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Best Practices from 14 CAH Executives Operating in Challenging Environments

Sharita R. Thomas, MPP; Kristin Reiter, PhD; George H. Pink, PhD

PURPOSE

CAHs are essential to the maintenance of the rural health care core and safety-net of providers for geographically isolated areas. As the operational and strategic head responsible for daily hospital management, CAH chief executive officers (CEOs) face a number of growing and persistent challenges from evolution in care delivery to technological advancements that demand more of their executive roles. However, there is little research examining the leadership practices of CAH executives and no research that we are aware of examining practices of CEOs operating in more challenging environments.

The objective of this study was to identify best practices related to tasks of daily operation, forecasting, and community health outcomes and to craft advice for other CAH CEOs. In this study, we examine the perspectives and experiences of CEOs who lead CAHs with a low risk of financial distress despite their operating environment. Participants were asked to describe their experiences with financial and quality issues, leadership roles, performance measurement, policy challenges, and community health.

BACKGROUND

The Critical Access Hospital (CAH) designation, a part of the Balanced Budget Act of 1997, was created in part to slow the growing number of rural hospital closures that started in the 1980s. Current sustainability challenges are compounded for CAHs as they differ from other rural hospital payment classifications[i] in multiple ways; CAHs are smaller, having 25 or fewer inpatient beds, and are more likely to be located in isolated areas as they must be:

1) at least 15 miles by secondary road or mountainous terrain OR

i. Rural hospitals payment classifications other than CAHs include, Medicare Dependent hospitals which have at least 60% of inpatient days or discharges attributable to Medicare patients, Sole Community Hospitals which must be located at least 35 miles from the nearest hospital or be designated as a community's sole source of health care, Rural Referral Centers which treat a large number of complicated cases, and Prospective Payment hospitals reimbursed at the traditional prospective payment system rate.

2) 35 miles by primary road from the nearest hospital OR
3) declared a "necessary provider" by the state's governor prior to January 1, 2006.[1]

CAHs are reimbursed based on reported costs, receiving 99% of Medicare allowable costs for most outpatient and inpatient services.[2,3] Communities served by rural hospitals tend to have older, sicker, and poorer populations with access to fewer health care professionals than those communities served by urban hospitals.[4] Rural communities served by CAHs may face a disproportionately greater risk of financial distress that could cause closure of the hospital. Since 2005, there have been 170 rural hospital closures in the United States, and approximately 36% of these rural hospital closures were CAHs.[5] The realities of continued hospital closures are important as CAH closures could put access to hospital services at a disproportionately greater risk for traditionally underserved rural residents.

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CEOS WHO WERE INTERVIEWED

This study focused on the CEOs of "turnaround CAHs" (hospitals that improved their financial distress index (FDI) score[ii] over six data years) and "high performance CAHs" (hospitals that operated at a lower than expected risk of financial distress given the characteristics of their markets). We identified 27 turnaround CAHs and 210 high performance CAHs from a dataset with a total of 1,255 CAHs. The method to identify turnaround and high performing CAHs and the sampling method for CEO interviews are described at the end of this brief. The final study sample included 14 CAH CEOs.

CEO participants included individuals from eight states located in the Midwest, South, and West Census regions. Of all U.S. CAHs, approximately 48% are located in the Midwest Census region, 26% in the South Census region, 21% in the West Census region, and 5% in the Northeast Census region. Of our 14 interviews, three were CEOs of CAHs located in Kansas, three were CEOs of CAHs located in Minnesota, two were CEOs of CAHs located in both Missouri and Oklahoma, and one CEO of CAHs located in Hawaii, North Carolina, Pennsylvania, and Washington. Of all U.S. states, Kansas and Minnesota have the highest number of CAHs (around 6% of all U.S. CAHs each), while Missouri and Oklahoma have a higher

ii. Using data from years 2012 through 2017, we predict Financial Distress Index (FDI) values for all rural hospitals. Our FDI model assigns rural hospitals to high, mid-high, mid-low or low risk of financial distress levels. More on the model here: Holmes GM, Kaufman BG, Pink, GH. Predicting financial distress and closure in rural hospitals. The Journal of Rural Health, 2017;33(3):239-249.

TABLE 1. Characteristics of Interviewed Turnaround Critical Access Hospitals

Participating CAH CEO	State	Region	Division	Rurality[iii]	Medicaid Expansion Status	Government-Owned
CEO 1	Kansas	Midwest	West North Central	Isolated	Not Expanded	Yes
CEO 2	Kansas	Midwest	West North Central	Small	Not Expanded	Yes
CEO 3	Minnesota	Midwest	West North Central	Isolated	Expanded	Yes
CEO 4	Minnesota	Midwest	West North Central	Small	Expanded	No
CEO 5	Minnesota	Midwest	West North Central	Isolated	Expanded	Yes
CEO 6	Oklahoma	South	West South Central	Isolated	Not Expanded	Yes
CEO 7	Washington	West	Pacific	Isolated	Expanded	Yes

TABLE 2. Characteristics of Interviewed High Performance Critical Access Hospitals

Participating CAH CEO	State	Region	Division	Rurality	Medicaid Expansion Status	Government-Owned
CEO 8	Hawaii	West	Pacific	Small	Expanded	Yes
CEO 9	Kansas	Midwest	West North Central	Small	Not Expanded	Yes
CEO 10	Missouri	Midwest	West North Central	Non-rural[6]	Not Expanded	Yes
CEO 11	Missouri	Midwest	West North Central	Small	Not Expanded	Yes
CEO 12	North Carolina	South	South Atlantic	Large	Not Expanded	No
CEO 13	Oklahoma	South	West South Central	Isolated	Not Expanded	Yes
CEO 14	Washington	West	Pacific	Isolated	Expanded	Yes

number of CAHs compared to the remaining states (around 2.5% of all U.S. CAHs each).

After review and analysis of each interview, a series of themes were common across both groups of CEOs. From these themes, we identified activities ("best practices") that could be implemented by any other CAH executive. These identified best practices were:

1. taking calculated risks;
2. being driven by data;
3. engaging and valuing staff; and
4. integration with the community.

iii. Levels of rurality are based on Rural Urban Commuting Areas (RUCAs). Large Rural Areas have a RUCA code less than 7, while Small Rural Areas have a RUCA code of 7, 8, or 9, and Isolated Rural Areas have a RUCA code of 10. For more information on RUCAs, please see https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx#.VCL_vufbYgA

BEST PRACTICES

Take calculated risks. The self-described attitudes of the CEOs were the most supportive element of the overall risk-taking theme. CEOs expressed the attitude of managing in a state where one is never complacent. Phrases like, "getting out of your comfort zone," and "overcoming fear to take a risk," were voiced. As expressed, these CEOs believe that they are more comfortable being aggressive and taking risks than the "average" CAH executive.

High performance CAH CEOs specifically expressed the importance of remaining flexible with risk-taking. For example, spending before you earn is a commonly practiced risk among those interviewed, however, remaining flexible with the practice was important. The use of goal tracking and the development and incorporation of alternative plans afforded the CEOs the option of minimizing damage in the event an action taken was not providing the desired results. For example, one CEO mentioned assessment and tracking of models of chronic care management (e.g., delivery in a primary care setting compared to home monitoring) so that they know which delivery models to put resources into expanding.

Turnaround CEOs based a majority of risk-taking on a belief that rural residents do not want to travel outside of the community for care. The uptake of telehealth services was identified as another calculated risk interviewed CEOs took that at first faced skepticism from other CAH executives. These CEOs felt that other CAH executives were wary of telehealth because they felt as if it were asking their patients to instead utilize another health facility for future health services. They believed that other rural hospitals' executives fear that "sending" patients away for one service will cause them to bypass the rural facility for future services.

Both groups of CEOs described weighing the risks of spending to provide or improve specific services against the time it will take to realize financial gain.

> "…from my perspective, be prepared to make decisions that may not be popular. It is your duty to be the expert on health in your area and on what is sustainable and what is not. Be honest with that and go with it. Be courageous."

> "You have to be able to take some leaps of faith, take chances, and hope and plan for things to work out. You cannot be scared to make a change."

> "Understand that there are alternative and cost-effective ways to deliver health care. Take risks when you can but take calculated and educated risks."

> "Be open to try different things. Don't be afraid of changing things. If you see a downward trend, you have to be willing to change something."

Be driven by data. According to these CEOs, in addition to taking risks, growth is sustained from constantly seeking and assessing data. All CEOs expressed placing value on understanding the elements critical to CAH financial health: the revenue cycle, service cost structure, and coding. Financial and market analyses were identified as necessary actions to better position the CAH, including understanding costs, leases, services, tax filing methods, and low interest loan options.

An understanding of financial development is an additional element valued by high performance CAH CEOs. Financial development for these CEOs means seeking funds to support hospital

services and equipment through grant writing and other forms of fund-raising. The importance of understanding how to raise capital through planning, fundraising, and contract review were mentioned by all high performance CAH CEOs. CEOs sought data from State Offices of Rural Health, state Hospital Associations, and contracted experts to review and establish benchmarks. High performance CAHs noted partnering with organizations and individuals more skilled at gathering and assessing this information than they might be. Additionally, executives from both groups identified the importance of group purchasing power. While this allows for a more accurate snapshot of community health needs, it also contributes to the knowledge and skill base of the CEO.

Tracking the hospital's progress toward achieving developed goals through performance indicators or review of dashboards during daily meetings are also methods by which all interviewed CAH CEOs collect and utilize data to influence decision-making. Surveys, including hospital-based internal surveys, are often utilized to assess quality. Community health needs assessments were identified as important as they provide CAH CEOs with information about the health status and health needs of their community. This information has service planning and development implications.

All CEOs recognized that seeking knowledge and data from other sources was just as important as collecting and analyzing information from their own hospital and community. Knowledge is sought through consulting and partnerships with other organizations, including local, state, regional, and national. These relationships involve conversations about best practices, technical assistance, and other forms of problem solving and information sharing. It is important to note that while these CEOs value data in decision making, they also explicitly maintain that any final decision will be the one that is ultimately best for the patients.

> "I drive home that decision-making is at its best with data. I try to ensure that we have the data we need to make the right decisions. If I could have anything I wanted, a data support team would be my wish. They could crunch data all day and provide me with constant information. CEOs of CAHs have to do it all—that's our challenge."

> "On the financial side, there is no other way than to break down your service line. Analyze cost structure, look at payer mix, and look at contracts. There may come a conclusion that even at the best scenario, based on payer mix, you may not be able to achieve the bottom line. But, the role of a CAH, and if you have a safety-net mission, is not to make tons of money. Adequate or high-quality care is the mission."

> "…the community health needs assessment is what I have used to help keep our cardiac rehab program. For the first three years that the program was in place, it was not a revenue center but was a cost center. And I would look at the costs and think that I need to cut it. But looking at the community health needs assessment, it kept pointing to cardiac issues. So, I needed to help the community by maintaining it."

> "Understanding the key concepts of the revenue cycle and understanding its efficiency are important. That is where I would start."

"The first thing I would say is to review revenue cycle and coding. If you don't understand those elements, you are really not going to be able to make any financial impacts."

"We get feedback from the community and we review that as well. We also do outpatient surveys to capture what HCAHPS does not. For rural, 70% of revenue comes from outpatient services but the HCAHPS is based on inpatient care. We survey our outpatient departments through a third-party and our quality monitoring program."

"We try to get every grant that we can find that will supplement programs, services, or equipment. We use a team-based approach to write our grants."

Engage and value staff. Generally, CAH CEO leadership philosophy was centered around bolstering staff engagement so they are encouraged to grow and share their ideas for improvement. "Meeting the staff as a peer" was a common sentiment among the respondents. Turnaround CAH CEOs often referred to staff of any level as "manager" or "vice president." All CAH CEOs stood firmly in the belief that staff who understood they were valued as employees who could also actively contribute to solutions, inspire and sustain the hospital culture. CEOs also noted that transparency on the financial and quality condition of the hospital was a large part of engagement and trust building among staff. The incorporation of town-hall style meetings with the staff allowed for an equal transfer of transparent hospital information and ideas and solutions produced by staff.

Staff were also recognized for their abilities rather than for their formal job title. For example, recognizing that vacancies could be filled by re-aligning current staff to job tasks more suited to their identified strengths. These methods also helped address challenges with recruitment and retention. In addition to reorganizing staff to tasks better suited to their skill set and interests, many CEOs expressed also allowing staff to complete "passion" projects within the hospital.

"I want my employees to be happy. Everything that I do, has my employees' happiness in mind. It is creating an environment where employees want to be and where they understand that they are valued. The employee is a part of a team of people who are all focused on accomplishing the same thing—providing the best care that we can to the community. It is a simple idea but is complex to execute. I want my employees to feel good about what they do."

"My advice is the same that I received: lead your staff because your staff will find the areas where you can focus and improve. Find fun ways for staff to get involved and be a part of the solution. And then celebrate success. Trust your staff, appreciate them, and motivate them. The CEO can't make changes alone."

"[My] philosophy [is] that [I] view [myself] as one of the team. I treat everyone with respect, and I am not authoritarian at all. I am participatory—I work to get consent and input. I believe that all employees are intelligent and if they have the facts and know the desired goal, they make great decisions. I stay focused on the patients."

Integrate with the community. All CAH CEOs interviewed operate with the mission to provide needed and necessary services to their community. The needs of the community are heard and assessed through multiple routes. One method is

use of a community health needs assessment which all participants mentioned performing and acting on the findings. Another method for integrating the community into the hospital is through having community representation on the hospital board or through the formation of community member-led task forces. Community inclusive task forces also extended to the practice of building up and recruiting of the community. The final method community needs are identified and assessed is through free or low-cost health services offered at hospital-sponsored fairs and other hospital-sponsored educational events hosted within the community.

CEOs stated that it is extremely difficult for CAHs to integrate with the community if the hospital CEO or affiliated system is viewed as an "outsider". Once the hospital is recognized as a part of the community and not just a community bystander, CEOs found they have access to general sentiment about their hospital, whether it be potential issues with quality or a perceived lack of services. Understanding community perceptions provides the opportunity for the hospital to actively manage public perception. The CAH CEOs expressed offering transparency on the financial and quality standings of the hospital to the community. Integration into the community allows for the interviewed CAH CEOs to modify their own marketing to play a part in educating or positively influencing the public's perception. Use of social media, online marketing and other forms of directed marketing and marketing teams were methods mentioned by these CEOs.

Additionally, turnaround CAH CEOs expressed feeling responsible for the survival of businesses in the community in addition to the survival of the hospital. They expressed solidarity with the businesses that support the economy of the community, even going as far as organizing fund-raising efforts for businesses in need. These actions also highlight how supportive and internally focused rural communities are.

> "I grew up in a rural community right outside a town of about 800 people where the hospital I was born in has since closed. I came to this position out of passion to keep rural health care alive and to keep access to health care alive. I am very passionate about maintaining health care in rural America."

> "To show our commitment to the community and to help the schools, I got a sponsor to pay for all the sports' physicals. We provided all the school kids' sport physicals for free. It gave us an opportunity to build a relationship with those persons who may be going to other facilities."

> "We post our scores for the staff to see and review quarterly with the staff. All staff is aware—from housekeeping to clinical staff. These are also posted so that patients can see. We don't want anything to be a surprise. We want the community to know if things start to take a different turn as well as if things are going great."

> "We follow kids who graduate from high school here, or people who have connections here, we follow them throughout medical school and residencies. If you can find someone who has a tie to the area, you have a better chance at recruiting them."

"I have a Community Health Director. We know we can't solve all the problems, but the main problems are food insecurity and mental health. We are collaborating on mental health and education. We have added mental health providers to be available to family health physicians internally. We are focused on collaborating with both population and community health efforts. We have set up programs to meet the food needs of the community and distribute food. We collaborate with the farmer's market, the school, the social workers—it's a community effort. We work closely with all of our local public health agencies as well as Extension."

"We don't turn people away though. We have patients with behavioral issues who may come in and we won't turn them away until we can find a bed for them. We do what is best for our patients first and then look on the back end and do what is financially viable second."

"Some people take a job in a rural setting as a stepping stone to a larger, urban hospital. I believe if you are not passionate about being in a small community, you will find it difficult to be engaged and involved in the community."

"I've been in rural health care for 25 years, and I know that if you do not have the community support, or if they turn on you, it is difficult to gain them back."

"Hospitals should look at what they can do to keep health care in the community—it extends beyond just keeping a hospital open. It should meet the needs of the community, and hospitals need to be honest with how it is meeting the needs of the community."

"Also, be creative and aggressive. Don't be afraid to tell the community about what makes you great."

"We have quarterly community meetings where we address the hospital's status and services, and then we will present other information or educate on important needs."

CONCLUSION

Rural hospital executives are tasked with broader and more general functions than urban hospital executives who have greater resources to employ area-specific specialists. As such, rural hospital executives have developed and fine-tuned a different skill set than urban hospital executives. This study found four major themes from the many identified skill sets of the CAH CEOs interviewed. These "best practices" likely helped contribute to the positive status of the CAHs interviewed and could also be a resource from which other CAHs could find utility. Information gleaned from this study highlights potential areas for resource development and technical support improvement for CAHs that may involve

1. Supporting rural-appropriate data collection and reporting;
2. Supporting competency training and development; and
3. Supporting rural resource sharing and collaboration.

Local, state, and federal government organizations could further support CAH executives to collect and benchmark targeted and relevant quality data. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey evaluates the patient's experience after an inpatient hospital discharge. Inpatient beds are not heavily utilized by CAHs other than for swing bed services, instead the bulk CAH care is delivered

in an outpatient setting. While rural hospitals typically score highly, HCAHPS scores do not provide much insight to the outpatient experience. CAHs are often left to collect and analyze quality data on the outpatient experience on their own. The Centers for Medicare & Medicaid Services (CMS) Hospital Quality Star Rating (Star Rating) is another quality data report that relies on self-reported hospital inputs. A hospital's Star Rating is accessible to the public and either rates hospital quality on a five-star scale or indicates that the hospital is not rated. CAHs are more likely to receive no star rating, due to not having sufficient data, compared to other rural hospitals.[7] While having no rating does not indicate poor hospital quality, the public may perceive it negatively.

> "Rural providers, in some cases, suffer from people feeling like everything is better in the city. Our quality can stand with any other organization."

> "The data reporting is an area that needs some serious scrutiny. We need to know what is useful to improve quality of care and that impacts patient decision-making. There are good intentions there, but we need to do more with it. A lot of these measures are not tailored for rural hospitals also."

Local, state, and federal government organizations could further support CAH executives in competency training and in creating links to individuals and organizations with skill expertise. CAH executives operate in volatile environments with limited resources and are often tasked with greater responsibility for a growing list of hospital operations. Several studies found that formal training on executive, financial, and marketing skills could be a potential deficit among rural hospital CEOs.[8-10] While the CAH executives interviewed came from many different educational backgrounds and professional experiences, there was consistent mention of the desire to build skills in marketing and community analyses. CAH executives do not have easy access to a variety of experts or other training resources due to geographical isolation and a number of other factors.

There is opportunity for the development of on-going leadership and skill building programs or the support of travel or technology stipends. Additionally, continued or additional support of existing resources, like State Offices of Rural Health and coordinators of the Medicare Rural Hospital Flexibility (Flex) Program[iv] and Flex partners, could improve capacity to support and improve CAH health care delivery.

> "Systems are also narrowing but they are not going anywhere either. There are a wide spectrum of options—from loose management affiliation to wholly owned, and rural can't lead the way on any of those, but rural has to have their eyes open to what is happening. Rural does not have much bargaining power, but rural also can't be an island."

> "I just completed the NRHA Rural Health Fellows program which opened up my eyes to more possibilities for health care delivery in my region."

iv. The Flex Program provides grants funding in support of CAHs and facilitates collaboration among CAHs and other health care facilities. For more information, see: https://www.ruralcenter.org/tasc/flex

"The affiliate hospitals gather once a month for a meeting to share best practices. When I first arrived, I was told my goal was to put the hospital 20 miles away from us out of business. That was the mindset at that point. But now, it is more about what can we do support and collaborate. We look at how can we share resources and best practices. The positive out of the hardship [allowed us to look at other health care facilities] as partners and collaborators instead of competitors."

"We just completed our CHNA. The SORH did the community health needs assessment for us. Otherwise, it would have been 20,000 cost to complete this. The SORH does it at no cost. They have vast resources and expertise."

"We focus heavily on education. Our board is constantly training and educating themselves. We attend all hospital association conferences. When you have your team engaged, develop strong provider relationships, and have a board that is educated, you can bring all these pieces together to take impactful actions."

"The Kansas Hospital Association gave me access to [a hospital analytics firm] and helped me do reporting to get market share information. They trained me on how to do it. They sent me information on provider recruiting through the University of Kansas Rural Works. They also provided me some information on board orientation. They provided me labor data, but it is not the exact data I need as that data is not available."

METHODS

CAH Sample Identification

Hospital financial, hospital market, and county health and market data were combined from the following datasets: the Centers for Medicare & Medicaid Services (CMS) Hospital Cost Report Information System files, the Provider of Services files, the Hospital Service Area files; the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute County Health Rankings files; and Claritas Pop-Facts files®.

Hospital-specific market areas were composed using the Medicare discharge counts by ZIP code from the CMS Hospital Service Area File. A ZIP code is included in the market if: when sorted on descending number of that hospital's Medicare discharges, it is among those that comprise 75 percent of that hospital's Medicare discharges; or if it contributes at least three percent of that hospital's Medicare admissions for the year. Except for hospitals in Alaska and Hawaii, ZIP codes more than 150 miles from the hospital are excluded. Hospital-specific markets were used to define communities and to assess demographic and socio-economic variables. As health outcome data is not available at the hospital-specific market level, the county where the hospital is located was used to assign health outcomes from the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute County Health Rankings files. We only included Critical Access Hospitals and further refer to these facilities as "rural" regardless of setting of location. Using data from years 2012 through 2017, we predicted Financial Distress Index (FDI) values for the sample hospitals. Our FDI model assigns rural hospitals to high, mid-high, mid-low or low risk of financial distress levels.

We identified a list of "Turnaround" and "High Performance" CAHs from which to conduct CEO interviews. Turnaround CAHs were identified based on improvement of FDI score over six data years. The turnaround sample included a total of 27 CAHs from 16 different states. High Performance CAHs were identified based on a modified z-score method to observe differences in medians. The high performance sample included a total of 210 CAHs from 14 different states.

Qualitative Research Strategy

We contacted all identified turnaround CAHs and a random sample of 30 of the 210 high performance CAHs with requests for participation in individually conducted open-ended semi-structured in-depth telephone interviews. We aimed to collect a fully descriptive case from any willing participant. As such, we did not sample for data saturation. A total of 14 CEOs representing turnaround and high performance CAHs evenly, agreed to participate in a semi-structured in-depth interview. In-depth interviews lasting 45 to 70 minutes were carried out from October 2018 through March 2019 via telephone. The qualitative data analysis software package was used to assist in the coding and analysis of data.

REFERENCES

1. Morton T, Pink GH, and Young S. Critical Access Hospitals (CAHs). A Guide. Rural Health Information Hub. Available at: https://www.ruralhealthinfo.org/topics/critical-access-hospitals Accessed February, 17, 2020.

2. Holmes GM, Pink GH. Change in Profitability and Financial Distress of Critical Access Hospitals from Loss of Cost-Based Reimbursement.NC Rural Health Research Program, UNC-Chapel Hill. December 2013.Sequestration, mandatory across the board cuts in Federal spending now extended through fiscal year 2027 effective April 2013, reduced the current CAH Medicare reimbursement from 101% to 99% of costs.

3. Rural Health Snapshot. NC Rural Health Research and Policy Analysis Center. UNC- Chapel Hill, NC. 2017. Available at: http://www.shepscenter.unc.edu/download/14853/

4. North Carolina Rural Health Research Program. Rural Hospital Closures: 2005-Present. 2019. Available at: http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/. Accessed April, 2 2020.

5. This hospital is located in the Kansas City area. Thompson KW, Randolph RK, Reiter KL, Pink GH, Holmes GM. CMS Hospital Quality Star Rating: for 762 Rural Hospitals, No Stars Is the Problem (June 2017). NC Rural Health Research Prorgram, UNC-Chapel Hill. FB 136. Available at: https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2017/06/CMSHospitalQualityStarRating.pdf

6. Hart LG, Robertson DG, Lishner DM, & Rosenblatt RA. CEO turnover in rural northwest hospitals. *Hospital & Health Services Administration*. 1993; 38(3): 353. Retrieved from http://libproxy.lib.unc.edu/login?url=https://search.proquest.com/docview/206724359?accountid=14244

7. Mick SS, Morlock LL, Salkever D, & de Lissovoy G. Rural hospital administrators and strategic management activities. *Journal of Healthcare Management*; 38(3): 329.

8. Stretton DV, Bolon DS. Recruitment and retention of rural hospital administrators: a multifaceted approach. *Hospital Topics*. 2009 Jan 1;87(1):10-4.