



The Future of Rural Health Leadership

December 2006

**Rural Health
Resource Center**
Technical Assistance and Services Center

The Rural Health Resource Center's Technical Assistance and Services Center (TASC) supports the work of the state offices of rural health and other health care organizations by providing technical assistance, information, and process tools to rural communities. TASC is funded by the Health Resources and Services Administration's Office of Rural Health Policy and is administered by the Rural Health Resource Center, a private, non-profit organization.

The authors of this report are Terry J. Hill, MPA, and Tami Lichtenberg of the Rural Health Resource Center's Technical Assistance and Services Center (TASC) and Valerie DeFor of the Minnesota Healthcare and Industry Partnership.

The authors of this paper would like thank the attendees of the Rural Health Leadership Summit held in Minneapolis, Minnesota in the fall of 2005 for their contributions to this paper and the advancement of leadership in rural health.

Questions regarding this paper should be directed to: Tami Lichtenberg at (218) 727-9390 ext. 230 or tlichten@ruralcenter.org .

**The Rural Health Resource Center's
Technical Assistance and Services Center**
600 E. Superior St., Suite 404
Duluth, MN 55802
(218) 727-9390
<http://tasc.ruralhealth.hrsa.gov>

“Leadership is very clearly the lever to make everything happen in rural health care.”

-Forrest W. Calico, MD

Background

The most recent Institute of Medicine report, *Quality Through Collaboration: The Future of Rural Health*, outlined core strategies for improving health care in rural America. Central to each of their recommendations was the need for profound change and enlightened leadership.

Most rural health stakeholders would agree that leadership is at the core of successful health care delivery. Its importance exceeds that of virtually every other critical variable used in predicting success for rural health programs, networks, hospitals and other organizations. Like quality, however, leadership is a skill that often defies measurement. Similar to medicine, it is often attributed to a combination of science and art. Some observers define leadership intangibly, and know it when they see it; others pursue it through long years of study and contemplation; still others work in the limelight of renowned health leaders, and hope some of the magic will rub off.

The rapid evolution into consumer-driven health care (CDHC) will require transformational change, and rural communities are often resistant to doing things differently. It is part of their charm, and, to some degree, it has been part of their strength. Health care providers, too, are proving resistant to a new system that not only grades them, but also openly questions their medical decisions. Professional life for these providers has become unfair and more than a little aggravating.

Nevertheless, change is here and will accelerate in the next several years. Rural health care must adapt or be judged irrelevant at best, or dangerous at worst. The key to this adaptation to change, and ultimately to success or failure, will be leadership—ordinary people in ordinary communities stepping forward with extraordinary commitments to excellence and quality.

The Rural Health Resource Center (RHRC), the federal Office of Rural Health Policy (ORHP) and many other state and national rural health organizations recognize this vital leadership piece as necessary to complete the rural health care system puzzle. They believe there is a need to define leadership in rural health terms, discover where it currently takes place, and identify strategies to develop and sustain it in rural health settings. To address these challenges, rural health experts from throughout the country met in Minneapolis, Minnesota at a Rural Health Leadership Summit Meeting in the fall of 2005.

The goals of the Summit, which evolved from two previous Rural Health Quality Summits in 2003 and 2004, were to:

- 1) Share information on rural health leadership initiatives currently underway. Determine where rural health leadership is today.
- 2) Identify what will be needed tomorrow regarding rural health leadership in terms of resources, education, and technology and determine the gap between where rural health is now and where it needs to be.
- 3) Identify strategies and recommendations for bridging the rural health leadership gap, and include them in a brief white paper that can be disseminated broadly.

The following is a summary of the two-day meeting.

Methods

Attendees

The summit attendees represent a geographically diverse group with varied experiences and expertise in rural health care. Specifically represented were individuals with extensive experience in academia, hospital administration, board leadership and development, system administration, and physician and nursing leadership.

Forrest Calico, MD, National Rural Health Association
 Paul “Buz” Davis, Davis & Associates
 Nancy Egbert, Office of Rural Health Policy
 Brian Haapala, Stroudwater Associates
 Bob Hartl, College of St. Scholastica
 Wayne Hellerstedt, Helen Newberry Joy Hospital
 Terry Hill, Rural Health Resource Center
 Dave Hoffman, Wipfli
 Geoff Kaufmann, Center for Diagnostic Imaging
 Tami Lichtenberg, Rural Health Resource Center
 Dan McLaughlin, University of St. Thomas
 Ira Moscovice, University of Minnesota
 Emily Nicholson, Rural Health Resource Center
 Mary Ellen Pratt, UHC-HC
 Cheri Rinehart, Pennsylvania Hospital Association
 Tim Size, Rural Wisconsin Health Cooperative
 Kip Smith, Montana Health Research & Education Foundation
 Jim Stokes, Management 21

Recorder: Valerie DeFor, Minnesota Healthcare and Industry Partnership

Focus/Goals

The summit focused primarily on health care providers in small, rural communities where critical access hospitals (CAHs) are the hub of the health care delivery system. Although recognizing that many other entities contribute to the health of rural communities – public health, clinics, migrant health, etc.- the organizers chose to focus on small rural hospitals.

The goals of the summit were to identify the current issues surrounding rural health leadership and identify specific resources and recommendations related to those issues, tying them back to the IOM report where appropriate. The group's consensus was that without effective leadership from hospital administrators, clinicians, and board members, rural hospitals and other rural health care providers, rural health would be unable to achieve the highest level of health care quality.

RHRC took advantage of having so many rural health care leaders in one location to ask each participant to share his/her own perspective on leadership in the field and update others on important work being done throughout the country. Several themes emerged from that environmental scan which became the focus and framework for the Summits' discussions. Those leadership themes included board education and development, population health, clinician leadership, and administrative or management leadership.

Process

Over the course of two days, the participants discussed the rural hospital leadership themes in a variety of small groups, facilitated discussions, and large group interactions.

The two days included a mixture of tightly facilitated and free discussion sessions. The agenda started with a facilitated discussion of leadership, an environmental scan, and a "campfire" conversation about leadership. The first day concluded with assigned dinner discussions that continued well into the evening. The second day was dedicated to drilling down into each of the four areas, synthesizing the ideas and solutions, as well as identifying the resources that would be needed to infuse exemplary leadership into rural hospital and health care settings.

The summit was facilitated by Terry Hill and Bob Hartl. Hill, the executive director of the Rural Health Resource Center has over 25 years of rural health care experience at the local, state and national level. Hartl, chair of the management department at the College of St. Scholastica in Duluth, MN, is an expert on leadership and has an extensive health care background.

Rather than spending time having the group discuss the widely variable definition of leadership and which definition to use, Hartl, provided a framework for the group to

evaluate the concepts of leadership and offered theories of leadership that the group could build consensus around. They identified the following traits of strong leaders:

- An influencer
- A consensus builder
- A change agent
- A potentiator – gets things done through others
- Servant leadership-emphasizes collaboration, trust, empathy, and the ethical use of power
- Can create a sense of urgency without panic

Proceedings

“How did we develop leaders in the past? I’m a rural health leader but I don’t recall ever being trained to be a rural health leader.”

Board/Governance Leadership

Excellent board leadership enables the organization to obtain and retain CEO leadership and focus on execution of organizational strategies. However, small rural hospitals often do not spend sufficient time or resources engaging and educating their boards, thereby enabling them to be effective advocates for health care in their rural communities.

In addition, participants recognized the critical role that governing bodies play in quality improvement. Participants contended that the overall quality of trustee leadership is better than it has ever been but that it is not good enough to effectively, and proactively, handle the challenges facing rural health care.

In today’s challenging health care arena, there is a need to improve at an accelerated rate and take on new challenges such as population health and quality improvement. In rural communities, board member selection, development, and leadership can be more challenging than in urban areas where the talent pool is larger.

Community leaders in rural areas are frequently overloaded by serving on multiple boards or organizations. As one participant noted, “The world is run by people who show up.” In a rural community, it can be difficult to get board members to attend meetings in addition to their other commitments. In addition to a generally smaller population from which to draw board members, rural hospitals may also have more difficulty finding the appropriate expertise within their communities. Keeping this in mind, how can rural hospital leaders overcome these difficulties and develop strong, effective governing bodies that are able to lead their organizations into the future?

Recommendations

Participants identified several key recommendations in the area of governance. Composition, education, and operational recommendations were identified as key areas of focus as were a set of research questions meant to collect concrete knowledge about rural boards.

Composition

Administrators and Boards should evaluate board composition with an eye toward identifying gaps in abilities and knowledge required to further the organizations strategic objectives. Board policies should also address this issue. It is not unusual for board members to be recruited based on their professions: an accountant, a lawyer, a banker, etc. In addition to focusing on professional experience, hospital leaders need to look for leadership qualities and skill sets that are currently lacking on the Board.

In addition, the hospital administrator should review the organization's board structure. For example, public hospitals might have different rules regarding board composition than private hospitals; some boards are chosen through elections and others by appointment. In hospitals with appointed board members, the administrator should be proactive about educating those who make appointments about the characteristics needed on the board.

Administrators and board members should evaluate whether all board slots need to be filled with community members. For example, the hospital might be better served by including out-of-town members or even out-of-state members, if those members provide a unique or currently unavailable skill set. Committee appointments for non-board members can be a useful way to strengthen the organization and groom potential board members. Advisory boards might also be used to gain needed expertise. Participants suggested that the Rural Health Resource Center's Technical Assistance and Services Center (TASC) could create and facilitate an advisory board that could serve all rural hospitals.

Education

Board members need education about their responsibilities, and should be given tools to enable them to fulfill those tasks. This direction needs to begin immediately upon service with a new board member orientation. An orientation tool kit should be made available to all rural hospitals. Orientation should be extended to include a mentoring program for new board members.

Education should continue for all board members and be an agenda item at each board meeting. The topics should be tied into the organization's strategic plan or be pertinent to specific needs of the organization. Presentations could be made by hospital staff, local experts, or even staff from other hospitals or health organizations. Education on medical

staff issues and the viewpoint of rural physicians should be a key component for every rural hospital board. Board education should be treated as a necessary expense and should be allocated resources in the hospital's budget.

In the past, the American Hospital Association publication, *Trustee*, was one method of providing timely information to hospital board members. In its absence, state hospital associations should strive to become a resource to provide education specifically targeted to rural hospitals. For example, many hospital associations and health systems provide seminars for board members, but too few hospitals take advantage of the opportunities. For those board members able to attend, too few have follow up educational support at the local board meetings to convey what they learned.

Hospital administrators need to be willing to identify these educational opportunities and to give board members the ability, resources and encouragement to attend educational events. Other outside experts should be identified to meet the specific needs of the hospital – financial, planning, epidemiology, etc. Special educational opportunities should be offered for board chairs. Participants suggested that a central clearinghouse be created which could include off-the-shelf presentations, tool kits, internet resources, or other easily accessible and affordable educational tools.

Operational

On a practical level, participants encouraged the use of a consent agenda. A consent agenda is a practice by which mundane and non-controversial board action items are organized apart from the rest of the agenda and approved as a group. This includes all of the business items that require formal board approval and yet, because they are not controversial, require no board discussion before taking a vote. Using a consent agenda can free up time for both board education and discussion of strategic initiatives.

Other suggestions included having clearly written job descriptions, conflict of interest rules, and strategic plans that include measurable objectives. It was recommended that boards have annual evaluations of their effectiveness and performance. These performance evaluations should contain specific measures to determine if the board members were working well together. Ideally, these measures could be compared with other hospitals. Participants identified a gap in the knowledge base as to what the key competencies of high performing rural boards are. It was recommended that TASC conduct a national study to identify the features and characteristics of high performing boards to share with rural hospitals throughout the country.

Hospital Administration and Management

Hospital administrators in rural facilities face unique challenges. Small hospital frequently lack mid-level managers or the cadre of specialized vice presidents available in large hospitals. This presents a challenge not only for experienced administrators but also for new administrators who are thrust into leadership roles without the proving ground/safety net of mid-level positions. Many participants likened the recruitment of administrators in rural areas to that of recruitment of rural providers.

The trends in education of rural hospital administrators were a concern of participants. The recent growth in non-accredited programs in hospital administration has led to greater variability in quality and less consistency in competencies upon graduation. The increased emphasis on distance learning was also seen as both an opportunity and a concern by participants.

With challenges facing rural hospitals, team-oriented education and training was identified as critical for the hospital leader of the future. Interdisciplinary education is also important for administrators to gain the skills needed to work with a variety of clinicians in various care settings. With the upcoming focus on population health, administrators will need to be able to work effectively with a variety of external organizations.

Recommendations

Three key themes came out of the hospital administration and management discussion: recruitment, competency/education, and teamwork.

Recruitment

Hospital administrators need to make and keep up-to-date succession plans. Active mentoring programs could help develop local talent. “Grow your own” and “find those with the passion for rural” are strategies that work for administrators as well as providers.

Education

Since the advent of prospective payment in 1983, hospital administration has become more business-centered and finance-driven. Health and hospital administration programs, which were historically housed in schools of public health, became more commonly housed in business schools. Those programs that did not move into business schools certainly incorporated additional finance and business content into their curricula. This focus serves administrators well in the financially driven environment of health care, but participants raised concerns about whether future administrators will have the collaboration skills necessary to forge the partnerships required by a population health agenda. These skills need to be highlighted in educational programs.

Support of accredited programs should ensure a consistency in the quality of education. Participants believed that while distance education can be effective for much of the content, these programs need to be complemented and strengthened by on-campus interactions with other students and faculty. At least one state, Mississippi, has enacted a minimum standard that requires hospital administrators to hold a Masters degree. With no uniform standard, and disagreement about imposing requirements on entry into the field, it is even more important that hospital administrators identify the skill sets needed in rural hospital leadership and ensure that they are incorporated into the curricula.

Teamwork

Existing university-based resources should be accessed and educational institutions should be encouraged to provide interdisciplinary, team-oriented education. In some parts of the country, area health education centers (AHECs) are a valuable source of education and training. Community leadership initiatives also provide a mechanism for rural hospital leaders to improve collaboration skills and make connections within the community. These initiatives are operating in parts of the country yet are often overlooked by the health care industry.

Clinician Leadership

Participants identified the role of the physician leader as being critical to quality improvement in rural health facilities. In addition, the inclusion of non-physician clinicians in leadership roles was identified as critical for rural hospitals, which need to focus on the involvement of many rather than exclusion and hierarchy. Focusing on one discipline (i.e., physicians) could perpetuate a silo mentality, counterproductive to the team-approach needed in the future. The current workforce shortage means that rural administrators often lack the ability to find the “best fit” for all job openings. Therefore, continued education and training is even more important to create a strong provider base with the leadership skills needed to take rural health care into the future. Participants also noted that physicians, in particular, operate under a very different paradigm than administrators. This divergence begins early in educational programs, which divide professionals into silos and discipline areas. As a result, students often lack an understanding of how to effectively interact and collaborate with others.

Participants identified several recommendations to improve and enhance physician and clinical leadership skills in rural hospitals.

Recommendations

Formal and Continuing Education

Participants contend that, for the most part, medical schools have failed rural America. Not only is there a shortage of physicians, but the experiences of most medical students do little to encourage physicians to choose rural practices. Medical schools need to adapt curriculum to reflect an interdisciplinary model of care. They also need to incorporate leadership content explicitly.

There have been, and are, very good examples of medical education which emphasize and encourage rural practice. These models need to be communicated, strengthened, and replicated. Osteopathic schools, in particular, were noted for successfully producing rural practitioners. Without an adequate pool of physicians from which to draw, expansion of leadership is more difficult due to workload demands and reduced opportunities for selective recruiting.

Historically, physicians have taken leadership roles in quality issues, but in the future, leadership on other initiatives will be required to implement IOM recommendations and to influence population health. Hospital administrators need to provide continuing education to physicians and mid-level clinicians so that they can be active leaders in all aspects of the organization.

In order for clinicians to take on multiple leadership roles in rural hospitals, additional training programs will be necessary. The American College of Physician Executives, American College of Healthcare Executives, and other university models could serve as starting points for training. In Montana, for example, the hospital association brought together medical staff leaders from its 45 CAH members to discuss quality improvement efforts. Other participants noted that physicians and clinicians could not continue to be left out of leadership development. To this point, the Marshfield Clinic system in Wisconsin, is implementing a large customized training program that pairs up a physician and an administrator for health care leadership training. An important piece of that project is the “re-entry” component that helps physicians counter-act the “gone to the dark side” reaction from other clinicians when they return to their practices.

Incentives

Financial and other incentives need to be in place to fully leverage the skills and interests of clinicians in ways that affect leadership. In addition to incentivizing clinicians to take leadership roles in quality improvement activities, financial incentives need to be aligned so that preventive and primary care services are more attractive to clinicians. Pay-for-performance (P4P) programs, at both state and national levels, are beginning to incorporate measures that reflect prevention and chronic illness management goals. This is evident in both hospital and clinical P4P programs that financially reward physician and hospital leaders for doing the right thing. On a long-term basis, the result may be

healthier patients and reduced health care costs. Provider leadership in any of these P4P programs will be integral to their success.

Administration and Clinician Interactions

Rural hospital leaders need to understand the physician paradigm and develop interactions and partnerships that help both parties achieve their respective objectives. In the past, administrators have attempted to force physicians and clinicians into the administrative world – a world frequently filled with slow-moving meetings – rather than leveraging the provider’s expertise and interest in alternative processes. Rural hospitals have a tremendous opportunity to adopt new ways of interacting with physicians due to the interconnectedness and relationships that pervade rural health care settings. New, streamlined communication processes, however, will be essential.

Population Health

The IOM focus on population health is both an opportunity and a challenge for rural hospitals. On the one hand, rural hospitals’ proximity to the communities they serve makes population health initiatives easier to implement. On the other hand, adding population health to the rural hospital agenda creates additional stress on an already overloaded infrastructure. While population health is recognized as being “the right thing to do”, participants noted that the current health system does not provide financial incentives for population health initiatives.

The dichotomy in participants’ views regarding population health was striking. Many believe population health is something that has always been done while others believe it is something that has yet to be developed, at least in meaningful ways. Participants even had different conceptual models of population health. Describing population health as including, but different from public health, participants agree that this is the concept that both holds the greatest potential and provides the biggest challenge. Improving health status through reducing disparities, providing preventive care, and addressing determinants of health directly related to health care, such as immunization compliance, requires significant leadership, collaboration, and commitment.

Recommendations

Recommendations in population health centered on the following themes:

- Incentives are not currently aligned to encourage population health efforts.
- The localized nature of population health initiatives requires effective communication, so that successes and failures can be shared across the country.

- Population health requires long-term vision that is not easily compatible with the short-term, crisis-oriented mode of rural hospitals that are frequently struggling simply to survive.
- Networking and partnerships need to be established to bring more visibility to rural health care.
- The business community should be a key partner with rural hospitals in population health initiatives.

Incentive Alignment

The current “system” of funding for health care in the United States does not provide hospitals with financial incentives to implement the types of population health initiatives envisioned by the IOM. In fact, there are many disincentives built into the current funding formulas. These incentives and disincentives exist in both critical access hospitals who receive cost-based Medicare payments, and in non-critical access hospitals that are paid prospectively. As an example, expanding a hospital-based “Meals on Wheels” program could dilute reimbursable costs in the dietary department of a critical access hospital. The dilemma rural hospital leaders often face is that these services may meet a critical need in the community. Discontinuing the services may be the right thing to do financially, but it will be the wrong thing to do for the health of the community. Hospitals should not have to choose between margin and mission. Both are essential. Incentives, therefore, need to be properly aligned to enable rural hospitals to implement population health in a substantive manner that does not threaten their financial viability.

Everything is Local

Each rural hospital is different, and each community served is unique in important ways. The participants identified vast differences in payer mix. Rural Mississippi and Alaska hospitals, for example, have a large Medicaid mix; Montana’s rural hospitals, on the other hand, have very few Medicaid patients and instead have a large Medicare population. Therefore, it is difficult to identify any one population health initiative that will work throughout rural America. Participants were able to identify many population health initiatives that were working in individual communities. It was recommended that a communication system be established to share these community models. In this manner, hospital leaders could learn from the experiences of others and create local initiatives that positively influence community health.

Long-Term Vision

Many rural hospital leaders have functioned in crisis mode for more than twenty years. Solving immediate problems such as recruiting providers, meeting payroll, implementing HIPAA regulations, and maintaining facilities keep hospital administrators very busy. Often, they are unable to develop long-term strategies and implementation plans. A long-term vision that incorporates providers, insurers, and the community is required for the

successful implementation of population health initiatives. A strategic framework, such as the Balanced Scorecard, and other planning and management tools can be useful in providing focus and direction.

Networking/Partnership

Several participants indicated that effective networks and partnerships are essential. For rural hospitals to survive and influence the health of their communities, effective administrative leadership is required to identify, enter into, and support networks and partnerships. Rural hospitals are *“tired of being statistically insignificant.”* They are pulling together to aggregate their numbers, compound their strengths, and provide means for benchmarking and comparing performance.

Business Community Involvement

Involvement of payers will be critical to improve the health of rural communities. At a national level, Medicare and Medicaid policy needs to be changed to support consistent population health efforts throughout the country. At the state and local levels, employers are likely to push for population health initiatives to improve health and reduce health care costs. Participants believe that it is critical for leaders to make an economic case for population health initiatives and to identify funding sources to support these efforts. Reaching out to the business community will require rural hospital leaders who are skilled at collaboration and who can communicate the long-term vision to partners.

Summary

The participants attending the two-day summit on leadership were passionate about the future of rural health care. While the challenges of rural hospital administration are many, they concluded, the opportunities are great. Capitalizing on these opportunities will require strong leadership on the part of administrators, board members, clinicians, and community organizations and businesses. Participants identified many recommendations related to leadership that will enable rural hospitals to address the Institute of Medicine (IOM) recommendations and improve the quality of health care in rural America.

The next step will be to take those recommendations and evaluate them for feasibility and resource availability. Participants also identified a number of recommendations that would not require increased risk or many extra resources that could be implemented in order to achieve short-term results.

One message that resonated throughout the Summit was that now is the time for action. Rural health leaders cannot afford to wait on the sidelines to determine where and how the health care parade will go and follow after. Rural health, with its smaller size and greater mobility, can lead the parade and create the future. In the end, the determining factor in health care reform will come down to leadership.

“Some is not a number, Soon is not a time.”—Don Berwick, MD