Rallying Around Rural Care:

Hospitals Strive to Deliver Accessible Services

ROBIN ROENKER
Contributor to *Health Progress*

Roughly 1 in 5 Americans — more than 60 million in all — live in rural areas across the country. For these residents of rural ZIP codes, locating accessible health care can feel like an uphill battle.[1]

The striking provider disparity between urban and rural areas in America is one key reason why. While urban areas currently average 31 providers per 10,000 people, rural areas have just 13 per 10,000 residents. And while urban areas boast 263 specialists for every 100,000 individuals, rural areas have only 30 specialists available per 100,000 people, according to the National Rural Health Association.[2]

Across the country, Catholic hospital systems are working diligently to bridge this divide and provide greater health care access to residents of small towns and farm communities.

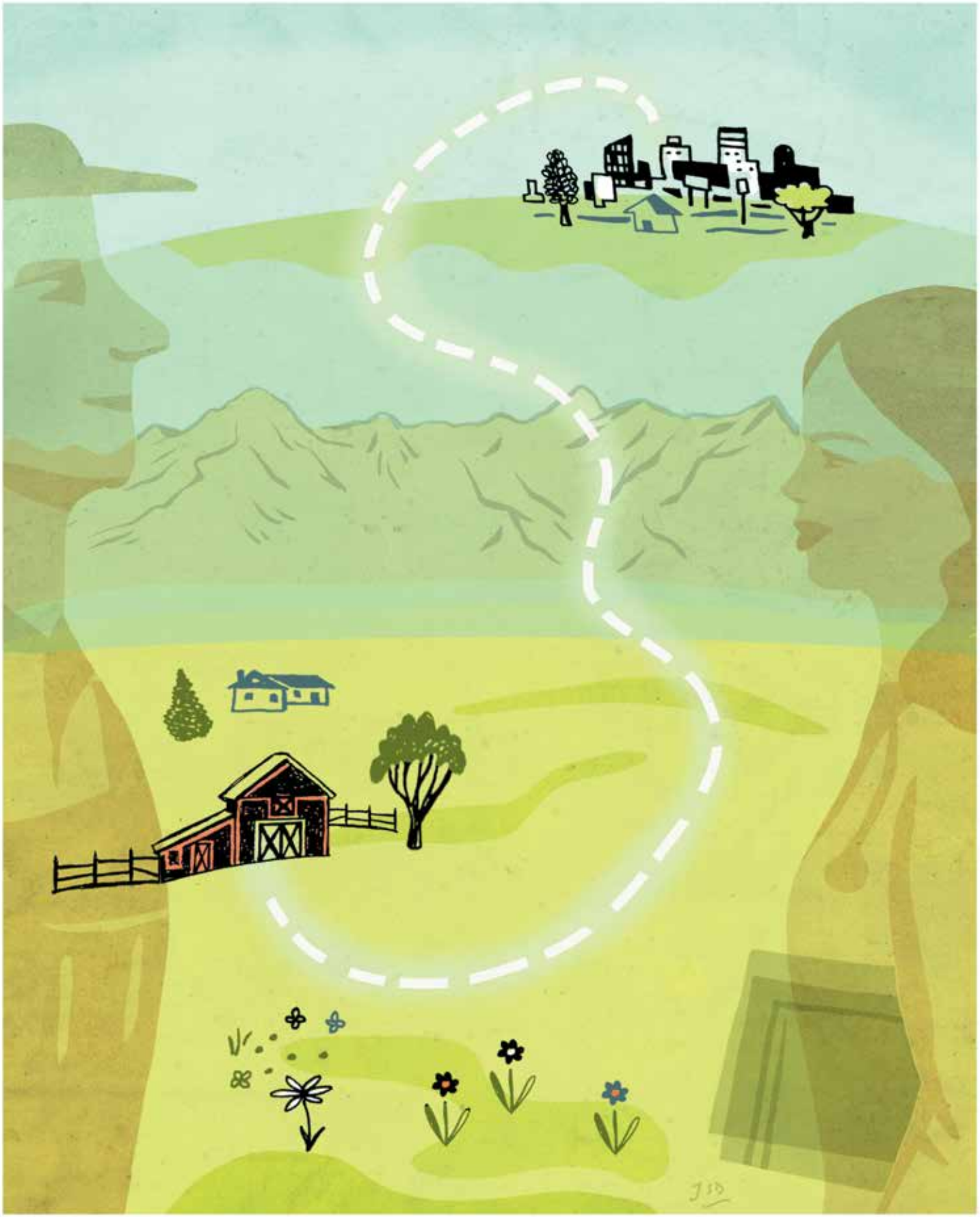
When it comes to maximizing rural health care delivery, "It's really a theme of each patient getting the right care at the right place at the right time," said Kevin Post, DO, chief medical officer for Avera Health. To pursue that mission, Avera has prioritized "keeping the patient at the center of focus, while leveraging innovative tools" to support rural health care providers, Post said.

Other systems, including SSM Health and Intermountain Health, are doing the same. Drawing on innovative telehealth applications, creative staff recruitment initiatives and organizational models that optimize the reach of available staff and facilities, Catholic health systems strive to provide all patients with top-notch care, unhindered by community size.

RETHINKING RURAL CARE DELIVERY

Historically, rural residents have poorer health outcomes, on the whole, than those who live in urban areas.[3] Death rates from heart disease, cancer, stroke and respiratory disease tend to be higher in rural areas,[4] leading to a life expectancy for rural residents that's roughly 2.5 years lower than their urban counterparts — a gap that continues to widen.[5] These outcomes are tied to a myriad of health determinants, from smoking rates and obesity rates to residents' access to nutritious food, health insurance and accessible health care, among other factors.

Hospital administrators said tackling this rural-urban disparity will require a multipronged approach, with telehealth programming serving as a powerful tool to help level the health care playing field.



Beginning with telehealth programming for critical care in 2014, Intermountain Health has grown its telehealth services footprint to include 105 programs, including telestroke, telehospitalist, teleoncology, telechaplaincy and telecrisis (behavioral health) services. The telehealth programs serve Intermountain Health's entire 33-hospital footprint, including five Catholic hospitals across Montana and Colorado, as well as 43 hospitals outside of the Intermountain Health system that receive services on a contract basis.

"Through telehealth, we can bring specialty care to the patients, instead of bringing the patient to specialty care," said John Williams, Intermountain Health's assistant vice president of telehealth services. Having access to specialists via telemedicine reduces travel time for patients, allowing them to receive expert care in smaller, local, critical access hospitals, which frequently do not have specialists, like neurologists, on staff.[6]

"If we have a patient who walks into the emergency room who is suspected of having a stroke, staff will call our command center to be immediately connected with our telestroke team," Williams said. "Typically, in under three minutes, [the remote specialists] are able to see that patient, and they're able to run through their assessments, using video technology, to work with the local physician or local APP [advanced practice provider], depending on how that hospital is staffed, to help develop a care plan for that patient."

"Through telehealth, we can bring specialty care to the patients, instead of bringing the patient to specialty care."

— JOHN WILLIAMS

Systems generally transfer patients to tertiary sites if a higher acuity of care or an ancillary service is needed to maintain quality and safety of care.

At Avera — where 37 hospitals serve a footprint of 72,000 square miles across South Dakota, North Dakota, Nebraska, Iowa and Minnesota — a similar approach uses telehealth to deliver specialty services, like cardiac or oncology care, to rural facilities without those specialists on staff. "Telehealth services allow us to leverage our care team to the top of license," said Post, noting that 90% of Avera's hospitals are critical access facilities with 25 or fewer beds.

"Our patients [in rural hospital settings] will see local, advanced practice providers, while getting remote access to specialists — perhaps back in Sioux Falls — so they really feel like they're getting cared for by a team," Post said.

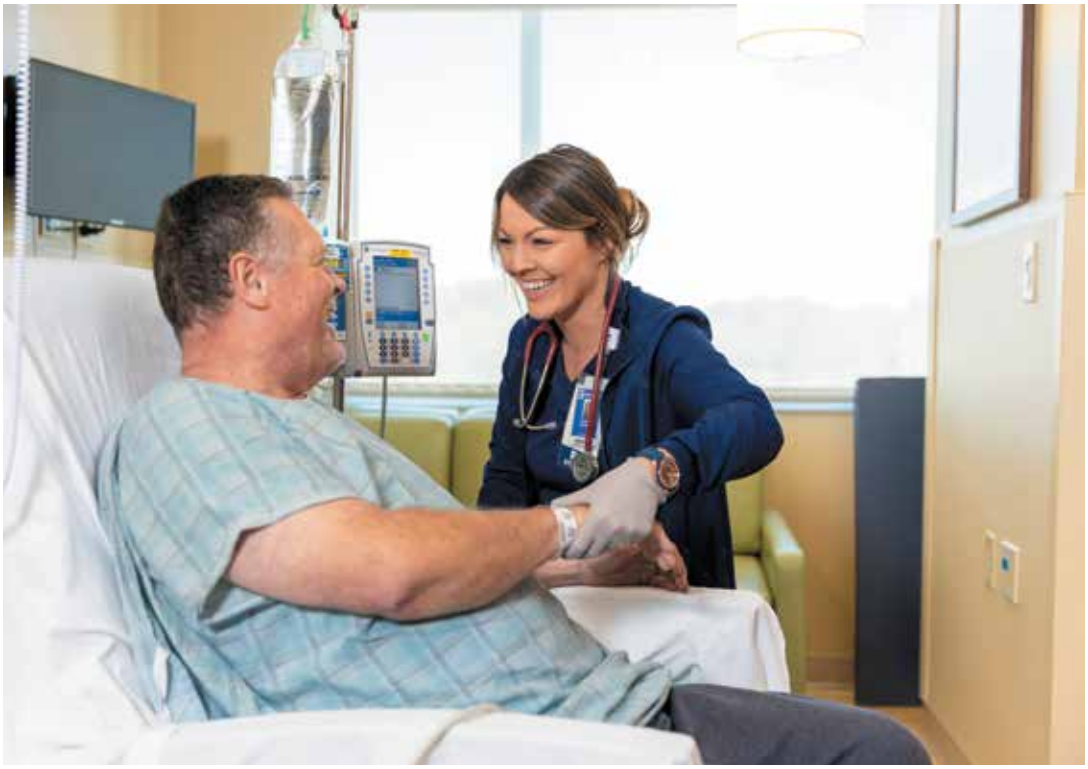
Operating 23 hospitals across Illinois, Missouri, Oklahoma and Wisconsin, SSM Health, too, is "leaning heavily into telehealth to see how we can better open up care access for our patients," said Stephanie Duggan, MD, the system's chief clinical officer. She notes that SSM Health's adoption of specialty services using telehealth — including stroke services — is well integrated across their network. Their next goal: integrating primary care using telehealth just as effectively, drawing on a regional service model.

"We need to lean into [telehealth] resources in a different way," she said. "Telehealth can feel a bit impersonal, but if we can develop a regional telehealth center [where patients see the same, regionally based primary care providers] ... we can help patients gain greater trust and confidence in the person on the other end of that camera."

Like many systems, SSM Health, Intermountain Health and Avera Health also use telehealth services paired with remote monitoring technology as a prevention tool. These programs provide real-time biofeedback for patients at risk of cardiovascular disease, diabetes or even prepartum[7] or postpartum complications. This allows providers to identify and address possible red flags before symptoms progress to critical levels.

From a health care provider's perspective, having the support of telehealth services can, in some cases, lessen the challenges of accepting a post in a rural area, where staffing can be stretched thin. Avera is among the systems that have found success, for example, in implementing an artificial intelligence-supported virtual nursing program that lets remote, central hub teams use in-room cameras to monitor patient fall or bed sore risk, reconcile medications and do other routine tasks.[8] This addition of "virtual eyes on beds" helps free on-site nurses to focus their expertise on other, high-level responsibilities, Post said.

Additionally, Intermountain Health found that hospitals using its nighttime telehospitalist services discovered it's now easier to retain staff, Williams said. "Because this service allows us to



Courtesy of SSM Health

Kalynn Bonifacius, today a registered nurse, checks the vital signs of Hank Villani at SSM Health Good Samaritan Hospital in Mount Vernon, Illinois, when previously in a nursing training program.

handle admit orders overnight virtually, on-site physicians no longer have to be on call 24/7. It allows the on-site teams to refresh and have some time with their families. As a result, these communities are able to recruit and retain physicians much more successfully."

BUILDING A RURAL WORKFORCE PIPELINE

Recruiting and retaining staff is a critical concern at rural hospitals and clinics, as it is everywhere in health care.

Administrators at SSM Health, Intermountain Health and Avera Health agreed that building a pipeline of rural care providers remains a key focus. Each system is developing specific outreach programming to address ongoing staffing needs.

"We have to have people see rural medicine in a different light," Duggan said, pointing to the power of offering on-site, rural shadowing opportunities for young physicians. "It's about showing [them] how vital and what an important role and a difference one can make by being a part of a smaller community," she said. "Often that is enough for them to say, 'Hey, maybe I could see myself living in a more rural community, even though I didn't grow up there.'"

For some providers, the rural setting is a real draw. SSM Health's two southern Illinois hospitals, St. Mary's Hospital in Centralia and Good Samaritan Hospital in Mount Vernon, for instance, have found notable success recruiting locally. Partnering with area community colleges, the hospitals offer a nursing extern program that allows current nursing students to gain hands-on training while still in school. To date, roughly 85% of program participants have gone on to accept full-time SSM Health nursing positions in either Centralia or Mount Vernon. The hospital system hopes to expand the program soon to include other modalities, including respiratory therapy.

SSM Health also actively works to build partnerships with area high schools, sending representatives to career days and health class presentations, all with the hope of attracting local stu-

dents to the diverse array of health careers at an earlier age.

"We're having to get more creative to build our own [workforce] pipelines," said Damon Harbison, president at both SSM Health St. Mary's Hospital — Centralia and Good Samaritan Hospital. "While we of course welcome outsiders, what we have found is that when you're able to attract locals who already have staked their claim to the area, so to speak, you're going to have more success in retention."

For its part, Avera has found traction in attracting and retaining nurses through internships and an innovative internal travel nurse recruitment program. This program offers high-paid travel placements limited to 13 Avera sites across three states.

"It's a win-win," Post said. "Participating nurses get the benefit of a higher compensation rate, but with the security of having employment by a health system. Meanwhile, from a system perspective, we're getting the benefit of placing our own team members who can move seamlessly between sites because they're comfortable with our care protocols."

OPTIMIZING CARE DELIVERY

Since 2005, 112 hospitals serving rural counties across the country have closed completely. During the same period, another 84 rural-serving hospitals converted to non-acute or non-inpatient care, according to the University of North Carolina at Chapel Hill's Cecil G. Sheps Center for Health Services Research.[9]

In the last five years, more than 100 rural labor and delivery units have closed across the U.S. Today, fewer than half of America's rural hospitals offer maternity services.[10]

These closures offer glimpses of what could become a growing trend. Already, roughly 44% of rural hospitals in America are operating with negative margins, according to KFF (formerly the Kaiser Family Foundation).[11]

As hospital system margins become further squeezed by health cost escalations and dwindling reimbursements, rural systems, especially, will need to continue making careful decisions regarding where and how best to deliver care to maximize efficiencies, leaders said.

Service delivery challenges may become even more difficult after the passage in July of HR-1, better known as the One Big Beautiful Bill Act. Those who opposed this legislation fear that reductions in Medicaid and Medicare funding could lead to the shuttering of many rural care facilities.

Just after the bill's passage, Ascension posted a statement from its president, Eduardo Conrado, noting that the impending cuts "risk destabilizing the health care system, especially in rural and underserved areas."[12]

While the newly signed legislation does include $50 billion in federal funding for a new "rural health transformation program," that figure represents only slightly more than one-third of the estimated loss of federal Medicaid funding in rural areas, according to KFF.[13]

While some details of the fund's allocation remain unclear, it's expected that half will be distributed equally across all 50 states, with CMS retaining discretion regarding allocation of the remaining $25 billion.[14]

In times when there's a challenging operational climate, rural systems will be forced to rethink their delivery approach, Harbison said.

"Twenty-five or 30 years ago, every community hospital was trying to offer every service they possibly could. Those times are over," he said. "With the impending reimbursement cuts, there will be a lot of boardroom discussions about the need to potentially close services or consolidate or close hospitals."

In navigating those decisions, SSM Health will focus on how best to deliver the precise, tailored services each community needs, Harbison said. To identify those services, the system already leverages a multistep approach, including patient surveys, dialogues with providers, and formal community needs assessments.

SSM Health also plans to continue building partnerships with community agencies and even competing health systems to ensure health services remain available in small market areas.

"If we can help patients by doing something together, then that's the right thing to do," Harbison said.

At Avera, care delivery optimization plans include ramping up core care services at its regional hospitals, so patients in very remote areas can still access critical care within, say, a two-hour drive rather than needing to travel four or more hours to an urban, tertiary site, Post said.

Avera also plans to remain laser-focused on meeting community service needs and developing local partnerships to address rural citizens' food, housing and transportation insecurities.

Additionally, across the country, many small

hospitals have found success working with larger regional hospitals — as either managed or affiliate partners — to leverage efficiencies in supply chain management, regulatory protocols and other top-level administrative demands.

These partnerships have led to substantial cost savings and operational advantages for participants in Illinois, said Harbison, who serves as president of SSM Health's Southern Illinois rural health network.

"Over the last several years, we have worked with smaller hospitals in the area to ... build relationships to ensure that everyone is working at the top of their scope to help their communities," Harbison said.

"I think we are going to see this more and more, that [community] hospitals are going to partner up with bigger systems" to operate successfully, Harbison added. "There's a sense that we don't need to be operating in silos. People are realizing there's power in working as a system to create a [best practice] playbook for rural health."

Finally, health care providers must continue assessing the quality of their care delivery through the lens of patient experience. At every turn, health care leaders said, their goal is to provide streamlined, accessible, top-notch care, regardless of an area's population size.

"I think one of the most important things we can do," SSM Health's Duggan said, "is to lean into available technology, standardizing where it makes sense, so our patients have a consistent, quality care experience."

ROBIN ROENKER is a freelance writer based in Lexington, Kentucky. She has more than 15 years of experience reporting on health and wellness, higher education and business trends.

NOTES

1. "How We Define Rural," Health Resources & Services Administration, February 2025, https://www.hrsa.gov/rural-health/about-us/what-is-rural.
2. "About Rural Health Care," NRHA, https://www.ruralhealth.us/about-us/about-rural-health-care.
3. Kendal Orgera, Siena Senn, and Atul Grover, "Rethinking Rural Health," AAMC, September 27, 2023, https://www.aamc.org/advocacy-policy/rethinking-rural-health.
4. Sally C. Curtin and Merianne Rose Spencer, "Trends in Death Rates in Urban and Rural Areas: United States, 1999-2019," NCHS Data Brief, no. 417 (2021): https://dx.doi.org/10.15620/cdc:109049; Macarena C. Garcia et al., "Preventable Premature Deaths from the Five Leading Causes of Death in Nonmetropolitan and Metropolitan Counties, United States, 2010-2022," *Morbidity and Mortality Weekly Report: Surveillance Summaries* 73, no. 2 (May 2, 2024): http://dx.doi.org/10.15585/mmwr.ss7302a1.
5. Jaime Aron, "What's Health Care Like in Rural America? We're Taking a Close-Up Look," American Heart Association News, April 30, 2024, https://www.heart.org/en/news/2024/04/30/whats-health-care-like-in-rural-america-were-taking-a-close-up-look; Jack M. Chapel, Elizabeth Currid-Halkett, and Bryan Tysinger, "The Urban-Rural Gap in Older Americans' Healthy Life Expectancy," *The Journal of Rural Health* 41 (2025), https://doi.org/10.1111/jrh.12875.
6. "Critical Access Hospitals," Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/critical-access-hospitals.
7. Julie Minda, "Avera Health Uses Remote Monitoring to Improve Health Outcomes for New Moms in Eastern South Dakota," *Catholic Health World*, June 2025, https://www.chausa.org/news-and-publications/publications/catholic-health-world/archives/june-2025/avera-health-uses-remote-monitoring-to-improve-health-outcomes-for-new-moms-in-eastern-south-dakota.
8. "Avera Expands Telemedicine Efforts to Virtual Nursing," Avera, Balance (blog), December 12, 2023, https://www.avera.org/balance/family-medicine/avera-expands-telemedicine-efforts-to-virtual-nursing/.
9. "Rural Hospital Closures," Cecil G. Sheps Center for Health Services Research, https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
10. "Stopping the Loss of Rural Maternity Care," Center for Healthcare Quality & Payment Reform, June 2025, https://chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf.
11. Zachary Levinson and Tricia Neuman, "A Closer Look at the $50 Billion Rural Health Fund in the New Reconciliation Law," KFF, July 24, 2025, https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-50-billion-rural-health-fund-in-the-new-reconciliation-law/.
12. Eduardo Conrado, "Statement on Medicaid and ACA Cuts in Newly Passed Legislation," Ascension, July 3, 2025, https://about.ascension.org/news/2025/07/statement-on-medicaid-and-aca-cuts-in-newly-passed-legislation.
13. Levinson and Neuman, "A Closer Look at the $50 Billion Rural Health Fund."
14. Levinson and Neuman, "A Closer Look at the $50 Billion Rural Health Fund."