Rural Health Equity and Quality Summit Report

September 2022

NATIONAL
RURAL HEALTH
RESOURCE CENTER

Rural Healthcare Provider
Transition Project (RHPTP)

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Preface

With the support of the Federal Office of Rural Health Policy (FORHP), the National Rural Health Resource Center's (The Center) Rural Healthcare Provider Transition Project (RHPTP) held a virtual summit with leaders in rural health care policy, health equity, value-based care, and clinical quality to address health equity in rural communities. This topic was chosen because the pandemic highlighted the fact that health equity[1] is key for quality of care, as inequity leads to poorer health outcomes for affected populations. This topic is aligned with the goals for RHPTP to support small rural hospitals and certified rural health clinics in improving quality in four areas: building infrastructure to maximize efficiency, improving care coordination, improving safety of care, and improving patient engagement and experience. The COVID-19 pandemic increased the urgent need to address this (Presidential COVID-19 Health Equity Task Force, 2021).

The goal of this report is to help rural hospitals, clinics, and network leaders move forward on their path to value-based care (VBC) and alternative payment models (APMs) by focusing on the objectives and outcomes of the summit, including solutions for achieving rural health equity offered by panelists.

The information presented in this report provides the reader with general guidance. The materials do not constitute, and should not be treated as, professional advice regarding the use of any technique or the consequences associated with any technique. Every effort has been made to ensure the accuracy of these materials. The Center and the authors do not assume responsibility for any individual's reliance upon the written or oral information provided in this guide. Readers and users should independently verify all statements made before applying them to a situation and should independently determine the correctness of any strategy before recommending the technique to a client or implementing it on a client's behalf.

[1] HRSA defines health equity as "the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographic areas in health status and health outcomes such as disease, disability, or mortality."

Executive Summary

A key focus of the RHPTP is to assist small rural hospitals, providers, and certified health clinics in transitioning to VBC and APMs such as patient-centered medical homes and hospital shared saving plans. This supports RHPTP's overarching mission of preparing rural health care entities for population health management.

In 2022, the National Rural Health Resource Center held a two-day, virtual national summit, in cooperation with the Health Resources and Services Administration's (HRSA's) Federal Office of Rural Health Policy (FORHP). The summit focused on the barriers and drivers to achieving equity in the delivery of health care to rural populations. This summit convened nationally recognized content experts to explore the small rural hospital and rural health clinic's roles in achieving health equity in their community.

This summary report of summit findings is intended to:

- Identify the association between rural health equity and health care cost and quality in the transition to VBC,
- Discover barriers that prevent health equity in rural communities, and
- Identify best practices and innovative models to achieve health equity in rural communities.

The report offers tips on how to maximize available resources and data to achieve equity. It identifies some of the greatest barriers to health equity, including reimbursement, operational cost and cost structures, and lack of resources, and focuses on **four areas of opportunity** chosen by summit panelists as the drivers to fuel health equity:

1. Existing finance/payment models and opportunities that can be leveraged to advance health equity
2. Population health services and resources in rural areas
3. The impact of operational costs and cost structures
4. Information services and access to quality data to drive performance

The report also includes resources in each area of opportunity and should serve as one of many tools for rural hospitals and communities in addressing and achieving health equity for their diverse populations.

The Summit

The Rural Healthcare Provider Transition Project Equity and Quality Summit took place on June 21 and 22, 2022. Building on lessons learned from previous virtual summits, prework was completed by the panelists whenever possible. This helped to make the best use of "screen time" and create an engaging and inclusive event for all attendees.

Attendees

The summit was facilitated by The Center's Multimedia Specialist Kim Nordin and Community Program Team Lead Selena McCord, with support from additional Center staff Rhonda Barcus, Program Manager; Kiona Hermanson, Senior Program Coordinator; and Angie LaFlamme, Program Specialist. Twelve nationally recognized rural health experts in areas such as health care policy, health equity, VBC, and clinical quality joined them to discuss ways to move the needle in implementing best practices and innovative models for rural health equity. Panelists included the following:

- Sarah Brinkman, Program Manager, Stratis Health
- Jill Bullock, Associate Director and Flex Program Coordinator, Arizona Center for Rural Health
- Christina Campos, Administrator, Guadalupe County Hospital
- Craig Caplan, Senior Advisor, Office of the Associate Administrator, FORHP
- Ray Eickmeyer, Director of Emergency Medical Services (EMS) and Paratransit, Safety & Preparedness, Lake Chelan Health
- Amy Elizondo, Chief Strategy Officer, National Rural Health Association (NRHA), Border Health Program, Community Health Worker Education, Equity Council
- Wade Gallon, Consultant, Stroudwater Associates
- Terry Hill, Senior Advisor for Rural Health Leadership and Policy, National Rural Health Resource Center
- Brooke S. McDowell, Practice Administrator, The Medical Center of Elberton, LLP

- Shena Popat, Senior Research Scientist, NORC Walsh Center for Rural Health Analysis
- Tim Putnam, Former Critical Access Hospital (CAH) CEO
- Peggy Wheeler, Vice President, Rural Healthcare and Governance, California Hospital Association

Jeanene Meyers, FORHP Project Officer, joined the summit as an observer.

Pre-Planning and Preparation

To make the most of the time together, The Center's staff conducted a series of pre-meeting activities and outreach with panelists, including the distribution of a detailed survey to identify challenges, drivers, best practices, and innovations in bringing health equity to rural communities. The goals of this survey were to:

1. Capture panelists' ideas and input, normally brainstormed during a face-to-face session, to prepare for more effective facilitation and to focus the summit discussions, and
2. Energize survey panelists for the virtual summit, begin "priming the pump" for the topic, and express value to the panelists for their contributions.

The results of this survey helped narrow the main areas of discussion for the summit breakout rooms, to keep the sessions focused and streamlined. The survey questions are listed below.

1. From your experience, what are the financial barriers in payment systems that impact advancing rural health equity for rural hospitals and clinics?
2. From your perspective, what are the specific barriers in value-based care that limit the equitable quality and access of rural health care?
3. What are the financial drivers in payment systems to fuel rural health equity?
4. What are the value-based care drivers to fuel rural health equity?
5. What are any other drivers specific to rural [communities] that can help advance health equity?

Using the survey results, the facilitators structured each day's activities to focus on the leading issues identified by panelists. The breakout sessions drilled down on solutions and strategies to support drivers to overcome barriers in payment systems and VBC in rural areas.

By exploring how small rural hospitals and clinics can advance health equity, and by implementing recommendations and solutions, it is anticipated that the quality of clinical care will improve for people in rural communities as these organizations move forward in preparation for VBC.

Rural Health Equity

To understand health care disparities relative to geography, the Centers for Medicare & Medicaid Services (CMS) have adopted the U.S. Census Bureau's definition of "rural," which first defines urban as "all territory, population, and housing units located in those areas and in places or towns of 2,500 or more persons outside urbanized areas." Any areas not classified as urban are considered rural (Farley, 2002 p. 53). According to the Rural

Health Information Hub, federal and state-level definitions of the term "rural" are wide and flexible, deliberately adaptable to best serve these populations in terms of grants, funding, and government programs.

According to the U.S. Census Bureau, about 60 million Americans (or 1-in-5) live in rural areas (Ratcliffe et al., 2016). This accounts for approximately 19.8% of the country's total population. There are substantial challenges inherent in rural health care, from lack of resources to unique social drivers of health (SDOH) that delay or prevent access to quality care. In a rural environment, achievement of true health equity requires specific regional and cultural considerations. What may be effective for the 80% of the population living in urban areas often does not translate to the unique issues and needs of a rural population.

> *Chronic illness, disease, and inequities lie downstream from social drivers of health and excessive profit seeking. If we choose to address payment reform and do something about these upstream social indicators, we can finally achieve the equality and improved population health that we seek.*
>
> *Terry Hill*
> *National Rural Health Resource Center*

The Robert Wood Johnson Foundation asserts that:

> "Health equity means that everyone has a fair and just opportunity to be healthy. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care" (Braveman et al., 2017).

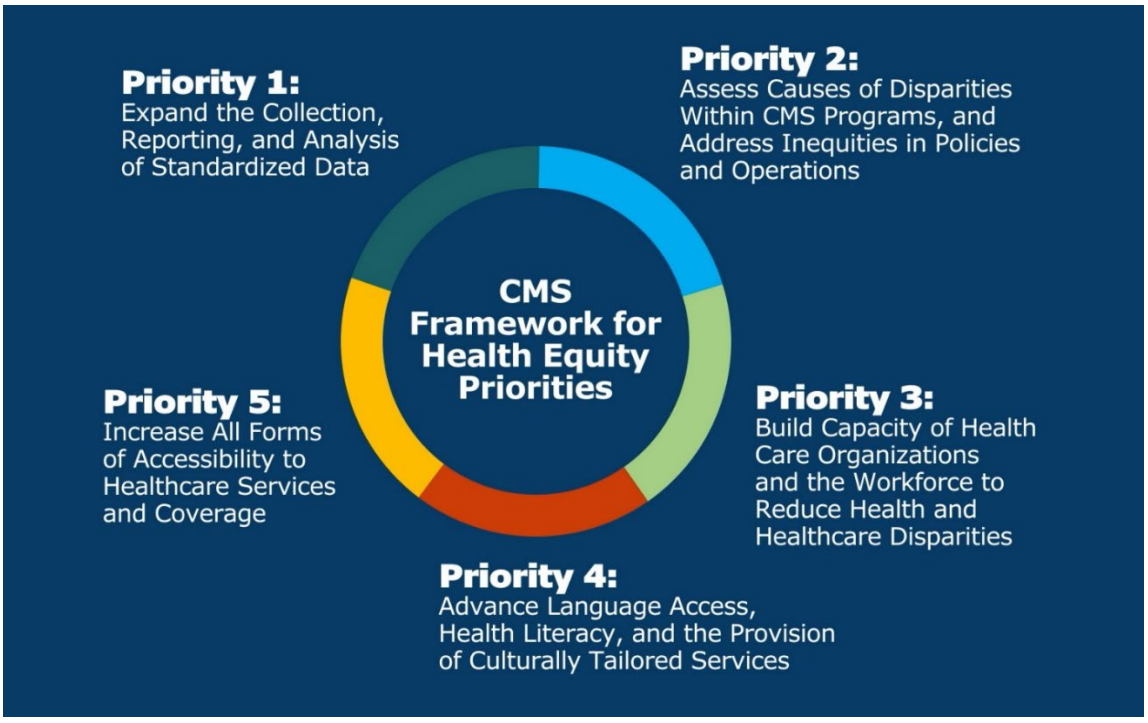
Health outcomes for rural residents are markedly worse than for those who live in urban areas (Gavidia, 2021). People living in areas with fewer resources can also experience exclusion based on age, race, gender, and sexual identity, and may face stigma that precludes or discourages access. Due to cultural biases and insufficient data, many individuals may not even be seen or recognized as part of the community. With payment models

moving toward using population health markers as a reimbursement measure, rural hospitals, clinics, and providers must work diligently to ensure that everyone in their region receives quality care, despite challenges like lack of basic resources and inadequate data.

Value-based payment models reward providers for coordinating care and achieving better patient outcomes (i.e., "value"), replacing traditional fee-for-service systems that pay by procedure and do not account for the quality or value of the care provided. As rural hospitals and clinics move to newer models, finding, defining, and serving everyone will improve the quality of care for all. As one panelist noted, "We don't fight for equity alone, but through focusing on quality and population health."

Since the mission of the RHPTP is to assist rural hospitals, clinics, and providers in this move towards VBC and population health, organizers saw value in focusing on financial and care barriers and drivers, to give rural health care providers practical solutions to support the evolution of payment models and coordinated care.

CMS has made health equity a top priority, setting out a framework with five priority areas of focus and three health equity-focused measures.



CMS included structural health equity measures in the 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, adopted August 1, 2022. The new quality measures are as follows:

> The first measure assesses a hospital's commitment to establishing a culture of equity and delivering more equitable health care by capturing concrete activities across five key domains, including strategic planning, data collection, data analysis, quality improvement, and leadership engagement. The second and third measures capture screening and identification of patient-level, health-related social needs — such as food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. By screening for and identifying such unmet needs, hospitals will be in a better position to serve patients holistically by addressing and monitoring what are often key contributors to poor physical and mental health outcomes.[2]

CMS sought comment on the proposed rule and acknowledged the need to improve data collection to better measure disparities across programs and policies, and approaches for updating the Hospital Readmissions Reduction Program (HRRP) that encourage providers to improve performance for socially at-risk populations. These may be incorporated into future rulemaking. Also, according to one panelist, there is potential that the measures could be promoted to CAHs through initiatives like FORHP's Medicare Beneficiary Quality Improvement Project (MBQIP) and CMS' Hospital Quality Improvement Contractor (HQIC) program.

During the summit, several panelists noted the necessity of high-level help in fueling equity in rural hospitals and clinics, and this effort by CMS shows progress in that direction. The new rule may result in rural hospital boards embedding equity efforts into their strategic plans as a measured element of quality improvement.

[2] New CMS Rule Increases Payments for Acute Care Hospitals and Advances Health Equity, Maternal Health | CMS

Barriers and Challenges in Rural Health Equity

As noted, rural residents have overall poorer health outcomes than their counterparts in urban areas (Gavidia, 2021). In 2017, approximately 10 million rural residents identified as Black, Hispanic, American Indian/Alaska Native, Asian American/Pacific Islander, or mixed race (Henning-Smith et al., 2019). Non-white residents comprise only 15% of the total U.S. rural population, but 30% of rural residents experience poverty. In addition to the limiting factors in a geographical context, bias, stigma, and language differences compound the obstacles faced by rural citizens.

While many may be familiar with the concept that "zip code determines health" (Roeder, 2014), rural environments highlight the stark disparities of geography. Simply put, individuals living in rural areas face markedly different challenges and health outcomes than their urban counterparts. Anecdotally, rural residents are often characterized as strong and resourceful in the face of these adversities. The challenges are substantial, however, and even more so for the non-white population, geriatric, and LGBTQIA+ individuals who reside in rural America. In these populations, Social Drivers of Health (SDOH) play a prominent role in poor health outcomes.

SDOH are "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes" and include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. (CDC, n.d.3)

> *Choosing to call rural America home should not serve as an earlier death sentence or a lost right for receiving quality and affordable access to care regardless of race, gender, or religious affiliation.*
>
> *Amy Elizondo*
> *National Rural Health Association*

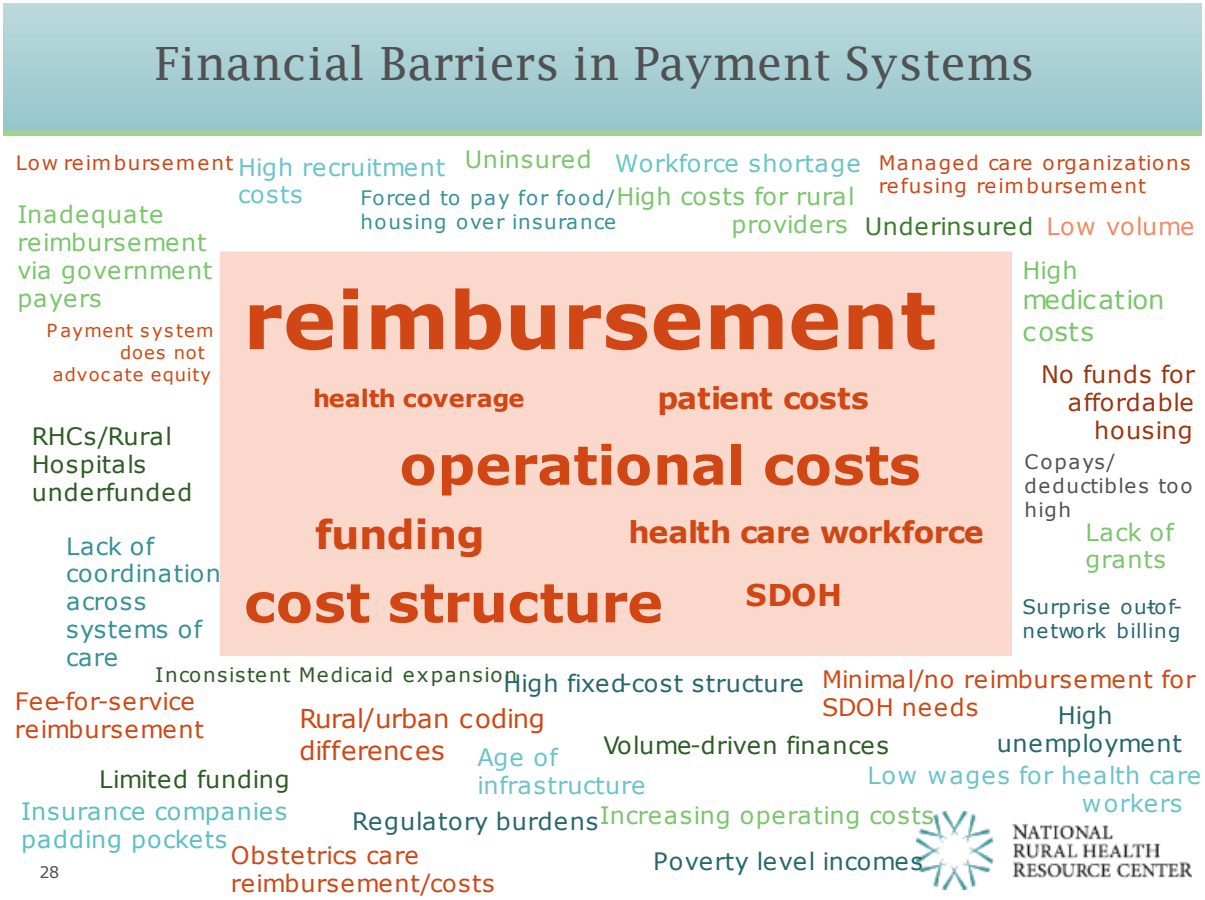
Relative to SDOH, the structural and individual risk factors in rural areas include higher rates of poverty, limited access to medical care, poorer

health habits like smoking and alcohol use, and lack of basic infrastructure resources such as transportation and broadband internet. Additionally, rural residents are exposed to environmental risks such as pesticides and toxins along with inherently dangerous tasks involved in ranching, farming, and agriculture.

Panelists identified these and other deeply rooted barriers rural communities face in recognizing and addressing health equity, focusing on the basics that affect access to quality health care. In discussion, several noted that inequity is a divisive and entrenched construct; systemic causes embedded in the culture need to be addressed to support the achievement of true equity. While acknowledging the gravity of inequity and the seemingly insurmountable cultural context of inherent biases, summit panelists worked to find cost-effective, practical solutions that rural hospitals and clinics could deploy to grow equitable practices in the future.

Recommendations referred to actions and policies specific to rural communities in the hopes that these can be the engine for the larger, systemic changes that may positively affect the roots of inequity. In the pre-summit survey, panelists uncovered the most formidable barriers in payment systems and VBC that limit the equitable quality of and access to rural health care. The group then narrowed its focus to the most critical areas in need of solutions:

1. Reimbursement
2. Operational cost and cost structures
3. Lack of resources
4. Information services and access to data



In keeping with The Center's overall mission to support the transition to VBC, panelists examined barriers to equity in the context of population health, APMs, and other financial drivers. In addition to the SDOH and economic challenges faced in rural America, panelists noted barriers to equity in a rural setting also include the following:

- VBC is based on an urban model
- Policy does not match community needs
- Rural health care has historically low volumes with no specialty services
- The VBC strategy is cost prohibitive
- There is a lack of resources including transportation and workforce recruitment
- The rural population has high rates of uninsured and underinsured patients
- There is a lack of adequate broadband to support telehealth
- There is a lack of wrap-around services like home health and hospice
- Different institutional billing in different ways leads to lower

reimbursement
- APMs are not focused on cost-based reimbursement for CAHs.

Many of the financial, payment model, and reimbursement challenges are rooted in institutional billing methods that do not easily translate in rural settings. In discussing the financial drivers that could fuel rural health equity, certain themes emerged, including an urgent need for building equity into strategic plans, educating and elevating boards so that they truly represent their communities, and leveraging the culture of "neighbors helping neighbors" that is both powerful and pervasive in many rural economies. Proposed solutions fell into four broad categories:

1. Data and information services
2. Payment models and VBC
3. Care coordination
4. Board leadership

Opportunities for Achieving Health Equity Using Information Services and Data Analytics

Recognizing the crucial role data plays in reimbursement, payment models, and the delivery of quality care, panelists analyzed the drivers and challenges of collecting and analyzing data in rural health care through an equity lens. This led to the seminal question of *"Who is being served?"*—an inquiry made more complex in rural settings because of the inability to capture enough information to answer, *"Who should we be serving?"* Accepting the premise that current data collection in rural health care may be missing the mark in reaching the total population, discussion focused on how to better capture health information about the whole population rather than just those who routinely access services.

Drivers

Panelists identified key drivers for areas of quality data and information services that can advance health equity, focusing on the impact and importance of SDOH while creating systems to find community members who lack resources or access. Current drivers in this effort include rural-relevant performance measures and the use of health information technology to its fullest to fuel equity in health care delivery. Despite financial challenges, investment in information technology (IT) and resources to fully understand and effectively stratify data must become a priority as rural health care institutions and providers move toward a focus on population health. Rural data collection can shift the focus from individual patients to the foundation of health in the community; collection of SDOH data is therefore an effective way to ignite equity in rural health care.

Barriers and Challenges

Information services in rural areas face the same overarching barriers as in other areas of health care. Resources can be scarce, particularly in terms of effective broadband in rural areas. Given the revenue challenges that accompany low volumes and reimbursement rates, hospitals and clinics often do not invest in the level of data analysis necessary to increase access, quality, and even reimbursement. Challenges in this environment that are specific to data include the following:

- Health providers' Hierarchical Conditional Coding (HCC) codes are lower in rural areas than in urban, indicating that rural patients are healthier than their urban counterparts, although this is not consistent with other research that indicates that rural populations are sicker than urban populations.[3] Coding patterns might affect revenue and reimbursement.
- There are repositories of national data, but extensive local data is lacking.
- CAHs, clinics, hospitals, and providers lack the capacity and time to

[3] Publication Details: CMS Hierarchical Condition Category 2014 Risk Scores Are Lower for Rural Medicare Beneficiaries than for Urban Beneficiaries - Rural Health Research Gateway

pull from data and act on it.

- Hospitals need to analyze and stratify data to determine if good outcomes are happening for the whole of the community, including diverse populations and those who do not access services.
- Overall, rural data is underreported, leading to lower revenue. Boards and leadership often do not understand the relationship between SDOH-based reporting and the potential for increased reimbursement.

Recommendations

Leverage data to increase equity and access.

In preparing to move to a focus on population health and VBC, hospitals and clinics can leverage available data, such as internal claims and data from state networks, to prepare for outcome-based payments that serve the entire community. This effort will first require education and technical assistance for rural hospitals, clinics, and providers so they can fully comprehend the data needs and gaps in current collection systems.

Specific education for all staff and leadership should address the importance of collecting patient-reported demographics, ideally through a patient portal where individuals can name and update such information. Demographic data should focus on race, ethnicity, ancestry, language (REAL) and sexual orientation and gender identity (SOGI) in addition to the standard markers such as age and sex.

Rural health care institutions may consider incorporating relevant SDOH assessment tools, such as PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experience), into their health information systems. The Pathways Community HUB model also addresses SDOH, acting as a centralized means for referring and tracking individuals who have been referred for services offered by the network of care coordination agencies, thereby eliminating organizational silos and reducing duplication of services. Both tools are discussed further in the section on care coordination.

Collaboratives and shared resources increase the reporting of relevant data while supporting the move to population health and equitable quality care.

A common theme emerging across all discussions focused on the unique ability of rural communities to collaborate and help each other, a critical skill born of necessity in areas that lack resources. This strength can be leveraged to help rural regions better collect, stratify, and analyze data that can fuel the equitable delivery of quality care while increasing the opportunity for reimbursement.

Collaboration is a vital tool also discussed in the operational costs section, where panelists made recommendations regarding regional and local cohorts for the sharing of costs and financial strategies. So too with data, regional and routine convenings on data collection, best practices, and analytics can result in a more intentional use of data to reach the whole of a rural population. Rural providers and systems can engage in training together on data analytics, a discrete skill that can lead to increased revenue and equitable care.

Rural health care institutions are encouraged to reach out to non-traditional partners to increase correct and informative data around diverse populations. If a hospital positions itself as an anchor institution in the community, drawing all stakeholders to the table, this will serve to increase trust and build relationships while opening pathways to better data collection. For example, hospitals can collaborate with EMS, behavioral health providers, social services, law enforcement, jails, and local nonprofit organizations to identify people in need of services. As equity becomes a potential quality measure, these partnerships will be both important and effective in growing population health services and systems.

Community health workers (CHWs) can act as a vital source of access to people without resources or individuals who historically mistrust the health care system and providers. Regional collaboratives may find ways to deploy CHWs in a cost-effective fashion, always keeping in mind that a focus on equity will help the transition to population health services. CHWs should have leadership training and take on leadership roles in the local health care systems. CHWs are discussed in more detail in the section on care

coordination.

Quality metrics increase the quality of care and growth of equitable health care in rural communities.

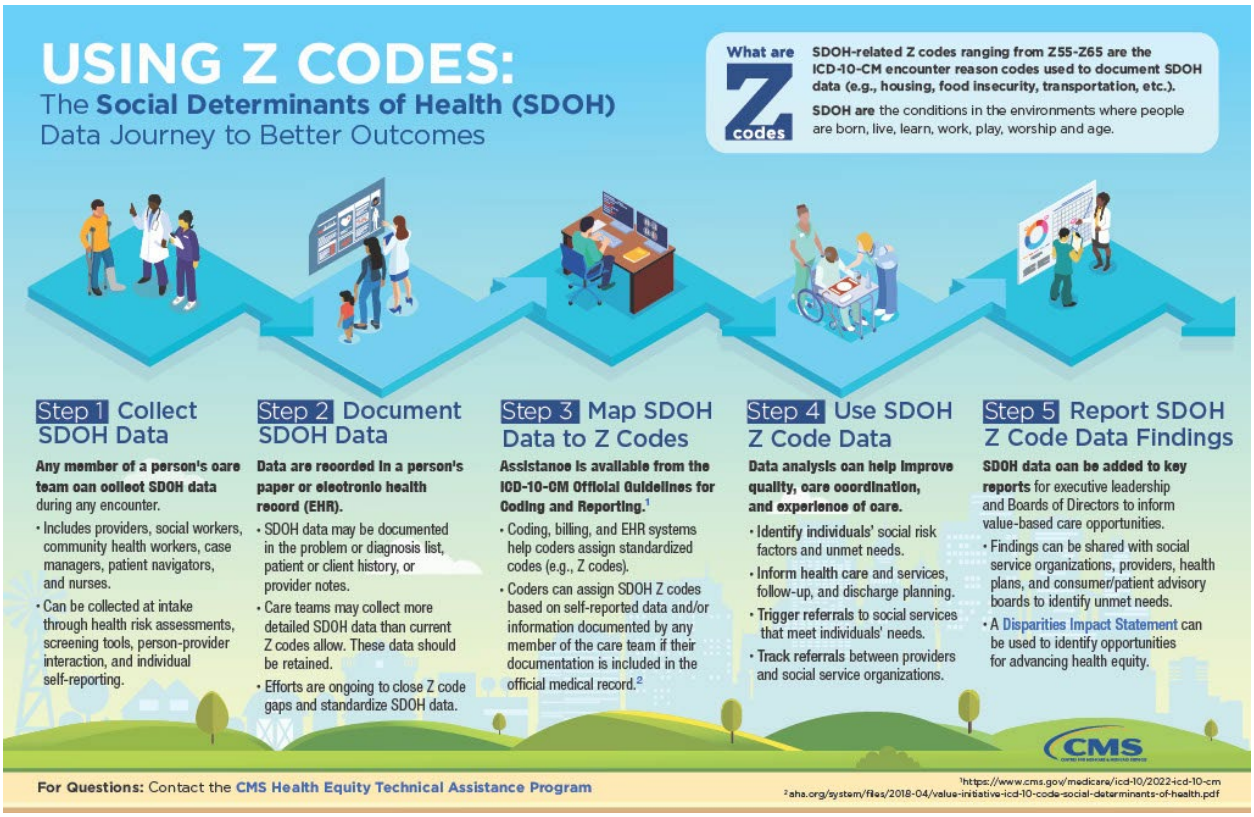
Quality metrics tied to health equity serve the dual purpose of appropriately building equitable systems while potentially increasing revenue. As noted in the introductory section on rural health equity, CMS recently implemented a rule that uses equity as a quality measure. Rural communities that prioritize the collection and analysis of SDOH data will have an advantage as APMs and VBC continue to evolve.

A model discussed throughout this report is Arizona's SDOH Community Cares Referral System, administered through the state's Medicaid agency. Community Cares turns the spotlight on social factors such as housing, employment, transportation, and community-based services interventions in care coordination. Designed to provide a streamlined referral system, Community Cares collects and uses data highly relevant to equity efforts while addressing the root causes of poor health.

Correct coding is crucial to increasing equity and the potential for reimbursement to support the whole population.

Given the complexities of medical billing, it is not surprising that, in under-resourced areas, hospitals, clinics, and providers often "under-code," not capturing the kind of information that could increase both quality and reimbursement. In addition to recommendations around collaborative efforts, best practices, and education, panelists suggested more training around the use of Z codes that capture data around SDOH.

With training that minimizes staff burdens, the intentional use of Z codes may accelerate quality improvement initiatives. Administrators can decide what Z code data to use and monitor to enhance patient care and improve care coordination and referrals, identify community population needs, and support quality measurement. With a team educated in the appropriate collection of SDOH information, coding can be an effective way to measure equity and quality of care.



Hospitals and clinic leaders who turn their attention to high quality data and information systems will create a pathway toward increasing the health of their communities as well as their budgets.

Resources

1. Conducting Rural Health Research, Needs Assessment, and Program Evaluation
2. Engage Communities Through Issues Forums (Braun et al., 2022)
3. *Pathways Community HUB Manual*
4. Arizona's Community Cares: SDOH data collection and resource referral
5. PRAPARE: Nationally standardized and stakeholder driven, the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
6. Agency for Healthcare Research and Quality SDOH Database

Opportunities for Achieving Health Equity in Rural Settings Using Payment Models and Value-Based Care

Despite substantial barriers, there is a rising tide of attention on dismantling inequity in rural areas. From CMS to FORHP, The Center and other entities and individuals are committed to the mission. Recognizing that low volume in rural settings can lead to an endless cycle of "chasing the payments," panelists focused on leveraging the granular systems, like operational costs, and other factors within the control of rural health care entities and partners. In the move away from fee-for-service and toward population health and outcome-based reimbursement, communities can recognize shared savings from VBC and use those savings to improve health equity. Solutions focused on opportunities to capture payment would positively impact health equity.

Payment Models and Operational Costs Drivers

The drivers fueling health equity in rural areas include equity-related quality measures tied to payment, higher reimbursement rates and predictable payments, and payment adjustments for SDOH to address patient needs and resources. Front loading and global budgets would give hospitals an upfront amount of money to spend as needed to care for their community. If hospitals spend this money keeping people healthy, they could save money because they would not be engaging in as much "sick care." The money saved through this approach can be used to help keep all people healthy, not just those with insurance. Hospitals and clinics could also spend the money saved on addressing SDOH, which are tied to inequity. A front-loading payment structure and global budgets take "chasing the payments" out of the mix, increase services, and help keep the whole population healthy while putting resources toward SDOH challenges.

Strong board leadership and commitment to equity, along with creative community engagement, may help harness existing systems to reach all rural residents. The grit and resilience inherent in rural living is an asset in finding creative pathways to positive health outcomes in areas lacking resources.

Barriers and Challenges

As noted previously, rural systems and providers often lack the requisite education and technical assistance (TA) to code payments for accurate reimbursement, which leads to "under-coding," thus undermining revenue. This, in turn, dilutes the potential effectiveness of global budgets or accountable care organizations (ACOs). Much of the higher-level decision making around reimbursement and APMs is out of reach, making it difficult for rural hospitals and clinics to even get to the starting line.

Other challenges specific to payment models in rural health care include regulatory burdens, which impede sustainability; cost-based payment, which does not incentivize investment in new SDOH services; and limited or no reimbursement for CHWs.

Recommendations

Despite the regulatory and cultural challenges and lack of resources, there are actionable plans and steps rural health care entities can take to ignite health equity, serve the whole of the community, and do so in a way that is both financially viable and sustainable.

Shared costs, collaboration, and education, along with group purchasing, can help hospitals and clinics learn from each other.

Building on rural resilience and a strong sense of community, hospitals, clinics, and providers can collaborate on cost-saving measures and co-learning in moving toward a VBC and population health model. The concept of community partnerships and health care cohorts came up in several contexts during the summit and are addressed further, looking at other recommendations around care coordination, information systems, and education.

The primary recommendation around operational costs in rural areas was the creation of networks and collaboratives to support education around best practices and investigate how regions can share the cost of goods, services, and even staff.

Actionable steps to use collaboration to reduce and share operational costs include the following:

1. Internally, hospitals and clinics can consider what resources they need and then convene a group between themselves and the local community to identify the common resources currently available and additional ones needed to advance health equity.
2. In the process of gathering information about resources and needs, it is critical that hospitals and clinics reach out to multiple types of community groups, including law enforcement, mental health, EMS, schools, and local nonprofits to bring all stakeholders to the table.
3. Rural health care entities can establish clinically integrated regional networks and facilitate peer-to-peer convening to share ideas and best practices. For instance, a regional cohort of chief financial officers (CFOs) can gather to discuss finance, or directors of nursing can meet regularly to talk about clinical quality, health equity, and the potential for shared costs.
4. These collaborative groups could explore understanding and knowledge of ACOs, APMs, data, and networks to get a sense of what TA is needed (again, a cost and initiative that can be shared).
5. Established collaboratives can then do a deep dive into what costs can be shared, from the cost of certain services to shared staff and group purchasing. They can also study best practices to address high fixed costs related to revenue and implement these practices regionally—an effort that will also support the growth of population health management in rural health care.
6. Health care entities can access the HRSA grant process to create and sustain these networks or collaboratives. FORHP grants may also support the building of rural health care networks.
7. To enhance education required around this strategy, hospitals and clinics can train staff as ToP Facilitators to support cohorts and collaboratives as they explore the impact of new payment models and potential for shared costs. These facilitators and subject matter experts can then help providers and staff understand the impact of

coding for SDOH, enhanced payment for resource-related care management, and other financial routes and incentives that support equity and population health.

8. Regional collaboratives should consider shared staffing with expertise in health equity. For example, one health equity director could serve several hospitals and clinics to advance quality and population health.

Support efforts to enhance equity through telehealth and TA.

Telehealth played a crucial role in supporting medical needs during the pandemic and was regarded as an improvement to the provision of health services (Monaghesh, 2020). The Centers for Disease Control and Prevention (CDC) noted that "telehealth policy changes might continue to support increased care access during and after the pandemic" (Koonin et al., 2020). Rural residents often lack reliable transportation to providers and clinics for routine care. Therefore, the use of telehealth to achieve equity in rural settings should be not only continued, but also expanded. CMS had payment policies in place that provided reimbursement for telemedicine visits (Medicare payment policies during COVID-19 | Telehealth.HHS.gov). In March 2020, CMS greatly expanded flexibility and reimbursement for telehealth services through 1135 waivers. Among the many important allowances established are the following:

- Expansion of types of providers who can bill for telehealth, including the addition of clinical psychologists and licensed clinical social workers
- Coverage of counseling services via telemedicine
- Development of 81 new HCPCS/CPT codes for common telehealth services

These practices should become a fully reimbursed part of routine care in rural settings.

To support and grow the use of telehealth, rural communities must advocate for widened and efficient broadband services because, as was seen in education during the pandemic, access to reliable internet for health care is an essential right for all. When hospitals position themselves as anchor institutions, they can help lead the effort to increase internet,

and thus health care access, in their communities.

As clinics and hospitals work on sharing operational costs, there can be incentives and rewards for those focused on health equity at a financial and quality level. FORHP and CMS could support efforts at broadening inclusivity by providing sufficient TA for rural providers, who are often left out of the TA and education that benefits other hospitals and clinics.

In terms of supporting institutional movement toward VBC, hospitals and clinics must be able to perform a financial outcome analysis based on their census, acuity levels, and other markers, allowing them (with education and support) to see the financial impact under new payment models. Burdened by historically low volumes, rural health care enterprises must have the time and support to understand and embrace the potential financial outcomes of the new models. FORHP, The Center, and other organizations offer resources and training in all these subjects.

Use state Medicaid enhanced payments for advanced care management that provides services above and beyond acute care, such as food, pharmacy, and vouchers, allowing reimbursement for anything in lieu of acute care services that produces health.

With SDOH playing a prominent role in rural health care, it is critical that resources and services get to the people who need them. These products and services, which relate directly to the lack of resources leading to poor health, can and should be reimbursed under state Medicaid models, like the California model. California's Enhanced Care Management (ECM) provides reimbursement for advanced care management and serves as a model for other state Medicaid systems.[4]

[4] For data on outcomes of the California Home Health Program which was the foundation for what Enhanced Care Management (ECM) is really trying to replicate statewide, see Pourat et al., 2020, and Pourat et al., 2022.

ECM in this framework is designed to:

> …address clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services. It will meet enrollees wherever they are—on the street, in a shelter, in their doctor's office, or at home. Additionally, enrollees will have connections to Community Supports to meet their social needs, including medically supportive foods or housing supports. Enrollees will have a single Enhanced Care Manager who will coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems, making it easier for them to get the right care at the right time (California Department of Health Care Services, n.d.2).

From a federal perspective, CMS looked at an advance payment ACO model in 2015 (CMS, n.d.1). The model was designed for physician-based and rural providers who collaborated to give coordinated, high-quality care to their Medicare patients. While the effectiveness of this pilot was inconclusive, as noted, CMS now includes equity as a quality measure.

To address workforce shortages, hospitals and clinics should collaborate with community partners, schools, and other local resources to "grow their own" health care workforce.

Leaders in rural health care settings are plagued by a consistently worsening shortage of clinicians, nurses, and staff. The U.S. Bureau of Labor Statistics has projected the need for 194,500 new registered nurses per year to address the shortage (American Nurses Association, n.d.). Staffing shortages are a constant source of stress and financial strain on rural hospitals and clinics. Some estimate the cost of nursing turnover and shortages after the pandemic to be between $88 and $137 billion (Volmer, 2020).

Across the board, the challenges hospitals are facing in this country are generally worse in rural areas, and the rural nursing shortage is no exception (Sablik, 2021). Rural hospital budgets are stretched and burdened as leaders must often rely on expensive options like traveling

nurses to fill the gaps. Again, community collaboration can create opportunities for a mutually beneficial solution, providing jobs for residents while building relationships and good will in the community. As early as middle school, programs can create interest and a pathway for individuals to serve as health care support in local clinics and hospitals. High schools and community colleges can support continuation of this path.

However, the problem is not just a workforce shortage, but also the underlying poverty and lack of economic resources to support the kind of education and vision in rural communities necessary to develop health care workers and clinicians. Beyond "grow your own" efforts, major policy and program interventions are necessary to develop a rural health professions workforce (MacDowell et al., 2010).

Resources

1. FORHP grants for developing rural networks
2. Washington State's Accountable Communities of Health Model: supported collaborative communities that were "designed to be a neutral convener, coordinating body, investor, and connection point between the health care delivery system and local communities."
3. For a detailed summary of value-based initiatives for rural providers, see the catalog created by the Rural Policy Research Institute.

Opportunities for Improving Health Equity Through Care Coordination

Care coordination "synchronizes the delivery of a patient's health care from multiple providers and specialists. The goals of coordinated care are to improve health outcomes by ensuring that care from disparate providers is not delivered in silos, and to help reduce health care costs by eliminating redundant tests and procedures" (NEJM Catalyst 2018).

Community care coordination, according to Stratis Health's definition, which

The Center adopted at its Rural Hospital Care Coordination and Population Health Management Summit, is "a partnership among health care professionals, clinics and hospitals, specialists, pharmacists, mental health professionals, community services and other resources working together to provide patient-centered, coordinated care" (Stratis Health, 2020).
Done well, care coordination shifts the focus of health to the patient in the context of community, resourcing individuals with all available services and support to improve health outcomes. As rural hospitals and clinics evolve from fee-for-service payment models toward population health, care coordination moves front and center to drive the process. Proceeding with an equity lens, rural health care entities and providers can use the shift to enhance the overall health of the whole community.

Drivers

Coming back to the theme of rural resourcefulness in collaborating to solve problems, effective care coordination is achieved through community-based efforts that use existing strategies in under-resourced areas.

Rural hospitals and clinics can identify ways to meet unmet community needs and resources by serving as conveners of community organizations. A rural hospital, for instance, can become the anchor institution in a community by intentionally gathering stakeholders outside the walls of the hospital. This effort not only builds relationships and good will but can also help identify those individuals who may not normally access these systems and services.

Here are some other identified drivers that fuel equity in care coordination in the move toward population health:

- Higher reimbursement for rural hospitals and providers
- Addressing SDOH as part of strategic plans
- Population health management support through technical assistance (TA) and education
- Expanding primary care via telehealth, using existing COVID reimbursement protocols
- Policies, payments, and reimbursement that match community needs

Barriers and Challenges

The biggest barrier in care coordination in rural settings is the lack of resources and reimbursement for the kinds of services and social support necessary to meet the needs of the whole community. These include:

- Lack of coordination across systems of care
- No reimbursement for relationship-building in communities to address SDOH
- No reimbursement for CHWs
- Low patient volume and limited services, hampering negotiating rates with managed care organizations (MCOs)
- No funding to track quality metrics and access to health at the community level
- Lack of wrap-around services, such as home health or hospice
- Lack of rehab, skilled nursing facilities (SNFs), or long-term care options

In addressing solutions, panelists focused on "boots on the ground" community engagement, which enlists individuals from within the community, like EMS and CHWs, to connect patients with necessary services.

Recommendations

Use CHWs to meet people where they live and act as grassroots care coordinators.

The American Public Health Association defines a CHW as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served."

CHWs are crucial in rural areas where health services are limited—particularly services for diverse populations or those who rarely access primary services, whether out of fear or stigma. CHWs share the cultural and geographic experiences of the population they serve, making them accessible and relatable for many individuals.

According to the HRSA funded Rural Health Information Hub, "CHWs in rural areas work to improve health care outcomes by facilitating health care

access, adding value to the health care team, and enriching the quality of life for their patients and clients, including those who are poor, underserved, and in racial and ethnic minority communities."

Trusted members of the community who work closely with patients in their homes and neighborhoods can be an invaluable tool in reaching diverse populations and making the kinds of connections that lead to more resources and services.

Rural health care entities should focus on building trusting relationships in the community to explore and expand access to care coordination services.

Hospitals and clinics can be centers of the community, creating connection and involvement that supports care coordination and equity. Health care organizations need to know their communities, which means they must do care coordination that is incentivized or reimbursed. This process organically enhances both health equity and positive outcomes for population health.

Leaders and providers should get "outside the box" of the four walls of the hospital or clinic and into the community. They should build alliances with churches, schools, law enforcement, mental health services, local nonprofit organizations, and groups that have the pulse of the whole community. As in every endeavor, the equity lens should widen to make sure the whole rural region can be reached. Community collaborators should include individuals and organizations that directly address those populations who may need more resources.

In many rural communities, churches are a vital source of support in reaching older adults, people of color, and individuals in need of services. Faith communities can be a valuable partner in providing transportation, for instance, or assisting with patients who cannot leave their homes. Law enforcement interacts with people dealing with addiction and substance use as well as those who may have a chronic mental illness. If health care entities and providers build authentic relationships with these community-based partners, the transition to population health and VBC could be more organic and less problematic. With these partnerships comes the

recognition that the entire community can benefit from a VBC shared savings to improve both health equity and quality of life in the region.

Use technology, platforms, and central registries to increase access to and effectiveness of care coordination.

As noted, Arizona's SDOH referral system, Community Cares, is a model of effective rural care coordination. Powered by the state's Medicaid Whole Person Care Initiative, the platform is designed to "connect health care and community service providers to streamline the referral process, foster easier access to vital services and provide confirmation when social services are delivered."

The use of technology recognizes the importance of social factors in health, illness, and access to care. An SDOH-based, closed-loop referral system ensures individuals do not "slip through the cracks" and do, in fact, receive the range of services available and necessary to health and healing.

Community Cares uses the NowPow platform for referrals, one of many available platforms available for addressing a spectrum of individual needs like food, shelter, and caregiver support. Acting in isolation, providers, hospitals, and clinics simply cannot provide these kinds of support to patients; but by leveraging technology in rural settings, health care systems ensure that patients are receiving the non-medical basic assistance they need to get and stay healthier.

The Pathways Community HUB model, created by the Agency for Healthcare Research and Quality, is a centralized means for referring and tracking individuals who have been referred for services offered by the network of care coordination agencies. The Pathways model tracks the progress of individual clients and monitors the workers providing services. The data can also help organizations evaluate their overall performance in serving the community, thus supporting appropriate payments, and promoting quality improvement.

Data collection, stratification, and analysis are a crucial part of increasing equity and providing care for the entire population, not just those who are insured or who routinely access services. Rural organizations can leverage

these platforms to deliver high-quality coordinated care to the whole of their community while potentially securing additional funding through the measurable outcomes provided.

Rural hospitals have resources to help them implement programs to integrate health care consortiums and community care coordination. In fact, in 2020, HRSA awarded more than $7.4 million in Rural Health care Coordination Program grants to improve access, delivery, and quality of care through care coordination strategies in rural communities.

Resources

- HRSA Rural Health Care Coordination Program Awards
- Rural Community Health Worker Network
- Resources for CHWs in Rural Settings
- *Pathways Community HUB Manual*
- ASTHO: *Collaborations Between Health Systems and Community Organizations*
- Rural Care Coordination Toolkits
- Care Coordination Canvas Guide
- Sustainable Community Care Coordination Guide

Opportunities for Improving Health Equity Through Robust and Educated Board Leadership

Drivers

As rural health care moves into different financial models with a focus on population health, hospital board leaders should be at the forefront of the transition, understanding the principles of VBC and the significance of broadening the equity lens in traditionally under-resourced areas. Since data is central to equity and new payment models, boards should also comprehend the interdependence of information systems, reimbursement, and community engagement.

As summit panelists focused on operational costs and financial drivers, they were particularly emphatic about how rural boards can and should be the engine of authentic change in their communities. A diverse and educated board can be the key factors in improving equity, including education on the importance of SDOH for population health, data analytics, and peer-to-peer support programs. Additionally, a board that is well educated on these topics can spearhead efforts to traditional and non-traditional partners. If boards cannot pivot to a broader perspective that welcomes education and innovative methods of serving the whole population, rural health care may continue to suffer attrition of providers and revenue. It is important to emphasize that hospital leaders remain responsible for equitable solutions.

Barriers and Challenges

Given regulatory burdens and low volume, rural hospital boards have traditionally been focused on budgets and financial stability, a perspective that may inadvertently divert resources and attention away from patient care and population health services to stay fiscally afloat. Rural boards face unique and complex challenges quite different from their urban peers. Rural board members are often local businesspeople who understand costs and revenue but may not comprehend the extensive responsibility of equity, quality, and inclusive patient care. Again, however, it is important to remember that adaptability is inherently part of rural living, and hospital boards can reflect that resiliency in moving towards equity.

However, rural boards may not reflect the whole of the population and are often comprised of white residents with some financial background rather than community members who mirror the actual population. In rural areas, non-white individuals and those with varied gender identities or orientations are rarely seen on rural hospital boards (Probst, 2010). The data show that non-white residents comprise only 15% of the total U.S. rural population, but 30% of rural residents experiencing poverty. One study found that up to 5% of the rural population identified as LGBTQIA+ which equals approximately 20% of the country's overall LGBTQIA+ population. The LGBTQIA+ community is, in fact, a "fundamental part of the fabric of rural communities" (Movement Advancement Project, 2019).

If a board does not embrace the fact that their community includes diverse

neighbors, and builds board membership accordingly, it is underserving its population. As clinics, hospitals, and providers inevitably move toward VBC and population health, a less diverse board or one continuing to travel down the traditional path could make rural health care even less sustainable.

Recommendations

Equity must be embedded in every hospital's strategic plan.

Strategic plans drive the life of an organization, its direction and longevity. As health care evolves, so must the guiding frameworks of rural hospitals and clinics. Just as quality became part of many strategic plans when CMS began tracking quality measures, so equity must be baked into the fabric of every rural hospital and clinic's strategic agenda.

As discussed, CMS has made equity a priority and has implemented a measure that affects payment based on factors reflecting equitable practices, incentivizing hospitals to make equity a primary focus in its standard of care. With a thoughtful process informed by the necessary education and facilitation, a rural board can guide its institution toward a new model of care that is equitable, sustainable, and a part of the everyday fabric of rural health care entities.

Build health equity goals and expectations into job descriptions.

Once health equity is a pillar in a hospital or clinic's strategic plan, it should be built into job descriptions as part of assessments and evaluations—just as other quality measures are now folded into job expectations, from environmental services to security, administration, and clinical staff.

Job descriptions for previously employed staff should be amended to include this measure, along with thoughtful education of all staff about equity and quality. As all employees level up to the equity outlook, a hospital and clinic culture can transform into one that improves outcomes for the whole of the community.

Rural hospital boards must intentionally build equity in their membership so that boards represent the whole of the community.

Human capital is limited in rural areas and small board size (often the case in rural settings) can lead to an absence of race and gender diversity. In a survey of rural board members, 95% identify themselves as white and 78% male. CEOs were also primarily white (98%) and male (82%).[5] This demographic excludes diverse community members, from non-white residents to women and young people and people with different backgrounds and experience.

As board members nominate individuals for new seats, they should keep this focus front and center: diversifying the board to represent the whole community will fuel the transition to population health and VBC models and advance equity by bringing the voice of the entire community to the table. Concurrent efforts may include a formal recruitment process where individuals with diverse backgrounds and varying experience and education can be identified and sought out for board seats. There should be a robust orientation program for new members, so they do not feel diminished or unwelcomed from the outset.

According to the American Hospital Association's (AHA's) Institute for Diversity and Health Equity, some hospitals go a step further, organizing and building community leadership boards that are:

> comprised of leaders of community organizations that are served by a hospital, such as social service agencies, faith community leaders, neighborhood coalition and educational institution leaders as well as leaders representing mental health, housing, law enforcement and emergency preparedness initiatives, among others. Convening these organizational leaders on a regular basis can help get information out to the community as well as provide a feedback loop to the hospital leadership about the needs, concerns, and satisfaction from the community (Henson, 2020).

Community health workers should serve either on a hospital board itself or on this kind of community leadership advisory board.

[5] Rural Acute Care Hospital Boards of Directors: Education and Development Needed

Rural boards must lead by example, inviting extensive education and training on how equity can fuel new payment models and population health outcomes.

Education was an overarching theme during the summit, with panelists emphasizing the necessity and importance of technical assistance and training for the new frontiers of information services, payment models, and the transition to VBC. Education can and should be provided to all employees, clinicians, providers, administrators, and board members regarding the expansion of access and services to make sure all community members are being served and supported. A rural board turning its attention to equity as a measure of quality should welcome education around the changing landscape of health care financial models and reimbursement, and how the wide net of community inclusiveness can improve outcomes measured in population health services.

The Federal Office of Rural Health Policy offers support, analysis, and evidence-based solutions for rural health care institutions. The Center also provides expertise and resources in building a robust population health and community services model on the journey to VBC through Visionary Board Leadership and the Transition to Value Video Series. Additionally, "Best on Board" is a voluntary, evidence-based certification program for board members that provides health care organization board training and health care governance education.

With education, skill, and diversity, rural boards can transform their institutions from hospitals struggling to achieve financial stability into leaders in both equity and high performance, and as anchor institutions in rural communities.

Resources

- Diversity on the rural hospital board: challenges for today and beyond
- How to Recruit Diverse Board Members
- South Carolina Rural Health Research Center: *Is Your Hospital's Board Prepared to Govern?*

Best Practices in Fueling Health Equity in Rural Communities

Hopefully, this report ignites interest and shared information about best practices in building rural health equity. In addition to the solutions panelists brought to the table—many containing new perspectives to promote and build equity in under-resourced rural settings—there are standards already in place for elevating equity as rural institutions and providers move toward VBC and population health management.

A Path to Equity for Rural Health: Key Takeaways from the American Hospital Association (AHA) and Institute for Diversity and Health Equity (IFDHE) (Hanson, 2020).

Just before the COVID-19 outbreak, the IFDHE convened at the AHA's annual Rural Conference. The gathering resulted in key takeaways on the path toward rural equity in health care:

1. Rural hospitals can lead in communities when they embrace their role as anchor institutions.

   As noted throughout this report, rural hospitals can no longer operate in silos in their communities. Rather, in the path toward population health, the community itself must drive change and hospitals can become the central force in the transformation by bringing stakeholders together, forming authentic relationships outside the four walls of the institution, intentionally expanding the diversity of their boards, implementing strategic data collection, and surveying for community health needs.

2. Leverage channels of communication throughout the community.

   Community partners or "connectors" cast a wide net in rural areas and create collaborative, engaging communication channels that generate transformation. As the community "anchor institution," a rural hospital can build partnerships that allow robust sharing of information and solutions. Types of community partners include schools, mental and behavioral health providers, EMS, chambers of commerce, local nonprofits, and faith-based leaders.

3. Narrow the focus to gain immediate improvements.

   IFDHE encourages rural entities to "capitalize on low-hanging fruit," building small successes that create trust in the community and among stakeholders. Bring the community together to collect data on relevant needs and then "act quickly" in simple yet powerful ways like creating leadership boards and neighborhood coalitions to start addressing identified needs and issues.

4. Identify funding sources.

   As rural health care struggles with low volumes and lack of resources, it is imperative that communities find creative opportunities to positively impact a variety of populations. Aid available during the pandemic may still be accessible, and the FORHP, AHA, and others offer grants to build networks and solution-oriented collaborations.

5. Sow the seeds of success.

   Even with the small wins, hospitals and clinics should share successes around practices and innovation in their communities, and with the AHA IFDHE and the AHA's rural issues webpage.

6. Drive policy reform to influence systemic change.

   Certain waivers, regulatory flexibility, and reimbursement changes granted during the pandemic can be extended or made permanent. Learn more about what the AHA is doing in this regard at the federal level and let rural health care's voice from local hospitals and clinics be heard in support.

Follow the AHA Health Equity Roadmap's Six Levers of Transformation.

The AHA IFDHE has created a wealth of guidance and resources to help hospitals and health care systems become more equitable and inclusive. The Health Equity Roadmap provides toolkits and guidance for organizations, whether they are just beginning to explore the pathway to

equity or have committed to making and affirming the transformation.

AHA IFDHE's Six Levers of Transformation (each with resources) are:

1. Culturally Appropriate Patient Care
2. Equitable and Inclusive Organizational Policies
3. Collection and Use of Data to Drive Action
4. Diverse Representation in Leadership and Governance
5. Community Collaboration for Solutions
6. Systemic and Shared Accountability

The literature overview appended to the Roadmap provides an additional wealth of information and resources on best practices in expanding health equity.

Follow best practices for data collection in rural areas.

The Rural Health Information Hub has extensive resources and toolkits for helping rural health care institutions collect and analyze quantitative and qualitative data in rural community health settings. This source sets out specific steps in improving data collection as well as evidence-based practice and policy indicators for a variety of health promotion and disease prevention initiatives. The National Rural Health Resource Center provides a tool with a web-based interactive dashboard to educate stakeholders on population health data analytics.

Community forums are a way to not only gather data, but also concurrently build relationships in the community. As hospitals aim to be that "anchor institution" in their region, authentic and trusting connections are critical; if the community loses faith in its health care institution and providers, outcomes and equity can suffer. Learn how to launch a community forum and use the data to expand your reach to all members of the community.

Innovative Models in Creating Equity in Rural Health Care

Summit panelists referenced several innovative models for fueling rural health equity; those already discussed and referenced include the following:

1. The Pathways Community HUB model addresses SDOH, acting as a central registry of at-risk individuals to eliminate organizational silos and reduce duplication of services. The model is discussed further in the section on care coordination.
2. The California Medicaid model provides reimbursement for advanced care management, serving as a model for other state Medicaid systems.
3. Arizona's SDOH referral system, Community Cares, is a model of effective rural care coordination.
4. Washington's Accountable Communities of Health model supports collaborative communities that are "designed to be a neutral convener, coordinating body, investor, and connection point between the health care delivery system and local communities."

There are many other models of innovation throughout the country addressing the nexus between payment models and equitable health care, particularly in the context of population health services and outcomes. Though not specific to rural areas, this ASTHO Report highlights successful collaborations between health systems and community-based organizations.

For a more extensive list of innovative models in health care delivery and finance in rural settings, see Rural Health Value's Profiles in Innovation. While not directed at driving equity, these models address the whole-person, whole-population service concept that inevitably leads to more inclusion and access for diverse populations.

So much of the success of rural models in health care depends on community collaboration. The CDC's Making the Case for Collaborative Community Health Improvement (CHI)) includes several examples of successful community efforts to improve the health of patients.

Often, inequity exists in the delivery of health care in rural settings because of fragmented and siloed services and institutions. The Rural Policy Research Institute (RUPRI) has a repository of successful models of innovation reflecting efforts to transform rural hospitals into high-performing systems. A review of the case studies highlights many of the panelists' recommendations on expanding the health and social services capacities of rural health care, a focus that organically ignites access and equity. The University of Minnesota Rural Health Research Center has case studies and best practices for rural community organizations building inclusive environments for LGBTQIA+ residents.

Finally, the experience of Mt. Ascutney Hospital in rural Vermont provides an in-depth review of how a rural critical access hospital (CAH) partnered with the state's dominant payers to test an APM that required innovative health care delivery and achievement of shared goals. This model requires that CAHs work with payers to develop value-based models that reimburse in ways appropriate to small rural hospitals. CMS studied the Vermont model (CMS, n.d.2) and concluded that, although the model did not achieve its all-payer and Medicare target goals, it achieved statistically significant Medicare gross spending reductions as well as declines in acute care stays.

Conclusion

Equitable health care increases quality for all. The move toward population health requires rural communities to ask the seminal questions, *"Who are we serving?"* and *"Who should we be serving?"* Many of the solutions and recommendations herein can help rural hospitals and clinics answer those questions through robust data collection, care coordination, and education.

The strength of rural areas lies in the communities' ability to band together in the face of formidable challenges, including the delivery of high-quality, all-inclusive health care and related services. The prominent theme of the summit was the concept that rural health care institutions can use that collaborative spirit to break down barriers and open to non-traditional partnerships, widening the reach of health care to provide better access, services, and health to the whole population.

Appendix A: Summit Panelists

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Appendix B: Resources and References

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