Rural
HEALTH VALUE

Rural Health Value Virtual Summit
Rural Healthcare Information Technology

September 2026

For more information about the Rural Health Value project, contact:
University of Iowa | College of Public Health | Department of Health Management and Policy
www.RuralHealthValue.org | cph-rupri-inquiries@uiowa.edu | (319) 384-3831

This resource was developed with funding from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $500,000 with 0% financed with non-governmental sources. The contents are those of the authors(s) do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. Government.

Overview

Rural health care is increasingly shaped by the shift toward value-based care and payment (VBC/VBP) – models that reward outcomes, efficiency, and coordinated care rather than volume of services. Within that shift, a key question facing all rural health leaders is how to make technology investments that improve the health of patients and the well-being of providers and staff, while also supporting the organization's financial success.

This report draws on the experiences of rural health leaders to offer practical guidance for rural health care organizations considering or deepening health information technology (HIT)[1] investments – investments increasingly viewed as foundational to succeeding under VBC/VBP models. The goal is to offer rural health leaders, regardless of their HIT sophistication, a framework for making decisions and investments that are sound, strategic, and built to last.

This report summarizes a central finding from the Summit – that technology investments need to focus first on people and processes, particularly as organizations position themselves for VBC/VBP. Five supporting themes gleaned from participants comments, examples, and insights include:

- Building the foundation with data governance, workforce, and use case clarity
- Considering workflow integration and engaging clinical champions to ensure technology investments are utilized
- Virtual care options as a key value-based care strategy that provides services locally that otherwise might not be available nearby
- Navigating the health information exchange landscape with realistic expectations
- The importance of ongoing HIT infrastructure maintenance and investments

Summit Participant Experience: *Setting the Stage for HIT Investments*

A 16-month-old girl came into a rural emergency room after a fall, with a serious head injury and no neurosurgeon within ninety minutes by ambulance.

The surgeon on call was experienced and capable, and by his own admission, had no business performing the procedure she needed without an expert at his side. A neurosurgeon joined remotely, assessed the situation, and determined the child wouldn't survive the transfer. So he did the next best thing: he talked the surgeon through performing an intricate procedure, in real time, from a screen on the other side of the state. The girl survived and recovered fully.

The physician who shared this story at a recent rural health convening was making a point about what the right technology investment, deployed thoughtfully, makes possible in rural care. For that community, virtual care was essential infrastructure; the difference between life and death.

[1] Health information technology was not specifically defined for the Summit. Instead, the Summit questions allowed the participants to respond from their own perspectives. That said, health information technology generally includes population health and financial management software, telehealth, interoperability issues, data security. Importantly, health information technology also includes the people and processes that support technologies.

Based on the findings and themes, the Summit participants offered four recommendations and concluding advice and guidance for rural health leaders seeking to leverage technology in support of VBC/VBP.

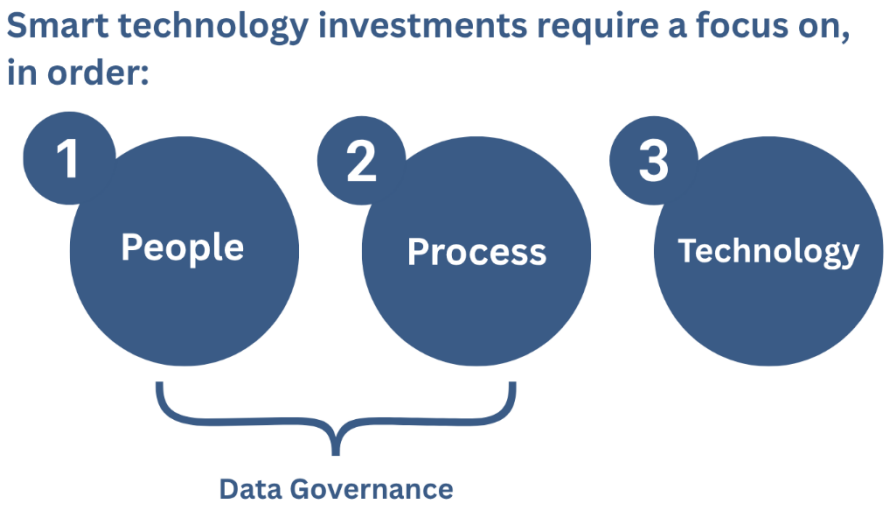
Background and Approach

Rural health leaders are navigating a swiftly changing and difficult landscape. Access to and capabilities of health care technology products is rapidly changing, and the Rural Health Transformation Program, which includes a strong emphasis on HIT is likely to accelerate adoption of HIT services and supports.

Given the current environment, the Rural Health Value team, with funding from the Federal Office of Rural Health Policy convened a small group of rural health leaders from across the country and across a variety of care settings, for a two-day, four-hour working session in April 2026 to obtain practical advice for rural health leaders considering technology investments. See Appendix A for a full list of participants. Support for value-based care / value-based payment (VBC/VBP) was a central theme of the conversation. With that lens, the group explored key questions around the most valuable technology investments, building versus buying technology systems, use of artificial intelligence (AI) in care settings, and more.[2]

Central Finding and Supporting Themes

The central finding that emerged from convening was that, for technology investments to be durable and high impact, the focus should be multi-faceted and start with people:



[2] *Participant comments have been edited for clarity and readability while preserving the speaker's intent.* For a summary of participants and the convening agenda, see Appendices A and B starting on Page 10.

1. **People:** Which individuals and teams need or will benefit from technology to support value-based care delivery? What do they want it to do (and not do)? Who will be trained in and how?
2. **Process:** What new workflows are needed to provide VBC? What data is needed and how can it be obtained and protected? With what organizations will data be shared? What governance models and policies are helpful and necessary?
3. **Technology:** What technologies support and enable people and process needs in VBC/VBP?

Comments from the convening that illustrate this central finding include:

- *"The technology is necessary, but not sufficient. It's so much about the people, the teams, the integration, and how you wrap the technology into actually being usable and sustainable."*
- *"When you're bringing something new in, it can't be an extra click, it can't be an extra step. We're trying to make this efficient and user-friendly for the clinicians and care teams who are supporting and providing that care."*

The sections below expand on this central finding through five themes. Participant comments follow each theme.

Theme 1— Build Your Foundation First: Data Governance, Workforce, and Use Case Clarity

Data Governance Before Data Analytics: Without clear ownership, definitions, and structure around data, VBC/VBP contracts can become "hope for the best" arrangements that lead to financial losses and clinical confusion.

Data governance: the set of agreements an organization makes about its data: **what gets collected, how it's defined, who is responsible for it, and how its quality is maintained** over time.

- *"We lacked data governance. We confused data analytics and governance. We weren't looking at it in real-time. So instead of being able to course correct, we just literally hoped for the best. It was like we approached the concept of VBC as free money, as in 'we'll just sign up for this, and we'll make a lot of money doing it.' That caught us off guard."*
- *"An important technology investment has been working on data governance, standardizing our data capture, making data monitoring a part of day-to-day workflows for everybody in the organization, not just high-level leadership."*

Real-Time Data Is the Goal. If data aren't available in real time, organizations are essentially engaged in quality *reporting* rather than quality *improvement*. If data that can influence processes or clinical decision-making isn't available until several months later, it doesn't allow for timely changes or intervention.

- *"You have to have a simple, usable layer of data that helps to support the decision-making and the patient care decisions real time. Otherwise, you're not going to be able to successfully drive any of those value-based payments."*

Theme 2—Take Steps to Ensure Technology Actually Gets Used

Start Small and Scale What Works: Some rural systems have succeeded in VBC by piloting with one payer or a small patient cohort, proving value, and then expanding; not by buying huge enterprise solutions that promise to solve everything at once.

- *"I personally think the lesson we learned was start small, start small, start small."*
- *"We worked with a very small cohort. Five years ago, we worked with only one payer. Now we have all four payers participating in a cost-saving program with us. We invested in people, we invested in technology, and we are continuing that journey."*

Workflow Integration Is Essential: Technology that lives outside the electronic health record (EHR)[3] or adds clicks to the clinician's day are much less likely to succeed; tools only create value when they are embedded where clinicians already work.

- *"Don't go out and buy your technology without a clear plan on what your use case is. You've really got to make sure that you have a good, solid workflow around it, because if it doesn't integrate with that frontline work, it's never going to be sustained, no matter how advanced that tool may be."*
- *"We have to make sure we're building the workflows first. Then choose the simplest tools that are going to support those workflows because if our team is not going to use that tool on their busiest Tuesday, then it's never going to sustain, and it's never going to be something that's able to drive us forward."*

Clinical Champions Drive Adoption: Technology projects led by HIT personnel alone are constantly challenged to gain traction and meaningful utilization; the same projects are much more likely to succeed when physicians, nurses, and frontline staff are at the table from design through rollout, and champion the tools right out of the gate.

[3] A note on the use of EHR (electronic health record) over EMR (Electronic Medical Record): EMR refers to a digital version of a patient's chart within a single practice, the electronic equivalent of a paper record. EHR is meant to convey a broader, more interoperable concept, a patient's health information designed to be shared across providers, practices, and care settings. The federal government (e.g., Centers for Medicare & Medicaid Services and Office of the National Coordinator for Health Information Technology) and most health policy literature standardized on "EHR" for this reason, especially since the HITECH Act and Meaningful Use programs in the early 2010s pushed the interoperability framing. As such, EHR is used in this paper.

- *"If it's implemented as an HIT project and does not fully involve all the stakeholders, it fails and you don't engage your population with that."*
- *"We have seen a transition from our HIT team being the leaders of things, to others outside of HIT being the lead, and HIT is the facilitator."*
- *"If you have physicians involved in leading the charge and leaning in... you can get projects done. The champions can drive the success. A few of those early adopters can help move things along."*
- *"Just picking a tool is not going to solve the problem. The important question is how do you implement the tool? What kind of support are you going to give, and who are the people who [are] going to promote it?"*

The Choice Is Not Just Build Versus Buy: Most rural systems can't build technology in-house, nor can they buy off-the-shelf products without adaptation. Partnerships with smaller vendors or product development partners who customize existing EHRs and workflows have proved to be a viable middle path. It is not an either-or choice, but rather, a continuum of options which reflects creative ways of engaging technology partners. Instead of a binomial build-vs-buy choice, rural health care is better served by a more flexible and appropriately scaled continuum of "build-partner-buy."

- *"We're doing the development work. We sell ourselves as being small and flexible and nimble enough an HIT company can build something with us and scale it up. We just don't have any ability to consider an in-house build."*
- *Start small. We spent 18 months collecting data before we ever sent it to an artificial intelligence (AI) engine. We didn't go with large companies giving us all these buzzwords and telling us they're going to take us to the moon; we partnered with a small AI startup where we could control the outcomes and tell them what we want."*

Theme 3—Meet Patients Where They Are

Virtual Care Is a Key Rural Growth and VBC Success Strategy: Virtual care lets rural systems extend expertise across vast geographies without building physical infrastructure. However, the persistent digital divide, particularly the lack of comprehensive broadband internet access in rural places, and varying patient comfort with virtual platforms, means it is not a universal solution.

Examples of virtual care offerings highlighted by participants included OB "take home" equipment packs, store-front virtual clinics for follow-up with specialists in more remote communities, specialist consults in the emergency department, and remote monitoring for various conditions.

- *"The investment that mattered most for us was virtual care. The ability to connect expertise to the patient in a place where the patient feels more comfortable, or the patient is more likely to get to, has been an absolute godsend for us in rural care."*

- *"Virtual care is going to be a foundation that you can scale. It's going to be one of the few ways that you can grow without building bricks and mortar, and all the other things that require huge infrastructure dollars to do."*
- *"We still do a lot for our older patients by phone – we can't ignore the continuing digital divide across age groups and in our more remote communities.*

Meet Patients Where They Are: Some participants found that in the communities they serve, texting was preferred to phone calls across all age groups, kiosks in grocery stores expanded access to screening, and self-scheduling improved patient engagement. Participants indicated they can better serve patients when patients and families help shape organizational decisions. Involving patients and families in decisions from program design and investment through implementation and evaluation helps ensure that initiatives align with patient needs. Patient and Family Advisory Councils (PFACs) were highlighted as one option for capturing that type of input and engagement.

- *"We were still using phone calls for everything, and no one was answering [their phone]. We said, 'well, they're more apt to text,' and we actually got a lot of pushback from people within the organization. But we rolled out a text-based communication tool, and it opened the doors huge. Patients who weren't showing up for follow-up visits, cancellations, those numbers fell off a cliff in the best way. Patients were much more apt to text us back than they ever were to answer the phone.*
- *"One thing people shouldn't overlook is having a patient and family advisory committee to help guide how the community actually responds to technology because those of us in healthcare think we know, but we often don't. In our area, the assumption was that our older patient population would resist technology. We used advisory feedback to adjust things like reminder frequency and how we communicate with patients. It's about engaging the community on how to make the technology actually work for them."*

Theme 4—Navigate the Data-Sharing Landscape with Realistic Expectations

Experiences With State-Based Health Information Exchanges (HIEs) Are Mixed: Experiences ranged from non-operational to transformative, but data measurement and reporting standardization is lacking Thus, multi-state healthcare organizations face find it difficult to navigate varying HIE systems and requirements. Primary challenges include concerns over completeness of what data is provided. Furthermore, the lack of real-time data availability limits the HIE's utility as a resource to support direct patient care.

- *"I've had a surprisingly very good experience with our HIE, as far as the connectivity and things that are there. Our state has a dedicated HIE that was more than happy to work with us."*
- *"The problem with [our] HIE is it's one-directional. Our hospitals are pushing data to the HIE, and they're not getting anything back."*

- *"We attempted to join our state HIE some years ago; nobody liked the data they were receiving; it melded everything together, trying to make it easier to read, but it just made it harder to figure out. So, we ended up not pursuing our connection."*

AI (Artificial Intelligence) Governance Is the Next Frontier: As AI vendors proliferate and marketing pressure intensifies, rural systems need frameworks for evaluating, adopting, monitoring, and retiring AI tools. Furthermore, they need to guard against algorithms, trained on urban populations, resulting in bias.

- *"If you don't understand your day-to-day operations it's going to be really tough to take advantage of AI, or you're going to get taken advantage of, essentially."*
- *"[It is difficult for small HIT teams to take on] long-term AI monitoring and ensure that we are not creating bias with AI tools and things of that nature, and I think that is a huge thing. We have people that would want us to do that, but that's a lot of extra burden that others don't think about for an organization our size. We have one data analytics person, one and a half."*

Theme 5–Challenges That Can Not Be Ignored: Infrastructure, Cybersecurity, and Parity

Investment in HIT Maintenance Often Competes with Other Priorities: Aging equipment, slow (or nonexistent) rural internet, and other technology investments routinely lose budget battles to clinical or growth priorities.

- *"A challenge in independent rural health is that everything that I want to do for technology, I'm competing with a new CT or something of that nature; it's not sexy to say I have to invest in the network*."
- *"It's hard to say, 'hey, we're going to focus on this forward-thinking technology,' when the blocking and tackling, the basics and the foundational stuff, isn't there to even support day-to-day."*
- *"AI tools that are efficient on our main campus, where we have better internet, take 20 to 30 minutes out at our rural health clinics. You can't do all of your testing just where your best internet is."*
- *"Underlying operational systems haven't been replaced, because 'they work.'' The technology moves so quickly that it shifts to being obsolete and we're having to isolate equipment running on older systems from the network due to the cybersecurity risks."*

Cybersecurity is Not Optional Anymore: It's not whether you'll be the target of a cyberattack, but when. A successful cyberattack can result in significant expense and operational disruption to a small facility makes cybersecurity investment a higher-stakes decision than many pieces of clinical equipment.

- *"Two and a half years ago, we were hours from being crippled by this; it will absolutely cripple you, and it almost did us. For any size organization, somebody*

will come after you, and you absolutely want to be up to date from an HIT security standpoint. It's critical."

- *"It is just going to happen to all of us sooner or later. All we can do is be well prepared, have the right insurance in place... it is and will happen anytime. We just have to be ready."*
- *"I'm always hyper-focused on cybersecurity. **When** I'm competing against the CT machine, or maybe a new MRI, my argument's always the same: if we're compromised, it's going to cost so much more than any of the medical equipment we're trying to buy."*

Same Expectation, Fewer Resources. Rural systems face the same VBC/VBP expectations as large systems with a fraction of the staff, making cross-training, redundancy, and local HIT pipeline development essential parts of any tech strategy.

- *"One capability every rural health system should build is resiliency and redundancy among your staff."*
- *"As more technology gets added, we have focused on cross-training staff to allow others time off."*
- *"Even though we're smaller and we're less resourced than tertiary care centers, the expectations in these programs are the same for our hospital as they are for hospitals with teams that are multiple times our size. We have to figure out the best ways to efficiently use our teams to meet those same needs without the resources that we're going to see from other facilities."*
- *"When large systems come to our rural hospitals and say, 'It's super easy to get started with the data, our data analytics team will get with your data analytics team,' we say, 'We don't have a data analytics team. We don't even have a data analyst.' And that stops the conversation right there."*
- *"It's really difficult for small rural hospitals that don't have the leverage of the bigger systems to make the changes that we need to be able to collect the information that's being required of us."*
- *"We've been engaging high schoolers to consider HIT as a career path, just like we do for clinical positions – we need a pipeline and just don't have the individuals with those skills readily available in our communities."*

Participant Recommendations

The participants convened for this conversation generously shared their experiences – the hard-won wins and lessons, and persistent challenges.
Four recommendations emerged, built on the experiences and insights of the group assembled:

Recommendation 1: Engage the right people, develop the use case, and establish effective workflows from the start. As the people-process-technology framework illustrates, success depends as much on people and processes as on the technology itself. Data governance, clear use cases, clinical champions, and workflow integration need to be in place before investing in technology. Tools that live outside the EHR or add clicks to a clinician's day may fail, no matter how well the rest of the strategy is built. The day-to-day reality of frontline clinicians and patient experience should be centered in HIT decision, design, and rollout.

Recommendation 2: Start small and rethink build versus buy. Rural systems have had success with piloting with one payer, cohort, or clinic and expanding what works. Testing in the toughest conditions, not the easiest, helps ensure what gets built or adopted is designed for your hardest constraints from the start. And rather than treating procurement as a build-or-buy choice, also consider creative partnership models with vendors who are willing and able to customize your EHR and provide tailored guidance.

Recommendation 3: Keep the essential infrastructure investments, and the people behind them, on the table even when funding is tight. Cybersecurity, bandwidth, and core HIT can be challenging to support financially, but rural leaders can (and should) keep them visible and continue to make the case for investment. Sustainable technology strategy depends as much on staffing, training, cross-training, and redundancy as on the tools themselves. If you can't staff it and support it in an ongoing manner, you can't sustain it.

Recommendation 4: Reimagine care delivery for your community. Think strategically about what can be designed or adapted. The opportunity isn't digitizing existing models or mimicking what larger systems have done; it's rethinking care delivery for your specific community and population, leveraging technology in smart and sustainable ways. As one participant put it: *We're reimagining, not just recreating. Believe that you can do things differently.* Patient and community input should shape these decisions from the start, and implementation of technology tools needs to be adapted to align with the local environment.

> *"We can get through this if we focus on reimagining (what works for us), taking what we have, listening to others, and believing we can recreate on a scale that works for us, not just replicating what others have done in larger organizations."*

Conclusion

The Summit participants who shared their experiences at this convening did not arrive with perfect systems or unlimited resources. They arrived with hard-won lessons about what worked, what did not, and what they wished they had known before they started, which is exactly the spirit in which this brief is offered.

To be successful as a healthcare organization today, technology use is mandatory. In addition, 2026 also brings the potential for significant HIT funding opportunities to rural health organizations—through the Rural Health Transformation Program— reinforcing an urgency to spend, to build, and to modernize. That urgency is understandable. But the leaders in this convening were consistent in one message: the organizations that got the most out of their investments were the ones that paused long enough to ask the right questions before they started.

Rural healthcare organizations do not have to solve everything at once to be successful in VBC/VBP. Start with one problem, one payer, one workflow. Map current HIT capabilities before buying something new. Engage staff before designing or buying technology. These are not complicated first steps, but they are the first steps that make every subsequent step more likely to succeed.

Rural healthcare organizations have always found ways to do more with less, to adapt, and to remain engaged for communities that depend on them. HIT, approached thoughtfully, is one of the most powerful and necessary tools available to help them do that. But that power comes with a requirement: HIT design, purchasing, implementation, and operation that is measured and deliberate. The investment is worth making and the work is worth doing well.

Appendix A. Convening Participant List

Name	Title/Role/Organization	State
Tim Bartholow, MD	Chief Medical Officer, Health Plans, MercyHealth (WI and IL)	WI
Rich Bettini	CEO of Waianae Coast Comprehensive Health Center; Board Chair of AHARO (a rural FQHC ACO)	HI
Jeremy Cauwels, MD	CMO, Sanford Health System	SD
Jay Erickson, MD	Assistant Dean for Regional Affairs; Assistant Clinical Dean, WWAMI Montana; Clinical Professor; University of Washington School of Medicine	MT
Priscilla A. Frase, MD	Interim Director of HIT/CMIO/Hospitalist, Ozarks Healthcare	MO
Matt McCullough, PhD	Rural Hospital Improvement Director, Utah Hospital Association	UT
Amber Rider	Director of Quality and Safety, Prowers Medical Center	CO
Sara Sundar	CIO, Waianae Coast Comprehensive Health Center	HI
James Wellman	VP & Chief Information Officer, Nathan Littauer Hospital & Nursing Home	NY
Rural Health Value Team		
Jennifer Lundblad	Rural Health Value Team / Stratis Health	MN
Clint McKinney	Rural Health Value Team / University of Iowa	IA
Keith Mueller	Rural Health Value Team / University of Iowa	IA
Karla Weng	Rural Health Value Team / Stratis Health	IA
Kristin Wilson	Rural Health Value Team / University of Iowa	MN
Health Resources & Services Administration (HRSA)		
Lawrencia Afagbedzi	Health Resources and Services Administration, Federal Office of Rural Health Policy	
Craig Caplan	Health Resources and Services Administration, Federal Office of Rural Health Policy	

Appendix B: Agenda & Guiding Questions

Day 1: Thursday, April 16, 1:00-3:00 pm CT		
Purpose: Surface how rural systems are thinking about technology strategy for value-based care		
Time	Topic	Objective / Notes
1:00-1:10 (10 min)	Purpose & focus	Share context on RHVT and this effort
1:10-1:25 (25 min)	Introductions & opening thoughts	Get to know who is in the session; use intro question to start discussion & exploration. Share: • Organization type and size • Brief overview of current VBP participation • Key technology investments supporting VBC (*In other words, small or large, what technology investments have most enabled VBC and VBP success?)*
1:25-1:45 (20 min)	Essential investments in VBC technology	If a rural health system wants to succeed in VBC and VBP, what technology capabilities are essential? In your experience: • **Which tools have a record of success?** • **What have you seen fail?**
1:45-2:05 (20 min)	Build vs. buy	Are there any investments which would you reconsider? Why? Did you develop any in-house, and what are your considerations in build vs. buy?
2:05-2:20 (15 min)	HIEs	Are you participating in the local/regional HIE? For those that are: What is the value? For those that aren't: What is the barrier?
2:20-2:45 (25 min)	Open discussion: rural-specific challenges	What barriers to technology investment and use are unique to rural organizations engaged in VBC and VBP?

2:45-3:00 (15 min)	Closing thoughts / preview of Day 2	Overnight prompt: *What advice would you give a rural health system beginning its VBC technology journey?*
Day 2: Friday, April 17, 11:00-1:00 pm CT		
Purpose: Surface actionable lessons rural organizations can apply		
11:00-11:10 (10 min)	Recap & framing for the day	Recap themes from Day 1
11:10-11:45 (35 min)	Using tech to operationalize	What technologies have actually changed care delivery in your organization? Please describe those changes.
11:45-12:05 (20 min)	Data management & reporting	What have you learned about using technology for managing data, developing actionable insights, and reporting performance for VBP contracts?
12:05-12:25 (20 min)	Emerging technologies	What emerging technologies show promise for rural VBC? (Assume they will talk about AI here but we, can prompt if not.) How will those emerging technologies impact care delivery?
12:25-12:45 (20 min)	Final reflections	Structured reflection – panelists complete one of the following prompts: • "The technology investment that mattered most…" • "A mistake rural systems should avoid…" • "One capability every rural system should build…"
12:45-1:00 (15 min)	Closing	Closing comments, group synthesis, final questions, etc.

Appendix C: Potential topics for continued dialogue

The Summit included robust conversation on a variety of topics, but the area of HIT is broad even when scaled to focus on VBC/VBP. Some of the items that were *not* discussed at the summit – but are aligned with VBP strategies are listed below.

i. Closing the Loop on Care Coordination: centralized care coordination and referral management platforms to address care leakage
ii. From Reactive to Real-Time: Clinical Decision Support: real-time EHR prompts and ambient AI documentation
iii. AI in the Revenue Cycle: coding assistance, CDI, claims adjudication, and contract compliance analysis
iv. AI Governance: Beyond Data Governance: frameworks for evaluating, adopting, monitoring, and retiring AI tools
v. The Legal Frontier: AI Liability: emerging questions about liability for following or not following AI recommendations
vi. Population Health Management: care gap closure, identifying rising risk patients, financial management