Process. They follow the IHI (Institute for Healthcare Improvement) closely and consistently strive to improve their care to achieve those Healthier Tomorrows for the community. Big hospitals and hospital systems have people, even departments, who think about quality and how to measure it. Rural hospitals need to crack the code and figure out how to be better using HEDIS, Leapfrog Safety Grade, and CMS Star ratings. TRMC is also looking to formalize what they do and begin the journey towards a High Reliability Organization focusing on Zero Harm. Just as Pope from Hill County says, "it is about the journey and making it part of your culture, not the prize of the award."

<sup>63</sup> Hill Country Memorial. (2014). *Application for the 2014 Malcom Baldrige National Quality Award*. [https://www.nist.gov/system/files/documents/2017/10/11/2014\\_Hill\\_Country\\_Memorial\\_Award\\_Application\\_Summary.pdf](https://www.nist.gov/system/files/documents/2017/10/11/2014_Hill_Country_Memorial_Award_Application_Summary.pdf)

## Addressing Inequity

The United States' history of economic marginalization and systemic racism has resulted in racial and ethnic minority populations having poorer outcomes concerning premature death and preventable disease.<sup>64</sup> The Office of Minority Health within the U.S. Department of Health and Human Services (HHS) strives to improve racial and ethnic minority health and to reduce or eliminate racial and ethnic disparities in healthcare and health status on the federal level. The American Hospital Association partnered with the American College of Healthcare Executives and the National Association of Health Services executives to create the Institute for Diversity and Health Equity (IFDHE).<sup>65</sup> The vision of IFDHE is to empower health organizations to provide equitable care for all persons. Their mission is to advance healthcare equity, diversity, and inclusion, which is a challenging task during a time of rapidly increasing diversity. While not a formal part of IFDHE, two of our Bright Spots have risen to meet this challenge at the local level: Kearny County Hospital and Titus Regional Medical Center.

**Figure 2. Premature Death Rate within Racial/Ethnic Composition by Rural-Urban Majority Group<sup>1</sup>**

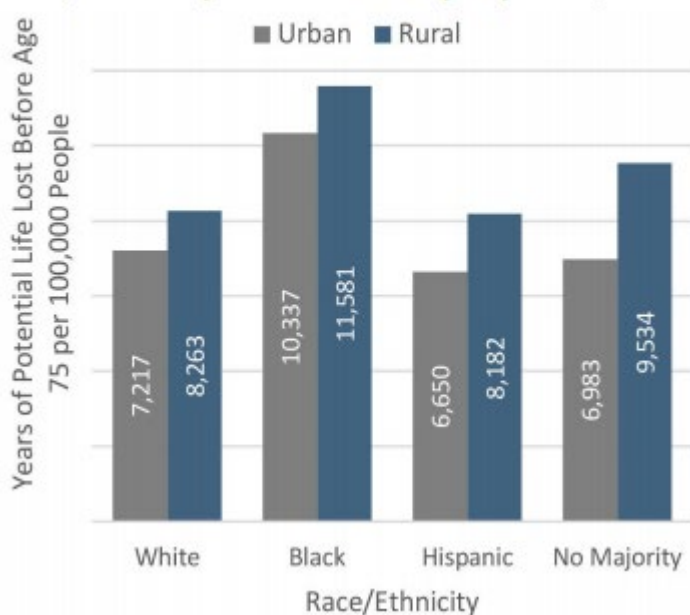


Figure 7: Differences in premature death rates between rural and urban racial and ethnic groups<sup>66</sup>

<sup>64</sup> U.S. Department of Health and Human Services. (2008). *A Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities*. Rockville, MD: Office of Minority Health. [https://minorityhealth.hhs.gov/Assets/PDF/Checked/OMH%20Framework%20Final\\_508Compliant.pdf](https://minorityhealth.hhs.gov/Assets/PDF/Checked/OMH%20Framework%20Final_508Compliant.pdf)

<sup>65</sup> IFDHE. (2021). *About Us*. <https://ifdhe.aha.org/about-institute>

<sup>66</sup> IFDHE. (2021). *About Us*. <https://ifdhe.aha.org/about-institute>

Both have seen their catchment area increase in minority immigrant populations largely due to large meat processing plants nearby; these growth numbers have not been reflected in the counties' official statistics because of the difficulty in counting mobile populations. The workforce of meat packing plants has historically been drawn from immigrants to the U.S. since the 1990s.<sup>67</sup> One Morton, Mississippi plant advertised in Miami's Cuban stores and newspapers to bus workers willing to accept lower wages, which was a tactic replicated across the South, according to University of North Carolina-Chapel Hill anthropologist Angela Stuesse. "This is part of the way this industry works, is by having these different communities they can lean into to keep costs down and keep the lines running," said Stuesse. Today, meatpacking has the fifth-highest concentration of refugee workers, according to the nonprofit Fiscal Policy Institute. So draws large groups of people to areas that face barriers to care like making wages near the federal poverty line, lacking robust health insurance, and speaking English as a second language.

Noting that it had often faced difficulty in the past properly engaging with this community, TRMC increased staffing to foster engagement. TRMC placed a patient navigator to work with the community's largest employer to promote primary and preventative care, often areas that are overlooked. In speaking with TRMC, they continuously expounded on their focus on wellness for all members of their service area. Being concerned about emergency room visits and putting resources into improving the outreach of primary care practice has been transformative for TRMC.

### **Health Disparities related to the COVID-19 Pandemic**

The consensus of research has pointed to the prominent inequity of the COVID pandemic on racial and ethnic minority populations, particularly Black, Hispanic, and Native American populations, as well as low-income populations. Two Bright Spots shone through as examples of organizations that addressed COVID with equity in mind. They both had the added complication of servicing areas with large-meat processing plants, which in addition to their normal challenges, were also early super spreader sites of COVID.

Kearny County Hospital reacted to the pandemic building upon previously created community partnerships. Among the largest employers in Kearny County is a beef plant. The plant employs many people who came as refugees without the cultural awareness of primary care in the United States. As of 2018, 13% of Kearny County residents were born outside of the United States. A few years ago, the beef processing plant's management realized that they had a workforce with poorly managed chronic disease conditions. While easily treatable, these chronic conditions required active engagement by both patient and provider, which due to

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<sup>67</sup> Groves, Stephen and Tareen, Sophia. (2020, May 26). Worker Shortage loom in Immigrant-Heavy Meatpacking. *ABCnews*. <https://abcnews.go.com/Health/wireStory/worker-shortage-concerns-loom-immigrant-heavy-meatpacking-70875927>



barriers to care, including costs, distance, and crucially language, were left largely untreated. In partnership with company leadership, Kearny County hospital created a chronic care management group that was able to engage with the 33 language groups in the area. They transitioned the mindset from one where one goes to a hospital when near death into having a wellness mindset where the employees can see how healthcare is their partner in wellness. Kearny County Hospital believes the success of this program has come from the comfort of being able to discuss health concerns with someone who speaks one's language.

During the pandemic, the beef plant struggled with two-week quarantine requirements for exposed workers. Management again reached out to KCH to lead testing efforts and determine the ability of workers to work. The success of the chronic care management group allowed everyone to feel comfortable talking with the hospital and trusting their advice. There were several notable employees at KCH whose work has been particularly helpful in these outreach endeavors. KCH has a grant writer with a social worker background. The grants help support the outreach to these population groups and work with emerging group leaders to connect them to resources and maintain trust with KCH. The goal is to change the mindset to one where it is known, it is possible to be healthy in rural Kansas, and Kearny County Hospital is the right partner. Erin Keeley, PA-C, completed a PA-OBGYN Fellowship and has a personal mission to help Somalians. Keeley lives in an apartment complex where many co-residents are from Somalia. During the pandemic, she was instrumental in getting accurate information about transmission and vaccination to this patient population. She made YouTube videos in different languages to help amplify her communication outreach. QR codes in the hospitals helped people recognize their language and easily navigate to their language video. See Erin's video series "It's a beautiful day in our neighborhood."<sup>68</sup>

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<sup>68</sup>It's a Beautiful Day in our Neighborhood.  
<https://www.youtube.com/channel/UC3R5HOv4ay7EiUZppUFNZcg/videos>

COVID-19 Vaccine Information language	Number of views as of 7/9/21
Rohingya	593
English	563
Spanish	526
Vietnamese	471
Burmese	450
Somali	363
Karen	285
Tigrinya	247
Arabic	184
Pleutdeutsch	159
Swahili	157
Oromo	92
Haitian Creole	79
Quiche	63

Table 1: Number of views for Kearny County Hospitals multilingual vaccine outreach YouTube channel

TRMC took a similar hands-on, honest approach to the pandemic. Due to its working relationship with area employers, the last in-person public meeting that the community of Mount Pleasant can remember from 2020 was a town hall meeting with Titus Regional Medical Center and the large, local employers. TRMC was able to position itself as a source of leadership and information during the pandemic. TRMC acknowledged the conflicting sources of information available about COVID and made the crucial decision to follow and disseminate CDC guidelines and to ensure the community followed. The TRMC leadership team became the trusted voice and source of information during the pandemic. TRMC organized townhalls on best practices and information. The early townhalls opened the lines of communication that served the community so well during the multiple surges of COVID outbreaks. By facing the challenging but natural transition of leading their community out of the pandemic and into the vaccination efforts, TRMC became an indispensable institution.

Titus Regional Medical Center remained calm in the middle of the storm. The medical center wanted to reach out to those populations who worked in the industrial sector in culturally appropriate ways to provide care. Always searching for a better way to do things and understanding the importance of communication to historically marginalized communities, the TRMC leadership team determined that they needed to become conversational in Spanish to better enact community outreach. This led the Titus leadership team to work with the University of North Texas for training and subject matter expertise in health messaging. By actively engaging with the community in a culturally appropriate way, the Titus team was able to communicate the risks of COVID-19 and proper risk mitigation procedures.

## **Optimizing Rural Maternity Care**

Rural healthcare is often harder due to the Balkanization of healthcare, with each specialty domain requiring specific, skilled expertise. Anecdotal evidence of this fragmentation can be found in obstetrics. Family physicians oversaw double the proportion of births in 1995 compared to 2004, indicating a move to a more specialized obstetrics workforce. However, rural areas are tremendously challenged in recruiting specialists who generally need a larger population to have adequate numbers of patients to support their practice. Hospitals desiring to continue to provide maternity care often must support more staff than the number of deliveries can financially support, an economic burden that is difficult to justify when financial viability is always in question.

Policy considerations and the inability to afford or retain skilled staff pose the greatest challenges to rural hospitals. The University of Minnesota's Rural Health Research Center provides an overview of the problem. They note that: "Many obstetric practice guidelines are not tailored to the needs and settings of rural hospitals, which may impact the adoption and effectiveness of such guidelines in improving maternal outcomes."

For these and other reasons, obstetrics care has been losing ground in rural areas. Fifty-two rural counties lost local, hospital-based obstetric services between 2014 and 2018. This closure trend was identified as early as 2004. While some rural clinics have stepped into the void to provide prenatal care, the loss of these hospitals means rural residents are more likely to give birth in an emergency room. Closure of OB units or entire hospitals exacerbates the higher infant and maternal mortality rates seen in rural communities.<sup>69</sup> This mortality risk is even more elevated for Black and Indigenous mothers. The March of Dimes Peristats website shows the infant mortality rate by race/ethnicity with options to search on state, county, or city level. Our Bright Spots are rural and do not have enough live births to have their statistics showcased. Due to the tyranny of small numbers, the small number of patients cared for at any given rural hospital; their data are captured in the state-level mortality data.

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<sup>69</sup> Kozhimannil, Kath B., Henning-Smith, Carrie, Lahr, Megan, and Gilbertson, Mary. (2020). *Making it Work: Models of Success in Rural Maternity Care*. [https://rhrc.umn.edu/wp-content/uploads/2020/11/UMN-Models-of-Success\\_Case-Series\\_11.5.20.pdf](https://rhrc.umn.edu/wp-content/uploads/2020/11/UMN-Models-of-Success_Case-Series_11.5.20.pdf)

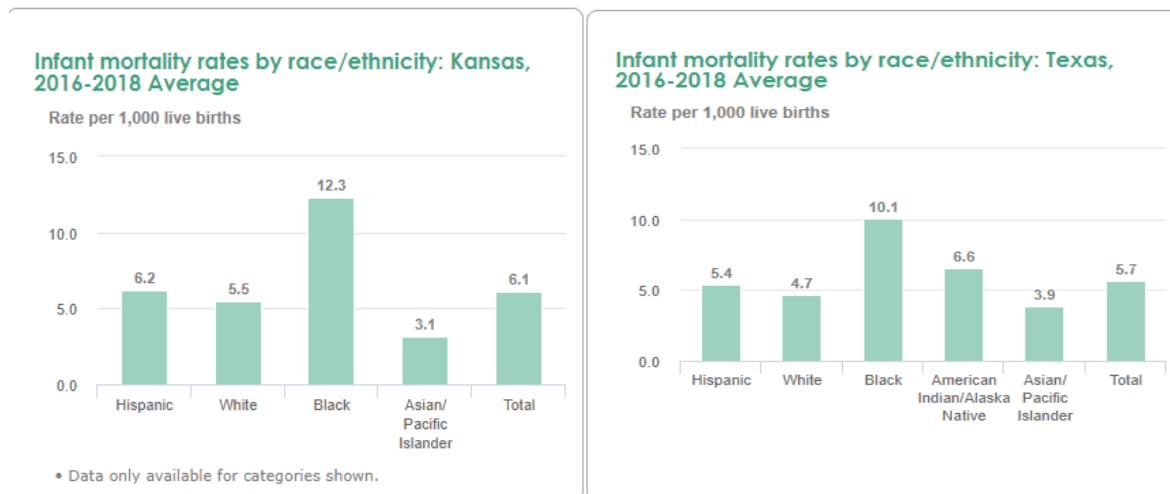


Figure 8: Difference in infant mortality rates by racial and ethnic categories in Kansas and Texas (from the March of Dimes<sup>70</sup>)

How did Kearny County Hospital defy the national trend of OB closures? The leadership team credits their mission-based recruitment and retention culture shift. Benjamin Anderson reports that people drive from long distances because they have heard of how well ALL people are treated and the quality outcomes. Dr. Drew Miller was quoted by the University of Minnesota November 2020 Case Series as saying that “people from 11 counties come to Kearny for OB care.” The mission focus extends beyond recruitment efforts and into a multicultural approach to birthing preferences via care coordinators and nurse educators. On average, one baby is delivered per day at KCH, and the obstetrics volume has increased by 67%.<sup>71</sup>

Like the nation, Texas has seen a loss of obstetric services in rural areas. Texas, the state with the most rural hospital closures, received a “D” on the March of Dimes 2020 report card reflecting a high preterm birth rate and high infant mortality rate.<sup>72</sup> The leadership of Columbus Community Hospital knew that they needed to maintain a birthing center for the health of their community. Many hospitals in Texas have closed their OB units out of financial considerations as well as declining patient utilization of these services. Columbus has a financially viable OB service because it is an essential part of the hospital service line. A happy and healthy birth can recruit the entire family to utilize the hospital for care. To ensure healthy births, Columbus participates in a rigorous obstetrics peer-review process. They look at

<sup>70</sup> March of Dimes. (2021). *Infant Mortality Rates by Race/Ethnicity: Kansas 2016-2018 Average*. <https://www.marchofdimes.org/Peristats/ViewSubtopic.aspx?reg=20&top=6&stop=92&lev=1&slev=4&obj=1>

<sup>71</sup> Rural Health Information Hub. (2021). *Kearny County Hospital's Physician Recruitment Model*. <https://www.ruralhealthinfo.org/project-examples/890>

<sup>72</sup> March of Dimes. (2020). *2020 March of Dimes Report Card*. [https://www.marchofdimes.org/materials/MOD2020\\_REPORT\\_CARD\\_and\\_POLICY\\_ACTIONS\\_BOOKLET\\_FINAL.pdf](https://www.marchofdimes.org/materials/MOD2020_REPORT_CARD_and_POLICY_ACTIONS_BOOKLET_FINAL.pdf)

such quality measures as postpartum hemorrhage, unattended deliveries, cesarean section rate, and fetal monitoring readings. They want to ensure that standards of care are met and/or exceeded and learn how to do things better as part of a quality improvement journey. They strive to remove the variables to achieve consistent positive results. With quality being such a key component of their culture, it is no wonder Columbus Community Hospital continues to be recognized as a Top 100 hospital.

Columbus learned that if you build it, they will come. They built a quality culture that helped them recruit family practice providers and OB-GYN specialists to expand the OB program. Dr. Eslam Elhammady, an Obstetrics and Gynecology specialist, is the Director of Obstetrical Services at CCH and has been instrumental in the success of this service line. If you want to recruit the best quality physician, have the best quality program. Columbus prides itself on the longevity of its staff. So, quality helps with recruitment as well as retention. A team that has been in place for a long time has improved communication skills which can be tied to improved patient safety and quality outcomes as well as operational efficiencies. Improving quality helps recruit, and we come full circle. There is a time burden associated with obtaining and maintaining state certifications such as maternal care designation level. A strong quality culture helps because there is no change in what you actually do, just time to certify what you have been doing all along.

The maternity care team at Columbus credits some of their success to the community. Community members are the best messengers when they share stories about the quality of care. Columbus Community Hospital does have marketing endeavors as part of its public relations work, but they have found time and again that word of mouth is the most effective strategy. With 302 babies delivered in a year, that is many mouths spreading the good news. Columbus Community Hospital is truly building excellence in its community by delivering quality care in a personalized manner.

The dedication and commitment of the entire hospital staff helped to keep all services running during COVID. It was personal. The staff of Columbus knew the community, the patients with chronic conditions, and the new moms-to-be and could not leave them wanting. These moms were their focus during the entire COVID-19 pandemic, as well as the “snowpocalypse” that gripped Texas in February of 2021. The whole organization backed the fight to maintain A-Z complete care. Relationships also helped during COVID. Primary care, telemedicine options, and a dedicated critical access hospital rounded out care locally, but they also reached out to strengthen relationships with tertiary care facilities to facilitate transfers.

When a state movement to develop guidelines for rural hospitals doing maternity care threatened to close even more maternity care units, Columbus Community hospital took the lead in the fight on how OB specialty requirements impacted them. They partnered with professional organizations at the state and national levels to

ensure that what worked for rural also met quality standards set by ACOG. Family physicians are a bedrock in rural communities and have been safely delivering babies for decades. The change in legislation to acknowledge this track record of success was of direct benefit to the bottom line at Columbus, but it also helped other rural hospitals and their communities across Texas. Darrold Bertsch, CEO of Sakakawea Medical Center, acknowledges the importance of advocacy but knows it is not attainable for everyone. He stresses how important it is for leaders to speak out on behalf of their organization and community. If you do not make your concerns known to legislators, then there is the chance they will think it does not matter or does not cause any problems. Working with others, as Columbus did, shows how a unified voice can accomplish great things. Columbus Community Hospital CEO, James Vanek, believes there are advantages to being rural. Rural communities can make decisions locally, which enables them to be more agile in responding to change. They can distill what will work in their community, what is best for the community, and then share that knowledge with legislators. The simple truth is that what works in an academic or urban setting is not always a rural reality. The difference in size translates into a difference in available resources, so a one-size-fits-all mentality does not work. Knowing what does work and advocating for that capability is one of the important roles for rural leaders.

### **Kearny Pioneer Baby Program**

The Pioneer Baby Program at Kearny County Hospital is a partnership between Kansas University School of Medicine-Wichita, the Children’s Miracle Network, Via Christi Health, the Kansas Department of Health & Environment, and Kearny County Hospital. The program was created to reduce pregnancy complications, gestational diabetes, premature births, extremes in birth weight, and cesarean sections among rural, at-risk, reproductive-age women in Kansas. It also has the aim to increase breastfeeding rates. Gestational diabetes occurs disproportionately among Hispanic, Asian, and American Indian women. These higher-risk groups are living in Kearny County, Kansas. Results from two studies in the KCH catchment area showed that nearly half of pregnant women were Hispanic (49.4%), low income, and had not had formal education beyond high school. 57.3% of pregnant women were receiving WIC benefits. Of those women with gestational diabetes, 75% were overweight, and 33% had an immediate family member with heart problems or diabetes.<sup>73</sup> These factors place pregnant women at an increased risk for chronic disease as well as pregnancy complications. The Pioneer Baby program decreased the rate of large birth weight babies, a complication of gestational diabetes, from 28% in 2015 down to 17% in 2018. The overall rate of mothers with gestational diabetes has decreased from 11% in 2014 to 4% in 2019.<sup>74</sup> Dr. Wolfe, a

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<sup>73</sup> Jacobsen, Lisette. (2019). *Pioneer Baby: A Multifaceted Community Approach to Improve Rural Health Outcomes Among Reproductive Age Women in a Midwestern State*. <https://osf.io/4bx7c/#!>

<sup>74</sup> American Hospital Association. (2021). *Partnering to Improve Birth Outcomes*. Podcast. <https://www.aha.org/advancing-health-podcast/2020-09-15-partnering-improve-birth-outcomes>

maternal-fetal medicine specialist, meets with high-risk pregnant women in an outpatient clinic setting on the last Friday of every month. Since 2014, Wolfe has had over 460 such meetings, which has helped reduce pregnancy complications and has increased the confidence of the KCH medical team, which is evidenced by a decreased transfer rate. Women from Wolfe's clinic are followed up weekly as needed by local providers and/or via telemedicine.

Wolfe is not the only addition to come from the Pioneer Baby program. The nursing staff at Kearny have stepped up for more training to achieve high-quality standards. A nurse has also been added to help moms prepare with pre- and post-natal education targeted to address concerns unique to rural women. One of the lessons learned by the Pioneer Baby program is that solutions that may work in an urban setting, such as a smartphone app, are not as appreciated in rural Kansas. The rural Kansas moms value the connection with their providers and nursing staff and want an intimate interaction that cannot be done via technology delivery methods. The connection and consistency of the care providers have created trust and established long-term relations to improve the entire family's health.

Becky Chappel, Perinatal Supervisor at KCH, credits strong team-based communication for their low cesarean section rate and the decreased transfer rate. These improvements lower the cost of care and improve the quality of the outcomes. Technology in the form of a dedicated channel on Microsoft Teams helped during COVID, but the trust and ease of communication have grown out of the long-term working relationship and common goals of the labor and delivery team. For teams that are newly forming and looking for ways to improve communications, the Agency for Health Research and Quality has TeamSTEPPS information available online.<sup>75</sup> TeamSTEPPS is an evidence-based set of teamwork tools to optimize patient outcomes by improving communication and teamwork skills.

Titus has more than 1,000 births/year, more than many larger hospitals, so it is essential that they keep their maternity care open. Leadership at Titus did not consider closing OB services; they chose that healthy babies are an expectation for their community and so they will have maternity care. The Labor and Delivery team is phenomenal and can back up that claim with data. They track safety measures and birth complications such as maternal hypertension and postpartum hemorrhage rates. They drilled down into the complications they saw and found that mothers with no prenatal care were more at risk for adverse events, so now they are focusing their efforts on fixing problems upstream. They echoed what Kearny and Columbus had discovered: women are the primary decision-makers for health in the family. So if TRMC takes away OB care, then there is no reason for mom to pick TRMC for other care, so TRMC keeps OB open to keep the hospital and health center open. TRMC Labor and Delivery team, along with the Nursery team, obtained Level II

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<sup>75</sup> Website available at: <https://www.ahrq.gov/teamstepps/index.html>

NICU status and Level II Maternal Services status during the COVID pandemic. This dedication and commitment to the community can be seen in the quality of healthcare provided to moms and babies in their region.



## **Optimizing External Partnerships**

Understanding the impact of affiliating with a health system is critical for rural hospitals. Research has pointed to decreases in hospital service capacity following affiliation.<sup>76</sup> Maintaining community-based services requires local administrators to optimize the push-pull relationship that often exists when becoming part of a larger system. This is especially true when a rural hospital enters this arrangement from a weak bargaining position, such as when needing a cash infusion to keep their doors open.

Data show that being part of a healthcare system and being in a Medicaid expansion state are protective factors for rural hospitals. Unfortunately, these factors cannot be controlled by the hospital CEO or the Board of Trustees. Actionable ways to find strength in numbers do exist. This section will showcase ways independent rural hospitals can collaborate to be stronger together. From collaborative program development to save money and improve efficiencies to sharing resources like policies, processes, and specialists, rural hospitals can maintain their independence while retaining local access to healthcare by helping each other

### **Defining Relations with a Large Health System**

Audubon County Memorial Hospital was faced with a dilemma, the dual necessity of retaining care in the local community while also developing a meaningful partnership with a larger hospital, better equipped in terms of specialists and high-risk emergencies. Audubon did not struggle as part of a larger health system because the system's rules clearly defined transfer procedures. However, the CEO and board of trustees at the time felt that the benefits from the relationship were unequal, with the large health system realizing benefits at the expense of Audubon and the community it serves. This realization was not instantaneous; instead, Audubon's CEO followed clear best practices in defining its system relationship.

Before making a final decision to separate from the system, Audubon administrators tracked four key measures (1) referrals to their tertiary facility, (2) referrals from the tertiary facilities back to the hospital, (3) contributions and management fees made to the system, and (4) contracts tied to the system such as group purchasing and legal services. Tracking revealed the inequality of their affiliation relationship; they were paying in more than they were getting out and losing service lines to the system. One of the earliest realizations came from examining the affiliations group purchasing agreement; the prices negotiated by the system were higher than what

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<sup>76</sup> O'Hanlon, Claire E, Kranz, Ashley M., DeYoreo, Maria, Mahmud, Ammarah, Damberg, Cheryl L, and Timbie, Justin. (2019). *Health Affairs*, 38(12), 2095-2104. doi: 10.1377/hlthaff.2019.00918

the hospital could get on their own and did not allow for the preferred ‘just-in-time’ approach to purchasing. The system set up purchasing agreements without consulting Audubon and forced larger quantities of bulk purchasing, which the small hospital could not use fast enough to avoid waste. As Audubon moved forward, the hospital administration went down the list of what the system had been providing and sought replacement contracts. They usually arrived at a more favorable or equal value contract that allowed them to include key vendors preferred by the hospital and at a lower volume purchase to avoid waste.

The system largely counseled that they would likely not survive without the affiliation pointing at the trends of rural consolidation.<sup>77</sup> After three years of separation, the independent Audubon County Memorial Hospital & Clinics are functioning as well as ever due to the leadership of CEO Suzanne Cooner (see *Optimizing Leadership*) and the work being done in conjunction with other rural hospitals, detailed below. The experiences of Audubon highlight the importance of both carefully considering the entrance into an affiliation contract and monitoring the evolving relationship between local hospital and system. Critically, hospital administrators should understand various contractual issues before entering into any affiliation agreement and then continuously evaluate the impact and actual performance of those agreements. Important metrics and contractual considerations include:

- Net Revenue flow
  - Referrals to/from
  - Salary contributions
- Purchasing agreements
- External Contracting
- Specialty support either in person or via telemedicine

It is important to note that not all agreements between a community hospital and a hospital system need be negative; the lesson of Audubon highlights the gains that can be made by a hospital when negotiating from a position of relative strength.

The CEO, Suzanne Cooner, suggests that one of the most important considerations in looking for a hospital partnership is finding a tertiary facility willing to accept a coequal exchange of patient referrals. The flow of patients should be bi-directional; often, community hospitals transfer critical patients to tertiary facilities and never see them again. Transfers can damage community hospital efforts in two ways: first, community hospitals lose the revenue from offering final stages of healing or

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<sup>77</sup> Williams Jr, Dunc, Thomas, Sharita R., Howard, Hilda A. and Pink, George H. *Rural Hospital Mergers from 2005 through 2016*. NC Rural Health Research Program. Retrieved July 14, 2021, from [https://www.shepscenter.unc.edu/wp-content/uploads/dlm\\_uploads/2018/08/Rural-Hospital-Mergers.pdf](https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/08/Rural-Hospital-Mergers.pdf)

rehabilitation to patients, and second, patients are separated from community support, often including aging spouses who cannot safely travel daily to the tertiary bedside. Community hospitals are even more financially at risk due to insurance repayment favoring hospitals providing “down-line” services. That is, the tertiary hospital offers rehabilitation services and encourages the patient to remain in the tertiary system rather than completing the care at home. Particularly challenging are the messages from specialists and tertiary centers that the quality of care is lower if they return to the local facility. Because insurance deductibles are charged on the first services provided for a patient, patients are typically responsible for paying for services from the community hospital, which risks patients being unable to pay for community services while insurance providers cover tertiary services. Crafting an equitable agreement requires a long and in-depth view of the contractual relationship with the tertiary facility.

### **Developing a Rural Collaboration Network**

After establishing independence from the system, Audubon administrators missed the opportunity to interface with other hospitals facing similar challenges. Audubon joined a collaborative, the Rural Iowa Healthcare Association (RICHA), to realize the importance of learning as part of a larger group. The collaborative is a group of 12 independent hospitals. The collaborative works together to increase service lines and share best practices over a wide variety of topics. The collaborative began to expand into joint operations by developing ways to build capacity and improve network infrastructure, enabling them to better coordinate and increase access to healthcare while preserving local autonomy. The group has explored alternative healthcare delivery models, including determining how to best utilize and share human resources. By aligning the collaborative’s resources, the group has worked on developing strategies to achieve economies of scale and address managed care challenges more effectively as a group than as individual providers.

The benefits of the collaboration are diverse and represent the many needs of rural hospitals. Some of the most impactful benefits lie in shared information to solve challenges facing small hospitals, including quality improvement processes and other practices, along with collaboration with physicians and key staff coverage. The group can pay contracted physicians as necessary, maintaining coverage for emergent needs. They are able to share certain specialty providers like a surgeon, dietician, and respiratory therapist, which some of the hospitals would be able to afford or provide the necessary demand for individually. Managing shared professionals leads to many challenging questions, but there are solutions available. In this example, a single hospital (in this case, Audubon) employs the surgeon, RT, and dietician and contracts their time to partner hospitals. This way, one hospital is

always the employer of record, not the collaborative. The collaborative puts the right people at the table to create the solution that benefits everyone participating.

Part of this larger agreement is an understanding to work synergistically. For example, the Collaborative members do not advertise in the counties served by partner members except for services not offered by that provider so as not to compete. As Suzanne Cooner says, “when the pie gets smaller, the table manners get worse.” The hospitals have formed affinity groups so that their staff can bring up challenges and develop and share best practices. The Collaborative’s CFOs, QI teams, and CEOs share knowledge and experiences with peers while mentoring other partnership members. Returning from a meeting, each member brings back lessons learned and new perspectives on any challenges. From the ARCHI research team’s perspective, these ‘fresh pairs of eyes’ on hospital problems are among the most impactful practices for rural hospital administration. The Project ECHO® location at ARCHI virtually brings together these administrators and provides a peer group nearly identical to the Collaboratives. Often administrators feel isolated without a peer group. Creating affinity groups either in-person, virtually, or over the phone overcomes isolation by spreading expertise, experience, and mentorship.

Healthcare collaboratives in the form of hospital networks face distinct legal challenges. Legal challenges arise around group negotiations due to anti-trust legislative rules; moving forward with any type of collaboration may qualify as anti-competitive behavior.<sup>78</sup> A best practice adopted by RICHA is always to have an attorney present when discussing payor or contract issues to make sure that they are not divulging too much information when they speak about negotiations, especially those with insurance companies. Due to these anti-competitive rules, the collaborative members cannot share insurance pricing, employee salaries, or Chargemaster information with the group.

### **The Nuka Way**

SCF is always asking how they can be better and sets clear expectations on their staff’s engagement with the public. Regularly SCF sends surveys within their service area. Just as regularly, those results are published, so the public can see their voices heard by SCF. Transparency is viewed as a critical component of public engagement, leading SCF to publish the results and share the actions they will take to meet public complaints. Public commitments are not broken. SCF has established

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<sup>78</sup> For an accessible reference see: *Antitrust Rules for Provider Collaboration*.  
[https://sftp.polsinelli.com/publications/pdf/antitrust\\_rules\\_for\\_provider\\_collaboration\\_mickey\\_raup\\_presentation.pdf](https://sftp.polsinelli.com/publications/pdf/antitrust_rules_for_provider_collaboration_mickey_raup_presentation.pdf)

an expectation of listening to customer-owners. SCF looks for themes and then can take action to change direction.

All employees are trained on SCF's organizational culture and values and become part of SCF's relationship-centered culture. This specialized training makes employees partners with SCF while remaining members of the community.

SCF listens to community needs and takes action. These actions may be outside of primary or hospital care. Learning Circles are an example. Learning Circles are opportunities for people to connect and build relationships through sharing stories. They promote a supportive community of peers through mutual respect and information sharing. SCF has Learning Circles for cultural activities, emotional support, healthy relationships, chronic conditions, parenting, vocational, life skills, recovery and addictions. In this day and this age, all people are struggling to find ways to connect. Learning Circles provide a safe place to connect. Learning Circles are led by a leader that is not necessarily a clinician. SCF has seen that these have helped reduce the backlog of mental health needs. Addressing mental health needs has helped decrease ER utilization, saving the system money even when not billing for some Learning Circle services. In Learning Circles, no notes are taken, and there it is 100% confidential, and everyone is comfortable with sharing. SCF has over 80 learning circles every week to address a variety of topics. All SCF employees have an hour/week wellness hour that they can use to go to the gym or attend a learning circle.

SCF has some collaborations outside of its core of tribal care. They have a contract with the Veterans Administration so that veterans can get care at local SCF clinics or have a choice in hospitals if they are in the Anchorage area. SCF also has research relationships with academic centers.

SCF had ER utilization from the homeless population, so they set up a primary care team in the local homeless shelter. Since this population is not a tribal population, they made it a Federally Qualified Health Center (FQHC). Part of the Nuka culture is to go to the people and meet them where they are. They have seen reduced ER visits and decreased 911 calls, so the city and police department have offered to help because they see the value of their work and decreased workload. The FQHC also opened up new revenue streams.

### **Collaborating with the Competition**

Before 2011 there was much competition for patient volume and workforce between Sakakawea Medical Center, a critical access hospital, and Coal Country Community Health Center, an FQHC located less than 10 miles apart. This competition put both facilities at an increased risk of financial vulnerability and damaged the ability of both facilities to provide care efficiently to their catchment areas. Efficient care is important not only for the physical wellbeing of the residents but also for the economic impact of the two organizations. Medical facilities often employ a

substantial number of insured people, have a large payroll, and help attract other businesses, industries, and residents to an area. The health of a rural community is inextricably intertwined with the health of its residents and the level of services in that area.

In 2011, both organizations came to the realization that something had to change. The duplication of services and division of patient volumes was causing an untenable financial situation. Staff morale at both locations was challenged due to the competitiveness between the two organizations. When the FQHC and its CEO decided to end their employment relationship, an opportunity for collaboration presented itself. While leadership vacuums can often be disruptive, in this case, it was an opportunity for growth, clearing the path for a new solution. The history of adversarial competition had left an impression in the minds of the board members of both organizations, the Medical Staff, and the community. Through the foresight of Dr. Garman, the then Coal Country Clinic's Medical Director, the window of opportunity for collaboration was opened. Darrold Bertsch, the relatively new CEO at Sakakawea, worked to establish trust between boards and the management of both organizations.

Trying to understand the unique issues faced by the separate organizations, he listened to concerns, utilized data to dispel myths, and helped unite the organizations behind the common purpose of promoting wellness within the community. Bertsch worked with the Medical Director at Coal Country FQHC and met with representatives from the Chamber of Commerce, and attended meetings with the county commissioners, city council, and economic development officials to promote the idea of a unified health system. Internally, he worked to build trust so that the staff and providers would understand why things were changing and how it would benefit their patients and them. Now, all the FQHC providers have hospital privileges and participate in the hospital ER call on a rotation basis, an important part of community-focused healthcare. More importantly, the joint management allowed for continuity of care. Providers follow patients while they are in the nursing home, hospice, or hospital, increasing patient satisfaction and quality of care. Bertsch had the right personality at the right time to take a good look at both organizations in order to strengthen both. Working together, we are greater than the sum of our parts, but that does not mean it was a seamless transition.

The journey towards collaboration took time. Along with the time it took time for the rivalries to fade, the legal challenges were immense. The hospital and the clinic had to engage legal counsel, a neutral third-party consultant, and HRSA (Health Resources and Administration) input as part of their due diligence processes. It was necessary to ensure programmatic and regulatory compliance could be met before formally collaborating. Both sides are clear that the relationship is a collaboration, not a merger. In March 2011, Sakakawea Medical Center and Coal Country Community Health Center created an integrated management and governance model

of rural healthcare. This unique model has a shared CEO to optimize community leadership around the sharing of resources, requires two board members to serve on the other organization's board to ensure transparency and alignment of healthcare delivery for their service area, and allows the two organizations to work together in strategic planning to meet needs identified by the community health needs assessment.<sup>79</sup> The external consultant helped to facilitate planning for the shared CEO leadership structure around three considerations: alignment of operations to avoid duplications and ensure coordination of care; contractual to avoid conflicts of interest; and enhancing organizational structure by establishing transparency and trust via the two shared board members.

Now that they share a CEO, collaboration between organizations has improved. Procedurally, the hospital's CEO is an employee of the FQHC, and the CAH pays their salary portion to the FQHC, and several other services are shared, such as HR, IT, and management. Services that were duplicated are now streamlined to one entity, primary care, ultrasound, CT, bone density, and stress testing. This streamlining allows both organizations to spend time focusing on quality outcomes for the community rather than competition. Screening rates have improved for breast, cervical, and colorectal cancers. Coal Country FQHC became the first Grand Prize recipient of the 80% by 2018 National Achievement Award. This award is given by the National Colorectal Cancer Roundtable to recognize organizations regularly screening 80% of adults over the age of 50 years. Moreover, the FQHC has seen an increase in well-child visits. Aligned under a single management structure, Sakakawea and Coal Country participated in the Blue Cross Blue Shield of North Dakota's Rural ACO program, which helped reduce avoidable hospital readmissions and preventable ER visits. Both organizations have benefitted from these cost-saving measures and operational efficiencies with increased days of cash on hand and better yearly net margins.

In 2015, in response to needs identified in the Community Needs Health Assessment, construction began on a \$30.5 million medical center to replace the aging hospital. The new facility opened in 2017 and now houses the CAH, FQHC health clinic, expanded ER and surgical areas, common areas, and patient rooms that are up to date with technology and help the staff provide the best patient care. This state-of-the-art building was possible only because of the financial success from alignment. The organizations are not fully integrated; the FQHC pays Sakakawea for its space in the medical center. Cost savings from operational efficiencies allowed them to upgrade and expand their current service lines while keeping cash flow positive throughout the opening of the medical center and into the COVID-19 pandemic. An additional benefit realized from the collaboration was implementing a common Electronic Health Record at both organizations. Providers and staff now have better access to health information while providing care at the

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<sup>79</sup> An example description of the statement can be found at <https://www.smcnd.org/collaboration>

FQHC or the CAH. Bertsch argues the journey of Sakakawea and Coal Country can be replicated in other rural communities, if not in whole certainly pieces of the collaboration could be of benefit. HRSA recently penned a “Guide to Rural Health Care Collaboration and Coordination to provide a blueprint for this kind of collaboration.”<sup>80</sup>

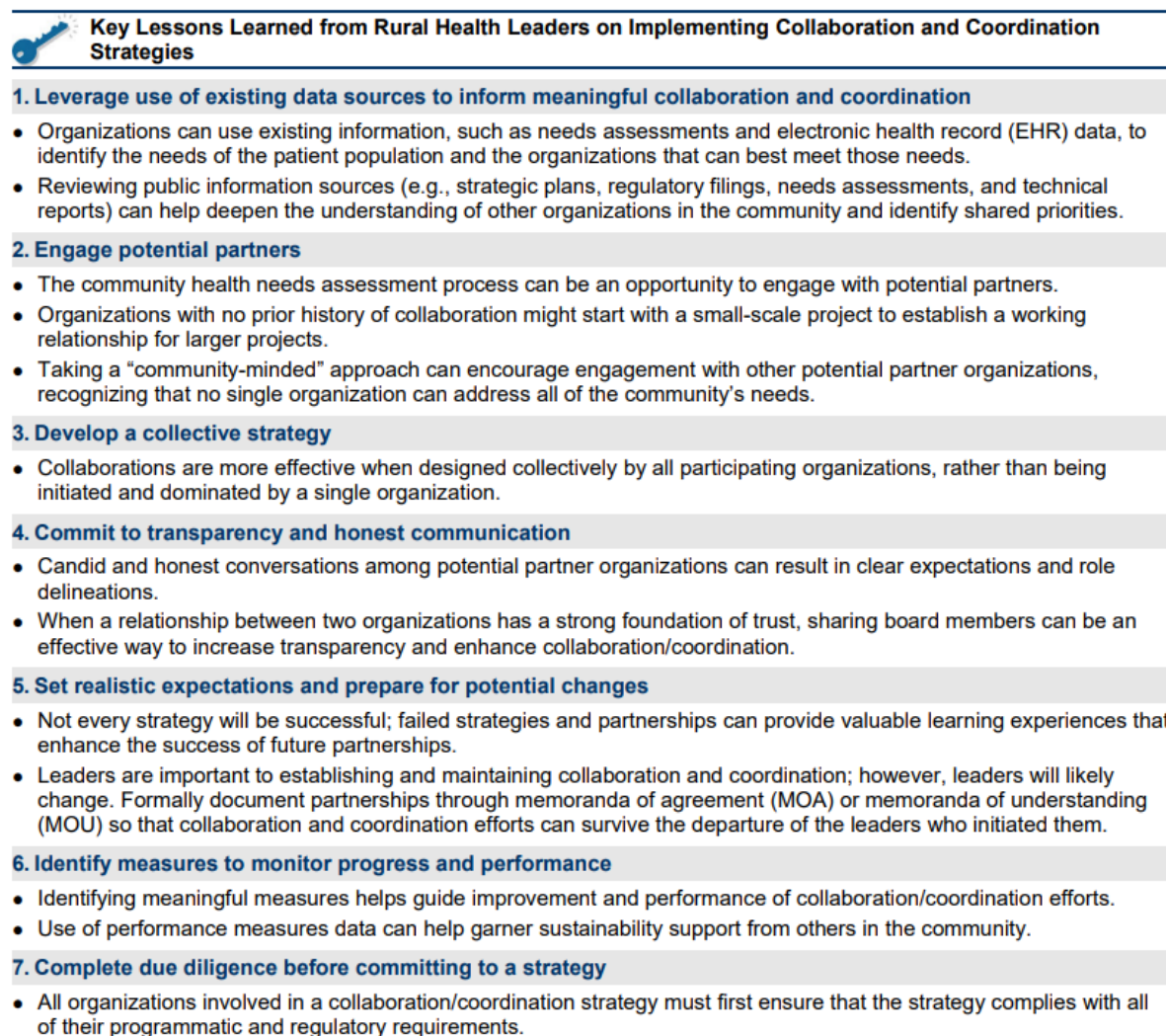


Figure 9: Key Lessons from Sakakawea and Coal Country Clinics Collaboration (from Health and Human Services)

In 2018, Bertsch was asked to be a board member of a local nursing home. This position provided better alignment between three critical healthcare organizations and a connection to long-term care after hospitalization. Additionally, the Medical Directors at all three organizations are physicians at CCCHC and provide care for their patients throughout the continuum of care. During COVID, all three were able

<sup>80</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration. (2019). *A Guide for Rural Health Care Collaboration*. Rockville, Maryland: U.S. Department of Health and Human Services.



to share supplies such as masks, workforce, and how to interpret and apply practices on issues such as who stays home, policy development, monitoring and interpreting CDC updates, and vaccine distribution plans. For this community, the silver lining of COVID-19 was in emphasizing the beauty of this collaboration. The organizations were able to discuss what concerned all of them and highlighted how easy it was for them to talk when others struggled to connect with groups facing similar challenges.

### **Collaborating with Academia**

In 2002, to overcome the disparities faced by rural residents in its surrounding communities, the Center for Community Health Development (CCHD) at Texas A&M's School of Rural Public Health developed a *community of solution* in the Brazos Valley Health Partnership. This partnership was founded as a joint effort between an academic institution and rural communities using university expertise to create solutions for communities' most pressing issues. Initially beginning in one county and later expanding to a seven-county region, the partnership developed resource centers to expand partnership communities' access to healthcare resources. In developing a "one-stop" approach, a shared space and combined overhead to community health resources, the partnership allowed for expansions in provider capacity by lowering entry and overhead costs of practicing in the community. These customizable centers could provide access to direct patient care and those services that address social determinants of health. Having all these resources in one location allows for improved coordination of care and reduces drive time and the corresponding expenses incurred by rural residents traveling to multiple locations. These efforts are constantly benchmarked through population health assessments, the annual return on community investment reports, and interviews with community stakeholders, equating to organizational adaptation and tangible metrics of success. The health resource center approach exemplifies the ability of communities to come together to beat the challenges of locality and rurality. Health Resource Centers are community-led, community-identified, and community-driven. By developing partnerships and leveraging available experience, rural communities can internally meet their challenges in a sustainable manner.

Each rural community is unique. The CCHD published a Toolkit that details the process to establish a Health Resource Center that meshes with the needs and resources of an individual community.<sup>81</sup> This Toolkit is a replication guide and is available for download on the Center for Community Health Development website. It has a companion read, the Community Health Resource Center Case Study, that details the history and evolution of Health Resource Center development. The case study may provide helpful information to new communities when they are ready to

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<sup>81</sup> Texas A&M Center for Community Health Development. (2021). *Community Health Resource Centers: A Toolkit*. <https://cchd.us/publications/#crc-case-study-toolkit>

implement their own Resource Center. While informative, these documents are somewhat dated. Fortunately, the Center for Community Health Development remains vibrant and engaged with rural communities ready to learn more.

The first step in creating a Health Resource Center is an assessment to identify local concerns and resources. The Trinity Memorial Hospital District Board has taken time to gather a wide array of input from community members. CCHD faculty and advisor to the Trinity Health Resource Center, Dr. Jim Burdine, says the Board did a good job of getting people to talk together. Focus groups were created to help prioritize needs for the general health of Trinity County. These groups drew from the wisdom of local businesses, county commissioners, local church groups, law enforcement, and members of the Black and Hispanic communities. According to the United States Census Bureau 2019 population estimates, the Black community constituted 9% of the population of Trinity County while the Hispanic or Latino community formed 11%.<sup>82</sup> The top needs identified were transportation, medication assistance, behavioral health, and a neutral (nonreligious) physical space for support groups to gather.

The second step in developing a Health Resource Center is to create ideas to use local resources to meet the identified issues. Key individuals were asked to form an advisory council to continue the productive discussions from the focus group. A key component of a sustainable solution is to have a stepwise approach to the implementation phase. Starting small and working up, according to available resources, is the recommended course of action. Trinity plans to launch with medication assistance because they have already researched websites and support agencies to help residents pay for their needed medications. They plan to hire a care coordinator to help with loaning medical equipment, doing the medication assistance paperwork, and essentially running the Resource Center. The initial gently used medical equipment comes from a Neighbors helping Neighbors group who already help do home repairs and drive people to medical appointments. Once open, the Resource Center can be used for a variety of support groups. They already have requests for 12 step programs such as Alcoholics Anonymous and a support group for patients after cardiac surgery. The transportation aspect will take more time to develop a comprehensive plan to help residents get to healthcare appointments.

The Board of Trinity Memorial Hospital District accomplished all of this during the COVID pandemic. While their initial plans were to open the Resource Center in January of 2021, plans have understandably been delayed. Additionally, in a truly responsive manner to community needs, the Board switched their efforts over to acquiring and distributing COVID vaccinations during the Spring of 2021.

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<sup>82</sup> U.S. Census Bureau QuickFacts. (2021). *Population Estimates, July 1, 2019*. <https://www.census.gov/quickfacts/fact/table/US/PST045219>

## Conclusion

The crisis of rural healthcare has been seen as a slow-moving train collision, as destructive as unavoidable. We do not believe that this must be the case. We ~~and our funders~~ believe that these challenges can be met through innovation, policy change, and learning from the lessons of both those organizations that have succumbed to the pressures of rural healthcare, and just as importantly, the organizations that have risen to meet them. To learn these lessons, we hoped to highlight some of the stories of organizations around the country. Like all rural healthcare organizations, they faced their challenges and possessed their own set of strengths. Undoubtedly what they did will not work in every locale nor for every problem, but only by disseminating and understanding the strengths of their innovative approaches can anyone else hope to gain.

Maybe our Bright Spots are bright spots because they have already adopted the practice of positive deviance. They had realized their problems, some before they became catastrophic, others after. The main thing that struck this research team was the humility of each organization. Every person representing these Bright Spots recognized their limitations and was still seeking improvements even as we tried to highlight their best qualities. They are all still searching for who has figured out a better way to learn from them. Southcentral Foundation sent a team to Cherokee Health Systems to learn lessons from how they integrated primary care into their behavioral health system. Southcentral Foundation applied these lessons to the Nuka System of Care and integrated behavioral health into primary care, so customer-owners have access to a behavioral health consultant the same day they are seen in the primary care clinic. This system helped SCF reduce the average wait time for behavioral services from 42 days to a maximum of 7-28 days, and 54% of behavioral providers and clinicians see the customer-owner within 1-7 days. Cherokee Indian Hospital was an SCF replication site, but the learning was bi-directional. SCF also visited Disney and Ritz Carlton to learn lessons on customer satisfaction. Hill Country Memorial pulled in experts from Boeing, Southwest Airlines, and Toyota to fully inculcate lean practices into their culture.

Titus Regional Medical Center was named a Bright Spot in the same month they applied to be part of the HRSA Vulnerable Rural Hospitals Assistance Program. They wanted to learn more about opportunities, increase awareness of rural health, and network with others experiencing the same struggles. Darrold Bertsch of Sakakawea and Coal Country Clinics told us that hospital leaders “don’t want to be complacent and just think they solved all the problems instead they need to search for new ideas that are out there for services, and shared efficiencies.”

The themes distilled in this research stressed the importance of leadership; connecting to your community, creating a culture to help recruit, retain, and achieve

quality; always seeking new ideas, and using data to link leadership to culture to the community.

There has always been power in stories. They convey information in an understandable, even enjoyable way, which can be so different from the rapid-fire dissemination of knowledge that has become commonplace. Because stories draw us in, they often remain in our thoughts long after the statistics have fled. It is our hope that the stories of these bright spots spark ideas and discussion around the country. We hope that this discussion continues as we discover more innovators together. As Benjamin Anderson says, the answers are in the audience or among our frontline workers. Bright Spots exist, and if we can connect and share, all of us in rural health are in a better place.

## **Appendix 1 Interview Guide**

The research team endeavored to connect with each Bright Spot location on multiple occasions. The introductory discussion, by phone or Zoom, covered the scope of the Bright Spots Research, the criteria utilized to select their facility, what to expect, and established points of contact. Interview participants were asked to tell the research team a little bit about themselves, their team, and their organization. This initial information was utilized to direct research inquiries and follow-up emails requesting clarification or additional details. The original expectation was that subsequent interviews would be conducted in person during the site visits. Travel was coordinated with the nine Bright Spots, and site visits were scheduled beginning throughout early 2020

The first site visit was made to Southcenter Foundation in January 2020. Anchorage, Alaska, had record cold temperatures that week and the visit was a transition for the ARCHI team from Texas. Southcentral Foundation receives many visitation requests and advised our team to attend a two-day Minicourse (Agenda included in [Appendix 2](#)) as well as the three-day Core Concepts employee orientation. The Minicourse was truly informative as materials were presented on their story of transformation, integrated primary care model, human resources, workforce development, data management services, and quality improvement. Questions were freely answered, and when questions arose that did not align with a scheduled session, we were connected with employees who could provide illumination. The Core Concepts days allowed us to immerse ourselves fully in the culture of Southcentral Foundation. We were educated and treated the same as every other SCF employee. It was an insider view that would not have been captured via Zoom interviews.

The COVID-19 pandemic was fully realized in March 2020 when travel was shut down for Texas A&M University and most of the United States. The Bright Spot facilities were busy taking care of their communities, and we all agreed to pick up the visit discussions during the summer when COVID-19 was sure to have resolved. Summer 2020 came, and COVID was still a pressing concern. While Texas A&M University permitted travel within the state of Texas, those Bright Spots located in the Lone Star State had visitation policies in place to protect their patients and staff, which did not permit us to come onsite. Zoom virtual meetings were selected to further the conversation with all Bright Spot locations without the risk of travel. Individualized discussion questions were sent to Bright Spot in advance to help optimize our time together. Follow-up questions frequently arose as the discussion progressed, and these were permitted to deepen understanding. The summer Zooms were 30-60 minutes because it was anticipated that travel would occur in the Fall of 2020, and these sessions would serve the role of being a touchpoint during a tumultuous year.

A compilation of some of these questions is included below.

*To facilitate a better conversation and better prepare you for our virtual meetings, the ARCHI team compiled the questions that will help in writing our report. Please review these and remember that we will not use any information provided by you without permission. All information will strictly be used to help the research team in writing the report.*

- How did COVID affect the operations of the hospital and clinics?
- Can the ARCHI team access, from both the clinics and the hospital, measures on:
  - Financial performance?
  - Quality performance?
  - Employee/Patient Satisfaction?
- What was the patient crossover before the transition, and was there a ‘breaking point’ both institutions realized ‘joint operation’ would work?
- What legal hurdles did you encounter around a shared CEO?
- Can you describe any succession planning?
- What was the process of advocacy for the legislature?
- What was the process to include who took the lead to identify the serious challenge?
- How do you keep up with policy if wearing multiple hats in a rural healthcare role?
- What aspects of leadership were most helpful to bring about change and sustain it?
- How did the board educate themselves?
- What were the greatest challenges in recruitment prior to building the culture?
- How do you identify service mindsets in potential providers?
- How do you support outreach to a largely migrant workforce?
- How do you engage with local companies?
- Tell us about your experiences with OB/GYN. How have you kept this service open when so many others have closed these services?
- What challenges did you have in terms of community outreach?
- How did you make this culture change?
- Please describe your quality process. How did you arrive at this process? What was the transition process like?
- What training programs are in place to reinforce maintaining improvement measures and the values of your culture?
- Can you walk us through the contracting process of the rural network?
- Please describe the transition from being in a system to being independent.
- What are the differences between your new partner hospital vs. what was it like to be in the system?
- What happened during the cultural transition period? Did you track the turnover rate during the transition?

The ARCHI research team met with all three funders in January 2021 to brainstorm project completion options in light of the continued ban on travel. It was decided to virtually gather as much information as possible to wrap up the project rather than

wait until travel was permitted. This was a difficult decision as the scope of the original proposal would be lessened without site visits. It is also more difficult to establish trust to facilitate the exchange of sensitive information when the meeting is virtual rather than face-to-face. These limitations were considered against the potential loss of valuable information as the research got long in the tooth and needed to be revisited and updated. 2020 saw a record number of rural hospitals close, and so the funders and research team wanted to bring these Bright Spot stories to light.

The remaining Bright Spots were contacted, and wrap-up sessions were scheduled during March and April 2021. Once again, individualized discussion questions were sent to each Bright Spot in advance of the interview. Questions were derived from unanswered or insufficiently answered research queries as well as interesting themes that arose from other Bright Spot interviews.

A compilation of some of these questions is included below.

*To facilitate a better conversation and better prepare you for our virtual meetings, the ARCHI team compiled the questions that will help in writing our report. Please review these and remember that we will not use any information provided by you without permission. All information will strictly be used to help the research team in writing the report.*

- Thoughts on the value of advocacy? Is this a path all leaders should pursue? Any tips?
- Did you have a mentor or role model?
- Any COVID pearls to share to highlight the benefit of working so closely nursing home/hospital/clinic?
- How do you get different cultures to work together?
- Any recommendations for formal leadership training or mentoring?
- How do you develop leadership within the team?
- How do you pass along your lessons learned to your leadership team and/or potential successor?
- How long was the transition period to your new culture?
  - Any stumbling blocks along the way?
  - How do you keep the vision of this culture alive?
- What aspects of leadership were most helpful to bring about change and sustain it?
- Why do you think Titus remained open when so many independent hospitals around you closed?
- What data do you collect?
  - How do you make sense of the data?
  - Do you set your own benchmarks, or do you have a trusted resource?
- Did your COVID outreach help you establish more trust with the population?
- You had said the hospital was going to return to the basics that won them the 2014 Malcolm Baldrige Award.

- Are you compiling your application to submit for another award?
- Can you link improvements/achievements that were gained as a result of preparing for the 2014 award?
- The application process is time-consuming. Would you encourage other healthcare facilities to consider making time? Why or Why not?



**Appendix 2 Southcentral Foundation Mini-course agenda**



**January Mini-Course  
Agenda: Day 1 of 2**

**January 6<sup>th</sup>, 2020**

- |                                |  |
|--------------------------------|--|
| <b>8 - 8:20 a.m.</b>           | <b>Breakfast &amp; Welcome</b>   |
| <b>8:20 - 8:30 a.m.</b>        | <b>Blessing / Review of the Day</b>  |
| <b>8:30 - 10 a.m.</b>          | <b>Southcentral Foundation Nuka System of Care Overview</b> <ul style="list-style-type: none"><li>• Describe SCF’s organizational history</li><li>• Review lessons learned in SCF’s story of transformation</li><li>• Describe the key elements of SCF’s Core Concepts</li><li>• Governance</li></ul>                          |
| <b>10 - 10:15 a.m.</b>         | <b>Break</b>   |
| <b>10:15 - 11:30 a.m.</b>      | <b>Behavioral Health</b> <ul style="list-style-type: none"><li>• Explore SCF’s population-based approach for overcoming barriers to behavioral healthcare</li><li>• Examine key elements of redesign changes in behavioral health services, such as immediate access with behavioral health consultants, co-location</li></ul> |
| <b>11:30 a.m. - 12:30 p.m.</b> | <b>Lunch</b>   |
| <b>12:30 - 1:45 p.m.</b>       | <b>Integrated Care Team Panel</b> <ul style="list-style-type: none"><li>• Describe different workflow models and their impact on care delivery</li><li>• Illustrate different integrated care team roles and their contributions</li><li>• Review health and performance indicators for integrated care teams</li></ul>        |
| <b>1:45 – 2:00 p.m.</b>        | <b>Transition to Primary Care Center</b>   |
| <b>2 - 3:15 p.m.</b>           | <b>Tour of the Anchorage Native Primary Care Center</b> <ul style="list-style-type: none"><li>• 2:00 – 2:30 PCC Tour</li><li>• 2:30 – 3:15 Traditional Healing Tour</li></ul>  |
| <b>3:15 – 3:30 p.m.</b>        | <b>Transition to NLWC</b>  |
| <b>3:30 - 4:30 p.m.</b>        | <b>Family Wellness Warriors Initiative (FWWI)</b> <ul style="list-style-type: none"><li>• Recognize the purpose and goals of FWWI</li></ul>  |
| <b>4:30 - 5 p.m.</b>           | <b>Debrief</b>   |

**Agenda: Day 2 of 2**

**January 7<sup>th</sup>, 2020**

- |                       |                                    |
|-----------------------|------------------------------------|
| <b>8-8:15 a.m.</b>    | <b>Breakfast and Review of Day</b> |
| <b>8:15-9:15 a.m.</b> | <b>Human Resources</b>             |

- Explore SCF's focus on work design and how success is driven by hiring the right people
- Examine the SCF HR Department's use of the relationship-based model
- Learn about the Nuka System of Care's approach to performance management

**9:15-10:15 a.m.**

**Workforce Development**

- Connect SCF's learning and development approach to its mission, vision and corporate initiatives
- Examine SCF's learning and development philosophy
- Describe SCF's learning and development structures, processes and workforce support

**10:15-10:30 a.m.**

**Break**

**10:30-11:45 a.m.**

**Data Services**

- Examine SCF's journey toward data management
- Review key steps necessary when thinking about building your own Data Services Department
- Explain the Data Information Request Tool and how it supports SCF's work prioritization process

**11:45 a.m.-1:30 p.m.**

**Lunch (12:45-1:15 a walk to the ANMC gift shop)**

**1:30 - 3:00 p.m.**

**Improvement Planning and Tools**

- Define improvement culture
- Describe the organizational structure of improvement as part of the Nuka System of Care
- Determine how accessing the voice of the customer helps the improvement cycle

**3:00-3:45 p.m.**

**Customer-Owner Panel**

- Listen to customer-owner stories and reflections on the Nuka System of Care

**3:45-4:45 p.m.**

**Q&A / Closeout**

- Q & A Session
- Review of the day