GROWING *America's Rural Hospitals*

As America's rural hospitals face the future, new opportunities and challenges await. But leaders must plan today for tomorrow's growth. Securing not only the future operation of rural hospitals, but planning for their growth and their continued role as a partner in America's communities are essential.

Many factors can affect the health of rural hospitals themselves, ranging from incorporating new technologies to recruiting doctors and nurses to maintaining financial independence.

Expected economic and population growth in many rural regions will require more forward-thinking guidance of health care facilities. What are the best ways to plan for and fund this growth? Facilities designated as Critical Access Hospitals find new financial security along with new rules and requirements. What roles will government regulations and financing play in the future for rural facilities?

Rural population trends, government regulations, workforce shortages, financing and replacing facilities: These are issues challenging America's rural hospital leaders today.

These issues are explored through the expertise of four professionals in the health care sector experienced with small and rural hospitals. From a recent roundtable discussion, sponsored by InnoVative Capital and QHR (formerly Quorum Health Resources), the National Rural Health Association offers these insights of trends and trials facing rural hospitals.

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PARTICIPANTS IN THIS ROUNDTABLE ARE:

Alan Morgan
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Morgan has been with the National Rural Health Association since 2001 and is CEO. Previously, Morgan served on the staffs of former U.S. Congressman Dick Nichols and former Kansas Gov. Mike Hayden. His experience includes tenures with the American Society of Clinical Pathologists and the Heart Rhythm Society, and he served as manager of government relations for the Veterans Hospital Administration. Morgan's health policy articles have been published in a number of health-related journals. In 2004, he was recognized by *The Hill* newspaper as being among the top sector-specific lobbyists in Washington, D.C.

Alan P. Richman
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Richman is president and CEO of InnoVative Capital, a health care financial advisory firm and HUD-licensed FHA mortgage lender with a market emphasis on rural, community and Critical Access Hospitals. With 24 years experience in hospital finance, public finance, and real estate banking, he has worked with hospitals in 40 states. Previously, Richman was head of municipal bond research at the Vanguard Group, a senior commercial banker, an investment banker and a municipal bond analyst. In these capacities, he has structured transactions for hospitals utilizing rated and non-rated tax-exempt bonds, fixed and variable rate securities, tax-backed debt, pooled loans, Fannie Mae and USDA guarantees, as well as FHA Section 242 loans.

John D. Short
President, Management Division
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As president of QHR's Management Division, Short oversees five U.S. regions and is responsible for development, operations, management advisory services and consulting support for almost 200 independent hospitals and health systems across the United States. Prior to this position, he was president of QHR's Central Division. Short has more than 23 years of experience in both the not-for-profit and for-profit health care sectors, as well as with two major national management consulting firms. His experience covers a broad range of hospital sizes and ownership structures in more than 35 states.

Brock A. Slabach
Administrator
Field Memorial Community Hospital
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Slabach has served as administrator of Field Memorial Community Hospital in Centreville, Miss., since 1987. He started his career in the health care sector as a respiratory therapy technician and since has served as administrator at several small and rural hospitals. Currently, Slabach sits on the Board of Trustees of the National Rural Health Association and is chair of its Hospital and Health Systems Constituency Group. Additionally, he is a member of the federal Office of Rural Health Policy's Rural Hospital Issues Group and the immediate past-president of the Delta Rural Health Network.

Who will provide leadership and governance to rural hospitals facing increasingly complex challenges and unprecedented opportunities? How will the ownership or structure of rural hospitals evolve?

SLABACH: Obviously, the leadership and governance structure of any rural hospital must be tailored to the unique health care and societal demands of the community. This includes the recognition that change may be inevitable. It is also going to require everyone in the community contributing to the development of something that works for all.

SHORT: The main thrust of QHR is to help independent hospitals stay independent. To accomplish that, we believe leadership must come from multiple sources. Trustees and community leaders as well as management, medical staff, and nursing — everyone has a role to play. But I think it starts at the top. What's going to make it happen is the trustees taking an active, visionary leadership role. It is more than attending meetings — it is a commitment to continuing your education to stay abreast of emerging trends and to establish a vision that looks beyond the present. In addition, one of the most important roles trustees play is the selection and evaluation of the management team, because that team has to execute the vision for the trustees. Investment of time in the selection process as well as feedback on an ongoing basis is extremely important.

As for the ownership structure, I don't think there is any one solution that is going to permeate throughout the industry. For many rural hospitals, the fate of ownership is in their own hands, provided they have a progressive board, results-oriented management and community involvement. Others, who don't take charge and are not proactive, may require a capital partner, or in the worst case, face closing.

RICHMAN: By the very nature of the services they offer and populations they serve, the majority of our Critical Access Hospitals are essential. But essentiality does not always translate into profitability or even self-sufficiency. In those instances, where operational re-engineering is not successful, a financial partner is often the only answer. For many hospitals this financial partner is the municipality itself. Because many CAHs are owned by their municipality, tax support can be the difference between financial health, operating stagnation, or insolvency.

Another trend I envision in the future is health care campus development in rural America. Private sector firms will buy land, facilitate the financing and development of a new hospital, add a medical office building, senior living facilities and perhaps a commercial shopping strip. This continuum of care and a campus environment with its ancillary activities will increase the overall profitability of the venture and be a real boost to the local economy. While there is no reason why this scenario can't be led by the municipality and hospital themselves, the inclusion of physicians and the private sector may accelerate the process.

MORGAN: Right now across the United States, with communities facing different challenges and different local economic considerations, you see many responses to both the leadership issue and the ownership structure. It is premature to pick one strategy that is going to work for all communities. But I would expect, in the next five or 10 years, two or three general strategies may lead all others in ensuring that communities can keep their hospitals viable.

National studies forecast positive population trends and accelerated economic development in rural areas over the next 10 years. Accordingly, how will rural hospitals determine the health care needs of their growing communities and provide the services that will meet those needs?

RICHMAN: With wireless telecommunications, the Internet and 70-mile-an-hour interstate transportation, businesses need not be landlocked in urban areas. The out-migration from cities to the perceived safety and civility of rural America has increased the desirability of farm and suburban living, and new communities are being developed 45 to 60 miles from an urban population source. There is a tremendous upswing of people who want to live in these communities, even though some will still work in the neighboring city. Because of this, health care needs in rural America are expected to grow tremendously.

An important aspect for a hospital to consider is the diversity of the employment base of its patient pool. If a rural hospital is planning its financial growth or a capital project dependent upon the benefit plan of one major company and that company downsizes, consolidates, merges, or leaves town, a hospital could very quickly experience a disastrous financial downturn. Lastly, hospitals cannot plan their capital projects and services around the notion of enticing economic growth, but rather should be one part of an overall community plan.

MORGAN: Today's technology advancements make rural living and employment an option for individuals and businesses that was not possible 10 years ago. I don't think we can underestimate the seminal shift we are seeing in census trends and even political power in the United States away from urban areas toward rural areas. The populating of rural areas with former urbanites is going to mean big challenges for hospital administrators because urban transplants expect a level of rural health care similar to the services provided in more populated areas. The ability to deliver diagnostic and urgent care at modern Critical Access Hospitals and to tap into a solid referral network will rise to the forefront of planning activities.

SLABACH: As the CEO of a Critical Access Hospital, I am perhaps a bit more reserved in my view of rural population growth because I think that many community hospitals in rural areas in

the throws of long-term economic and population stagnation are truly vulnerable. There are many who depend totally on Medicare or Medicaid to pay for services that they receive and are challenged by limited reimbursement and also increasing bad debt exposure. This will really test the ability of community hospitals to meet the expectations of delivering a competent level of health care in rural areas.

SHORT: To effectively identify and prepare for the future health care needs of the community, every hospital needs to have a three- to five-year strategic plan, updated annually, because the trends are moving. The market is not static, and the plan needs to be data-driven based on what is happening with the population, socioeconomics and changes in health care delivery and medical/clinical technology. There are many sources of information that hospitals can access to project forward how the shifting population might affect them — not just total population, but also age and gender distribution. Demographic information can be combined with utilization information that is readily available from state health plans, state hospital associations or external consultant databases to build a forward-looking profile for market demand and volume, which is extremely important when you try to establish future service, facility and capital needs. There are also physician demand models to use in a medical staff development plan. This is needed for recruitment planning because we know how hard it is to recruit physicians to rural communities, particularly in some specialty areas. This is a data-driven approach, but includes the qualitative input of your medical staff. It is very important to involve your physicians in your planning process.

All of this analysis creates a demand forecast that you can examine: Do our facilities, do our technologies, does our equipment give us the ability to provide access to the level of care and recruit the physicians our community needs? If not, what is it going to take to get there? You have not only day-to-day operating requirements, but you also will have capital requirements.

MORGAN: It is the education system and the health care system in rural communities that attract and retain people. Not surprisingly, in almost every rural community, these are the two largest employers as well. When you look at what is happening now with the CAH program, you see these small rural hospitals upgrading their facilities. You see their patient volumes increasing as well. Once you start this movement, it continues, it builds upon itself. This is going to impact the changing demographics and population shifts.

As physicians and nurses are the lifeblood of any hospital, what are some effective recruiting and retention strategies? How can the hospital board, administration and medical staff work together to support recruitment and retention?

RICHMAN: In recruiting medical staff, physicians and nurses, you want to tell them how this opportunity benefits them. They are interested in building a good life for their families and being able to work in an environment that is professionally fulfilling. Hospitals with well-conceived facility modernization plans already in place and publicized community support should have the most recruiting success. But never make promises prematurely, or those you cannot keep, because this will only build disappointment and may serve as a catalyst for medical staff departures. For both nurses and doctors, a hospital investment in local students enrolled in medical schools and nursing colleges through scholarships and work study can boost loyalty among possible recruits.

SHORT: Look at board governance, medical staff and management as a three-legged stool, and if any one of those legs weakens or breaks, the stool falls. One of the big keys to retaining physicians and building that leg of the stool, if you will, is to bond physicians to your organization by giving them a meaningful role in governance and leadership. Physicians will generally be happier with their practice setting if they've got a say in organizational direction and a role in planning for current technology and facilities. So the challenge for management and the board is to sell today's tough operational and financial decisions to its medical staff in a way that leads toward a better future practice environment — if there's a plan to create that, you will have more success recruiting and retaining physicians.

As for nursing, we've learned over the years that the practice environment is even more important than compensation as the determinant of whether nurses stay around. That means providing a practice environment that offers a role for nurses in shared governance on the nursing units and the empowerment to make decisions and improvements when something is not right, without having to go through a bureaucratic process to get it done. Despite national nursing turnover rates of around 20 percent, I have seen hospitals that have implemented this shared governance approach reduce turnover rates to less than 5 percent.

MORGAN: More than 20 years of research into physician and health staff recruitment and retention has shown an underlying principle that you have to grow your own. They have to be from rural America if you're going to be able to recruit them and keep them in these areas. That's easy to say, but that's tough to do because it requires leadership within the hospital administration and it requires collaboration between the community hospital and the local education system, from high school to two-year community colleges to four-year colleges.

Not surprisingly, as the homegrown workforce is not always large enough to meet hospital staffing needs, the Department of Labor has identified the rural health care workforce marketplace as having a high growth potential. They are now spending a lot of resources at the Department of Labor trying to determine what creative models work to recruit and retain health care professionals in rural America. And they're coming up with innovative solutions that follow along these same lines: How do we bring together the education community, the business community, and the health care community to make sure that people from rural areas have an opportunity to stay and work and live in their communities?

SLABACH: I've always been intrigued that Medicare payment policy assumes labor is cheaper to hire in rural areas than it is in the cities. I find that you have to pay a little bit more to get

people to come to the rural areas, particularly in professional categories. So, obviously, the pay scales have to be competitive. The board, administration and medical staff have to work together to be as creative and innovative as possible in accommodating the staffing needs of your facility.

There are many ways to increase the supply of these critically needed professionals. For nursing recruitment, I would suggest partnering with community colleges that are training nurses, but are having a difficult time attracting teachers into their programs. Our facility has allowed some of our nurse practitioners to be faculty members in those community colleges and then have students train in our hospital or our system.

MORGAN: Brock raised a good point regarding the reimbursement bias against rural hospitals when comparing Medicare and Medicaid versus private pay. Another hurdle for physician recruitment and retention is the physician liability crisis. That is playing a significant role, especially in the medical specialties, such as obstetrics/gynecology.

Hospital modernization is a high priority for many rural hospitals as it is well-documented that new facilities can contribute to improved physician recruitment, patient satisfaction and financial performance. How should a hospital determine its project, scope and budget?

SHORT: As discussed earlier, assessing potential market demand is one place to start the facility planning process. This includes evaluating current service area out-migration patterns. What is the potential to recapture some of these lost patients? While I've seen numerous new hospital facilities increase patient volumes, you have to be prudent to avoid an overly aggressive sizing of your project, or for that matter, under-sizing relative to your future potential.

At the same time, you need to establish your true financial capability to absorb the cost of a project. This is based upon historic and projected operating measurements and financial benchmarks that serve as key indicators of a prudent capital budget and not something that potentially mortgages the future of the hospital. Once you have a sense of the financial side, you can bring together a team to tackle your master plan, the demand and the marketplace. This quantifies the bricks and mortar component, the equipment needs, and the professional fees that are associated with your project. The goal is always to keep the project budget within the boundaries of the true financial capacity of your hospital. This means focusing not on the question, "How much can we fund and borrow?" but rather, "How much should we fund and borrow to ensure long-term financial viability?"

RICHMAN: I agree completely with John about assessing your financial capability. Personally, I have been astonished over the last four or five years, just how often hospitals embark on costly project design and architectural work without ever assessing precisely, or for that matter, even approximating what they can realistically afford. Also, where they are going to get funding and at what cost are often unanswered questions. This "field of dreams" approach to project development and capital financing is a guaranteed failure.

For many Critical Access Hospitals, our organization recommends initially what we have coined a "static debt capacity analysis," which incorporates historic utilization levels with minimal demand increases. We recommend this for two reasons. One, the CAH's cost-based-reimbursed methodology subsidizes a major portion of its project-related costs, including interest and depreciation. Two, unfortunately for many small hospitals, their demand will remain somewhat static for a while even after the new hospital is built due to local economies that take some time to reap the benefits of the new facility. But after a base analysis, the hospital will need to retain professionals who can analyze its population fully to validate and possibly remodel the project in sync with potential market needs and its current physician base. A successful project is both affordable and suits the needs and desires of the community.

MORGAN: It is important for any hospital to make sure that it solicits appropriate professional assistance before moving forward. Fortunately, there are a number of rural-focused firms and individuals that can help rural hospitals. I would encourage hospital leaders to seek assistance from firms that are truly aware of the rural environment and can help them make the right decisions.

SLABACH: The project needs to have a mission-driven orientation, not an architectural-driven orientation. My sense, from listening to people discuss their projects and how they're going about these things, is that they defer too much to facility designers and not to their own expertise in their own community.

In August 2005, the Centers for Medicare and Medicaid Services issued a ruling concerning the construction of replacement facilities for "Necessary Provider" Critical Access Hospitals. This ruling removed previously proposed barriers that would have made it all but impossible to replace these hospitals with new facilities in locations other than their current sites. What affect will this have on CAHs in rural America?

MORGAN: The new ruling allows a Necessary Provider CAH to relocate its facility if it meets all of the following tests: (1) it continues to serve at least 75 percent of the same service area; (2) it continues to provide at least 75 percent of the same services; and (3) the new facility is staffed by 75 percent of the existing personnel.

This particular issue was extremely important to the National Rural Health Association. The proposed regulation would have greatly limited the ability of CAHs to build new facilities in the future, and it was directly opposed to the fundamental mission of the NRHA. I am pleased that CMS chose to revise its position. It is going to mean that many rural communities will have the option of building new facilities better suited to address the specific needs of their communities.

RICHMAN: This ruling will profoundly impact most Necessary Provider CAHs that have been precluded from entertaining hospital relocation projects under the previous CMS proposal. By replacing barriers with this "triple 75 percent test," the CMS has created an eminently fair and very passable threshold for a rural

hospital to meet. This should kick-start the hospital financing and development process for previously mothballed projects, expedite those loans already in process, and provoke new discussions within the boardrooms of CAHs that had been contemplating new hospitals. All things considered, this is a great relief for the CAH financing industry, and I hope to see many new facilities financed and built in the next few years.

SLABACH: I know of several hospitals that were put in the position of having to place all their construction activities on hold until this matter was resolved. One facility had expended more than $1 million in design development and had construction documents ready to be released to bidders. With this ruling, these hospitals should be able to begin construction on their new facilities very soon.

However, I am concerned about how this new rule will be implemented and what accompanying directions will be given to the regional offices of CMS. For example, in what manner will the CMS require a hospital to document that the new facility location will serve at least 75 percent of the population that was served in the old location? I hope that CMS is reasonable in its expectations as it rolls out this new rule.

SHORT: With more than 50 CAH clients, QHR was obviously following the proposal concerning Necessary Provider hospitals very closely. We have a number of clients that had construction or replacement programs in their plans and even as part of the initial strategy when they first converted to CAH status. The proposed rule created real uncertainty for hospitals in this situation and in some cases brought things to a halt. The final rule clarifies the conditions under which replacement and relocation can occur, thereby allowing hospitals to move forward. It also provides more certainty in the planning and financing process. The final rule will assist QHR and our clients to make better, more informed decisions when evaluating CAH conversion and facility replacement options.

What sources are available to finance the construction of the next generation of America's rural hospitals? Will the federal government be the best partner for this purpose or is the private sector a viable option?

MORGAN: I don't think the federal government is always going to be the best partner, but I certainly hope that each community looks at the FHA Section 242 mortgage insurance program and the USDA community facilities loan program as possible options. The federal government has clearly identified facilitating rural hospitals with access to capital as something that merits its assistance. Certainly the expansion of the Critical Access Hospital program has highlighted in Washington the crucial need for access to capital in rural communities across the United States.

SLABACH: While the federal government has the advantage of having deep pockets, like other funding sources, it also has limitations and potential pitfalls. For example, while the FHA Section 242 program makes construction loans, it does not do straight refinancing without a capital component. Whereas USDA loans can be for refinancing purposes, it is customary that they do not make construction loans, but rather, serve as the permanent take-out loan for interim commercial construction. Further, when working with the federal government, there is a greater need for retaining pre-approved consultants and adhering to rules and regulations. I think the rural hospital sector is going to need the combined efforts of public and private lenders. In any event, the federal government can always be helpful in terms of direct granting, especially for technology infrastructure needs.

SHORT: For independent nonprofit rural hospitals the federal government may be the best financing source because, unfortunately, the private sector historically has been somewhat disinterested in these institutions, although this seems to be changing. Municipal hospitals, many of which benefit from the direct tax support of their communities, may find their best access to capital coming in the form of tax-supported general obligation bonds. QHR has experienced this recently with two rural Arkansas hospitals whose local tax initiatives are paying for beautiful replacement facilities now under construction. This was their best choice.

My point is that no hospital should automatically go down one single path, but determine what all the options are and evaluate which one works best for your community and the financial operations of your hospital. Each hospital is different, and there is a right answer out there for every hospital and each situation.

RICHMAN: To find out which financing option is best for your organization, you must first have a thorough understanding of the hospital sufficient to determine if, on its own, it has the income and cash flow to support the debt service on its desired loan. Otherwise, local government support or a capital partner may be required. While some rural hospitals are well-off financially, the majority are only modestly profitable from operations; therefore, they are constantly battling to accumulate more cash. While I agree that some municipal hospitals can use tax-supported municipal bonds to finance their capital needs, this is often only possible with the passage of a voter tax referendum, which may be an impossible task for communities seeking to allocate their tax support to non-revenue-generating enterprises such as schools or public safety.

For most small municipal hospitals and nonprofit CAHs, determining the best financing method means our primary chore is to make projects affordable. The most variable and expensive cost in a project budget is the financing component — annual interest expense — not the construction itself. Therefore hospitals have to find the cheapest source of capital they can qualify for rather than rushing to finance something at a higher annual cost. Since the hospital will have to live with its loan for 25 to 30 years, FHA Section 242 Mortgage insured loans or USDA loansare often their optimal financing choice. But this may not be practical due to their current financial condition, the local competitive environment, or a need for immediate action on a project — say an expiring certificate of need, or a life-code safety matter. Many rural hospitals will require private sector lenders, credit enhancers and investors to fill the obvious gaps in the federal programs.

Federal programs such as the Critical Access Hospital designation, and FHA and USDA loans provide financial benefits to many rural hospitals through improved reimbursement and affordable capital. What do you expect for the future of these programs?

SLABACH: Any federal loan guarantee program is going to be positively affected by the preservation of CAHs and their unique cost-based reimbursement. Conversely, the absence of a CAH designation for a hospital may spell trouble for its financial performance, especially when it comes to repaying a loan. This fact is not overlooked by private and public sector lenders, credit enhancers and investors. If there is any doubt whether the CAH designation of a hospital is in jeopardy, a hospital loan applicant will be evaluated both with and without cost-based reimbursement to see if they can afford to repay their loan. While I don't think the USDA or the FHA Section 242 programs are in jeopardy of going anywhere, like any lenders, they are handcuffed by potential regulatory situations having to do with CAHs.

SHORT: I believe there is enough commitment to rural health care that these programs will continue in some form. However, it won't be without a fight. With the state of the federal deficit and budget, there will be pressure to cut and balance the budget. It is going to take a lot of effort by rural hospital leaders, trustees, and organizations like the National Rural Health Association to communicate with political leaders, both state and federal, and to continue to carry the message of the importance of the local hospital to the community. Our congressional representatives have full plates, and we need to be vocal advocates because the elimination or dramatic cutback of these programs will create peril for the rural hospital system. I know personally, from QHR's perspective, many of our hospital clients benefit from these federal programs. It is going to take all our efforts working together to make sure we preserve them for rural hospitals.

MORGAN: When it comes to the federal government nothing is ever certain; however, it is hard to envision an environment in which these two programs would cease to exist. CAH administrators consistently identify the most pressing issues as reimbursement concerns, workforce concerns, and access to capital. There is strong support in Congress for the CAH program. As long as that support remains, you will have these two loan programs as options. I am particularly impressed by the commitment of the FHA staff in making the Section 242 program work. Both of these programs rely on the continued existence of the CAH program. We may see changes and modifications to the program, but the definition and the program itself has strong support in Washington.

RICHMAN: The FHA Section 242 program is not currently characterized as a federally subsidized program. As such, it doesn't drain the budget and is not subject to annual volume caps, which is a good thing. Why is this the case? Due to the quality of its administrative staff and underwriting process, it has the lowest default rate of any of the FHA mortgage insurance programs. If the CAH program remains unaltered and the financial performance of rural hospitals continues to improve, I believe that the government will significantly increase its portfolio of FHA Section 242 Mortgage insured rural hospital loans.

Over the past year, the USDA program has had unprecedented growth in its direct loans and guarantees made to hospitals, in both per deal size and aggregate volume. Along with this growing number of loans has come a greater percentage of the overall USDA budget going to hospitals. While the FHA Section 242 program is solely for hospitals, the USDA program serves a multitude of community development purposes such as schools and clinics. For this reason, I am waiting to see if there will be a continued emphasis in growing the USDA's book of hospital business or a future dogfight for these valuable finite allocated federal funds from potential non-hospital recipients, communities and consultants.

What final advice can you offer rural hospitals to help them lead their organizations in these dynamic times?

SHORT: Let me offer four suggestions. First, engage your medical staff. Get them involved in governance and leadership of your organization. Don't treat them as a necessary evil but as a key partner to the process of leading your organization. Second, make sure that trustees, playing such an important role, commit to board education. Some hospitals are actually requiring in the board bylaws a certain number of educational hours on current trends and issues within health care, which is so important in today's environment — it's more challenging to be a trustee today than ever before. Continuing education is key for trustees to effectively govern hospitals.

Third, make sure you have a forward-looking and fluid strategic plan with a strong financial component. Proactively plan the financial future of your organization, thinking ahead so that you don't find yourself unnecessarily in a position of having to find a capital partner and perhaps losing local control of your organization. Lastly, engage your legislators. Get involved politically with grassroots efforts and make sure you continue to communicate the hospital's importance in providing the community with local access to care as well as serving as an economic engine driving community development.

MORGAN: With Medicare and Medicaid both being such an important payer for rural hospitals, and taking into account that state and federal officials are changing the rules of the game yearly, it is important for rural hospital leaders to stay engaged and to continue their educational efforts to learn what is working, what is not, and how to anticipate and plan for change. You don't necessarily think of the rural health care environment as rapidly changing, but it is. It is important for leadership to stay abreast of the changing dynamics.

RICHMAN: A hospital has to take a leadership position in its future. The rural hospital has not just an immediate, but more important, a long-term responsibility to its community to provide local access to health care. You have to understand that there are trials and tribulations in seeking to accomplish something special, such as financing and constructing a new hospital, and throughout the process you have to remain enthusiastic and realistic. You need to have partners both within and outside of the organization that are committed to supporting the hospital in good times and bad. This undertaking represents the end of the status quo, and you need to know that the team that has come

together will remain together from beginning to end and thereafter. This means hiring both internal and external parties committed to the common cause. I always say to hospital boards that you need a *raison d'être* — a reason for being — for your hospital and its project. This is a must. If you stay committed, focused, and creative, at the end of the day, I think you will be surprised at what you can accomplish.

SLABACH: The local community hospital is the centerpiece of most of the health care activities in a rural area. A rural hospitals has to take the responsibility not only for the treatment of individuals but for looking beyond its walls and starting to collaborate with entities in the area that provide related services — home health agencies, diabetic education, hypertension, and such.

To accomplish this, there has to be a willingness to become, as one of the physicians at our facility says, "innovative and creative." Not to be worried about roles and who is going to take the credit, but about how we are going to improve the health status of our communities.

As long as the hospital is the center of that focus and stays relevant to the community, the facility will be able to drive all of the issues that we're talking about here because the community simply cannot do without the local hospital.