A Framework for Rural Health:

Securing the Future of Community-Based Care

Presented By:

THRIVE
FINANCIALLY SUSTAINABLE HEALTHCARE SOLUTIONS

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A Framework for Rural Health: Securing the Future of Community-Based Care

EXECUTIVE SUMMARY

Rural healthcare is under immense strain. Community Health Centers (CHCs), Rural Health Clinics (RHCs), and Critical Access Hospitals (CAHs) together form the backbone of care for more than 60 million Americans living in rural areas. CHCs alone served over 34 million patients in 2024 (NACHC, 2025). In many rural towns, these institutions are the only consistent access point for preventive checkups, maternal care, and chronic disease management. When they falter, entire communities lose their lifelines. At THRIVE, we've seen CHC leadership and their boards of directors forced to weigh payroll against patient services and staff uncertain if they will have a job the next month. The strategies that work are not flashy—they are practical, grounded, and urgent.

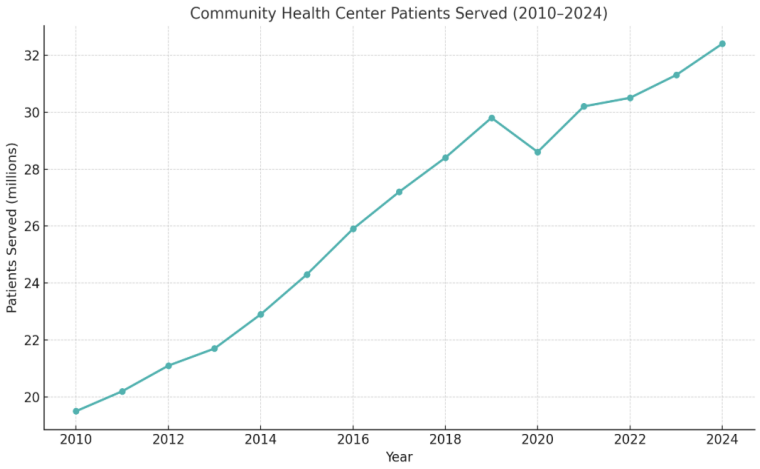
The keys to success are a framework that incorporates workforce strategies, financial resilience, leadership and governance, collaboration and partnerships, and integrated care.

WHY RURAL HEALTH MATTERS

CHCs, RHCs, and CAHs are essential safety-net providers. CHCs are community-anchored and deliver care regardless of insurance or ability to pay. RHCs extend access into medically underserved areas. CAHs keep emergency care available and treat patients who require inpatient care. When these institutions close, patients travel hours for care, chronic conditions go unmanaged, and local economies can be severely impacted.

Community Health Centers: The Backbone of Primary Care

CHCs provide comprehensive, integrated care. Nearly 68% of CHC patients live below the federal poverty line, 18% are uninsured, and 64% identify as racial or ethnic minorities (NACHC, 2025; KFF, 2025b). With future cuts to Medicaid, the number of uninsured patients will grow significantly. CHCs serve 1 in 10 people in the U.S., and in rural America, they are often the only



Sources: NACHC, 2023a (UDS data 2010–2022); NACHC, 2025.

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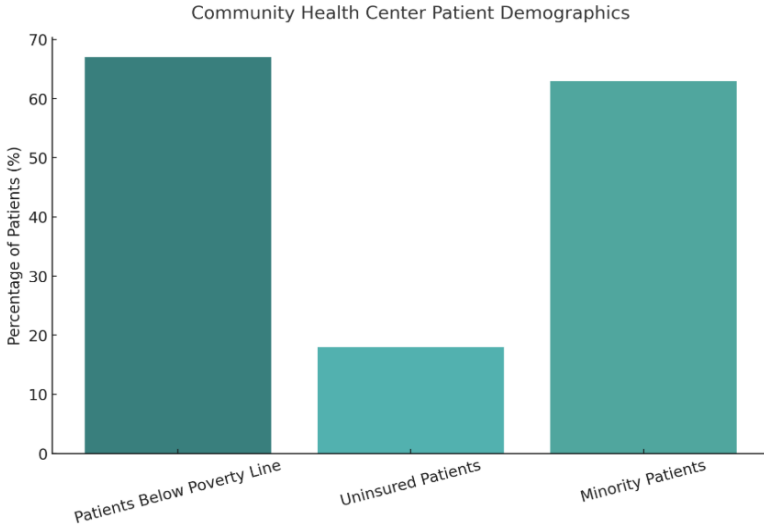

Source: NACHC,2025; KFF, 2525b

consistent point of care (NACHC, 2025). They provide behavioral health, dental, maternal health, and substance use services in addition to traditional primary care. This breadth makes them essential, not optional.

By emphasizing prevention and continuity of care, CHCs not only improve health outcomes but also reduce unnecessary costs to the broader health care system. At the same time, CHCs have strengthened their access and coordination capacity, as 88% now offer timely appointments, and telehealth availability has surged from just 24% in 2018 to 96% in 2024 (Commonwealth Fund, 2024).

The Role of Rural Health Clinics

RHCs extend primary care access into areas where CHCs may not operate, and more than 5,200 certified RHCs operate across the United States, serving millions of rural residents (NARHC, 2023). RHCs are unique in their adaptability: many are small, community-based practices that are affiliated with Critical Access Hospitals, allowing them to serve as both a point of first contact for everyday health needs and a connector to higher levels of care when needed. The strength of RHCs lies in their ability to leverage flexible care teams that often include nurse practitioners, physician assistants, and increasingly, community health workers—providers who can deliver essential preventive services, chronic disease management, and urgent care in areas where full-time physicians are scarce. Beyond brick-and-mortar clinics, many RHCs operate mobile clinics and partner with local schools, churches, and community organizations to bring health care directly to residents in remote areas. By embedding themselves deeply within communities, RHCs not only expand access but also build trusted relationships that improve care continuity and health outcomes. While their reimbursement model was designed to stabilize rural care, it has not kept pace with costs. Still, they play a critical role in preventing total healthcare deserts.

Critical Access Hospitals

To qualify as a CAH, a hospital must be located in a rural area, maintain no more than 25 inpatient beds, and ensure round-the-clock emergency care services (CMS, 2023). Beyond emergency and inpatient services, CAHs play a major role as anchors of rural health systems and economies. They serve as frontline emergency responders for trauma, stroke, and cardiac events—conditions

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where minutes can mean the difference between life and death. At the same time, many CAHs expand beyond acute care, offering swing beds that can be used for both acute care and post-acute rehabilitation, obstetric services, outpatient surgery, and specialty clinics that would otherwise be unavailable locally. Increasingly, CAHs also partner with RHCs and CHCs to coordinate care, integrate behavioral health, provide lab and radiology services, and sustain preventive services for their populations.

For many rural communities, the local CAH is more than just a hospital—it is an institution of trust, a safety net for families, and often the last line of defense against the erosion of rural health infrastructure. Despite their need in the community, CAHs also face financial strain, employee shortages, and risk of closure.

THE WORKFORCE REALITY

Ask any rural CEO about their biggest worry, and you'll almost always hear the same thing: staffing. Rural areas have only 12.8 physicians per 10,000 people (RHIhub, 2024b)—compared with nearly 35 in urban areas. And the workforce is aging, particularly in rural areas compared to urban areas (RHIhub, 2024b). To adapt, CHCs and RHCs lean on nurse practitioners (NPs), physician assistants (PAs), and community health workers (CHWs). We've worked with CHCs that reorganized care teams, allowing NPs and PAs to manage more patients, while CHWs connect families to housing, food, and transportation support. We anticipate this trend will continue. It's not only a path to survival, it's also a path to comprehensive patient care.

POLICY AND FUNDING CONTEXT

The sustainability of CHCs and RHCs is deeply tied to federal and state policy. These organizations operate as safety net providers in underserved communities. Still, their ability to maintain services, expand capacity, and innovate in care delivery is largely determined by how they are financed.

Federal Grants

For CHCs, Section 330 grants under the Public Health Service Act remain the foundation of funding, providing core support for serving uninsured and underinsured patients (KFF, 2019). These grants allow CHCs to offer sliding fee scales, enabling care for patients regardless of their ability to pay. However, demand for CHC services continues to outpace funding growth, as patient volume has more than doubled since 2000, while appropriations have not kept pace (NACHC, 2023).

As we look forward, we must consider the impact the "One Big Beautiful Bill" ("OBBB") will have on this funding source. The bill slashes Medicaid funding by over $1 trillion over the next decade—cuts that grimly echo through rural and safety-net providers. Section 330 funds made up about 11% of CHC revenue as of 2023, down from nearly 16% in prior years (KFF, 2025b; Pillai, 2025). With Medicaid cuts looming, the future of Section 330 funding becomes even more precarious.

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On the other hand, the Rural Health Transformation initiative, funded by the OBBB, will provide approximately $50 billion to rural hospitals to help them transition to these lower funding levels. While this funding aims to offer some financial relief, it is important to note that these grants will not fully offset concurrent cuts to Medicaid and Medicare. To receive funding, rural hospitals must collaborate with their states and other healthcare providers to develop plans focused on improving rural healthcare access, outcomes, and financial sustainability. The Centers for Medicare & Medicaid Services (CMS) must approve these plans by December 31, 2025. Half of the initiative's budget will be equally distributed among states, while the remaining half will be allocated based on rural population counts and related metrics. Given the anticipated funding shortfall, Rural Access Hospitals should design their plans not merely to replace lost funding but rather to prioritize strategies that reduce their dependence on previous federal funding sources (Modern Healthcare, 2025a; Modern Healthcare, 2025b).

State Reimbursement Policies

Medicaid reimbursement is another essential pillar, accounting for nearly half of CHC revenue nationwide. Yet, reimbursement policies vary widely by state, leading to uneven sustainability across the country. We have seen some states expand Medicaid under the Affordable Care Act, strengthening CHCs' financial base and increasing access to preventive and chronic disease care. In contrast, states that have not expanded Medicaid often leave CHCs, RHCs, and CAHs serving a larger uninsured population with fewer resources to cover uncompensated care compared to expanded states.

It is important to note the loss of federal support to states that did expand under the ACA. This lack of support shifts costs back onto already-stretched-thin state budgets, and states must make tough choices: raising revenue, cutting other services, or reducing health coverage. For communities, it means more neighbors losing insurance, skipping doctor visits, or facing medical debt. And for rural health providers, it means a surge of uninsured patients—in addition to the already high patient load—walking through the door with no reliable way to cover the cost of their care. In other words, the result is more strain on fragile rural clinics and hospitals, and a widening gap in access for the very communities Medicaid expansion was meant to protect (KFF, 2025a).

RHC Reimbursement Mechanics

RHCs are reimbursed by Medicare and Medicaid through cost-based models, which were designed to stabilize care delivery in sparsely populated areas. However, these reimbursement rates are capped and have not kept up with rising operating costs, inflation, and workforce expenses, leaving many rural clinics financially vulnerable (NRHA, 2023). This financial strain is especially severe, as RHCs are often small practices with limited administrative capacity to restructure around changing regulations or negotiate supplemental funding streams.

Again, the OBBB threatens the reimbursement mechanics for RHCs due to the funding cuts contained within. OBBB's structural changes to Medicaid and funding cuts, paired with stagnant Medicare caps, contribute to the process that has weakened the once stable, cost-based reimbursement model into a fragile lifeline that no longer matches reality. Without policy fixes—

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such as inflationary adjustments to RHC payment caps, targeted Medicaid protections for rural providers, or dedicated stabilization funds—RHCs risk becoming the next casualty of rural health system erosion.

Medicaid Waivers

State-level innovation also shapes the financial landscape through Medicaid 1115 and 1915 waivers, which can either expand opportunities or create new constraints. In some states, waivers have been used to broaden telehealth reimbursement, enabling CHCs and RHCs to sustain access for rural and hard-to-reach populations (Commonwealth Fund, 2024). In others, restrictive eligibility criteria or enrollment processes have reduced Medicaid coverage, undermining the stability of rural health providers and placing additional strain on uncompensated care pools.

OBBB, by shrinking the Medicaid pool, effectively raises the stakes of every state waiver decision. With fewer federal dollars available, states may be forced to use waivers not as tools for innovation, but as mechanisms for cost containment—tightening eligibility, limiting benefits, or capping enrollment. This means that instead of waivers expanding telehealth or integrating behavioral health, many states could redirect them toward restricting coverage to balance budgets. Without strong federal guardrails or stabilization mechanisms, the OBBB risks turning state waivers from bridges that connect patients to modern, flexible care into barriers that ration access. And in rural America—where options are already few—that could mean the difference between steady, preventive care and an avoidable trip to the ER.

FINANCIAL STRAIN

For CHCs, Medicaid and Section 330 grants are lifelines. For rural hospitals, Medicaid reimbursement is often the only thing standing between survival and closure. The problem is, both funding streams are strained. Nearly half of rural hospitals already operate at a loss (Chartis, 2025). RHC reimbursement doesn't keep pace with real costs. And value-based payment models, while promising in theory, often leave primary care providers chasing metrics without the dollars to back them up. VBP models can work beyond theory, though, if CHCs pair it with the right support, including upfront funding and strong infrastructure for care coordination (Lumeris, 2024). Programs like ACO PC Flex and Making Care Primary show how tailored models can give CHCs and RHCs the resources to succeed under this approach (Lumeris, 2024). We've worked with boards staring at red ink, and the most successful ones are those willing to diversify revenue, renegotiate contracts, and plan around reality—not proceed passively on hope.

Additionally, the cost of an ED visit is exponentially higher than a visit to a CHC. The National Association of Community Health Centers (NACHC) reports that the average cost of a CHC visit was $322 compared to an ED visit costing $2,600. For CAHs to manage costs and properly utilize scarce resources, they must deploy medical staff to higher-acuity cases and rely on CHCs and RHCs to provide preventive and lower-acuity care.

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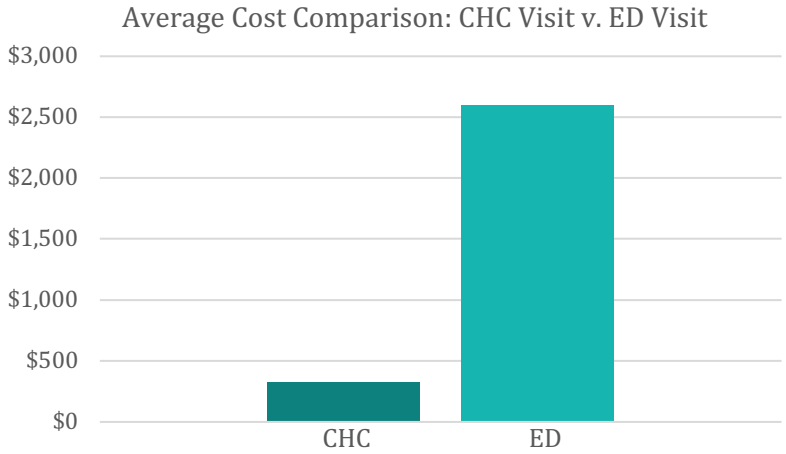
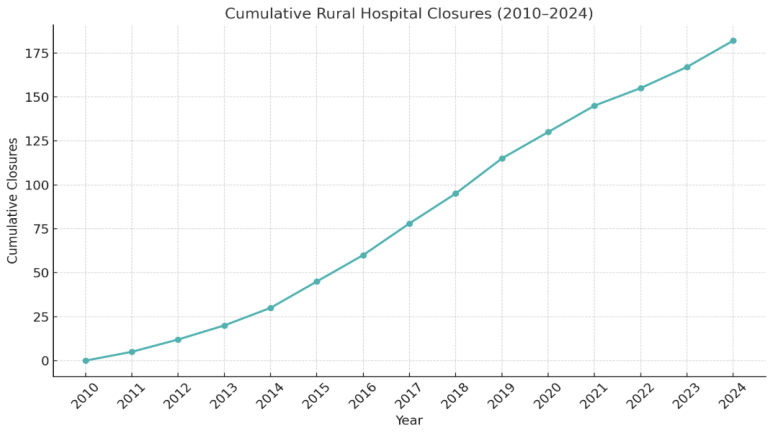


Source: NACHC, 2023b (citing from UHC)

RURAL HOSPITAL CLOSURES

Since 2010, 182 rural hospitals have closed, leaving whole counties without inpatient or emergency care (Chartis, 2025). Currently in the United States, there are over 750 rural hospitals at risk of closure, with 40% being in a state of imminent risk (Becker's Hospital Review, 2025). These at-risk hospitals are located in nearly every state, and financial problems are the main contributor to the risk due to losses on patient services, insufficient revenues from tax sources or government grants, and the accumulation of debt (CHQPR, 2025). The problem is so pervasive that more than half the states risk at least a quarter of their rural hospitals closing in the next 6-7 years (Becker's Hospital Review, 2025).

The impact of these closures extends far beyond the loss of the facility. For patients, rural hospital closures result in increased travel times to a different facility and increased mortality due to delayed care. Closures also create ripple effects on the local economy, marked by local job loss and the secondary effects of reduced business activity, population decrease, and diminished attractiveness for new employers.



Source: Chartis , 2025.

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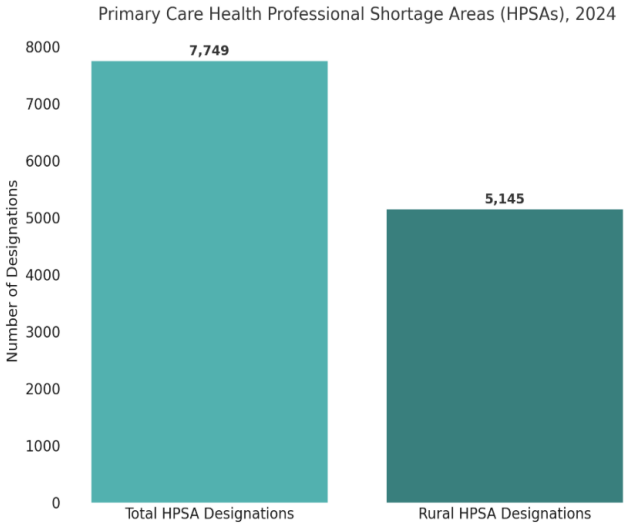
PRIMARY CARE ACCESS GAPS

More than 66% of primary care Health Professional Shortage Areas (HPSAs) are in rural regions (RHIhub, 2024a). These areas are federally designated and highlight communities where the population's needs outpace the supply of providers. This shortage of professionals leaves millions without regular access to a provider, resulting in delayed diagnosis and limited preventative care, and worsening outcomes for chronic disease, maternal health, and behavioral health.



Source: HRSA, 2025

The reality of living in an HPSA is that it is burdensome to get care; there are long drives to the clinic or hospital and long waits for appointments. The cost of travel, the need to take time off work, the lack of transportation, and the fatigue of having to jump through all of these hoops lead many to forego treatment entirely. It is for this reason that otherwise more manageable conditions can become much more serious and costly, as the condition worsens and the patient has no choice but to seek care.

LEADERSHIP AND GOVERNANCE

CHCs and RHCs have the potential to overcome the challenges before them, but not without bold leadership. In a constantly shifting rural healthcare environment, contingency planning and decision-making must be adaptable. The ability to pivot quickly when faced with funding fluctuations or unexpected staffing losses can mean the difference between maintaining services and closing doors.

However, leadership and boards must also anchor their governance in their mission—even as that mission evolves and requires consistent reflection, clarification, and redefinition. Leadership that can balance adaptability with mission-centered governance will ultimately ensure that their CHCs and RHCs remain flexible, resilient, and capable of growth. Bold leaders are those who can guide their organizations through crisis and foster innovative solutions.

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CASE EXAMPLES

Many CHCs, RHCs, and CAHs have overcome financial and workforce issues by implementing innovative solutions and now operate facilities in the very rural areas where they almost closed their doors, or have expanded services to better serve their community.

Case Example 1: South-Central Rural Partnership

In a rural area in the south-central region of the United States, access to primary care was limited. In this area, a privately-owned CAH that also ran an RHC was practically the only option. When the local taxing district commissioned an assessment to determine if the overall healthcare needs of the community were being met, it was determined that additional capacity was needed in the community, and that residents did not see the RHC as a "healthcare home."

In response, a Federally Qualified Health Center Look-Alike (FQHC LA) was formed, a facility was constructed, staff were hired, and an integrated model of care was developed. The CAH coordinated with the FQHC LA, providing lab, diagnostic imaging, and other services. In addition, data interfaces were created to connect the CAH, the RHC, and the FQHC LA. Over time, the FQHC LA formed partnerships with teaching hospitals and social services groups to expand its reach. This allowed for a comprehensive system of care—rooted in local collaboration—that included medical care, dental services, behavioral health, and social services (Winnie-Stowell Hospital District).

Case Example 2: Southeast Rural Collaboration

An FQHC serving over 45,000 patients across multiple counties partnered with neighboring health centers, local colleges, and community organizations to address widespread poverty, transportation barriers, and high rates of chronic disease. The FQHC joined with others to pursue a value-based care consortium, where incentives earned from Medicaid managed care companies were used to reinvest in their health system. In 2017, over $650,000 of these incentive payments were used to fund CHWs, transition teams, and embed behavioral health services.

These collaborations led to dramatic gains in preventative care. In two years' time, colorectal cancer screening rates more than doubled, from 21% to 48%. Additionally, the use of regular performance reports and dedicated teams focused on specific types of patients enabled increased screening and counseling for various physical and mental conditions. The initiative demonstrates how rural health centers can leverage cross-sector partnerships and shared financial incentives to expand care beyond clinic walls, improve outcomes, and build sustainable workforce pipelines (Commonwealth Fund, 2020).

Case Example 3: Collaborative Stability for a Great Plains CAH

A small hospital in the Great Plains faced financial peril due to low patient volume and high overhead. They worked with an organization to address these issues, and the first step was to convert to CAH status. This alleviated some of the CAH's problems relating to financial performance, but left other issues concerning collections and physician relations unaddressed.

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By joining a regional health network and working with a community organization, the CAH was able to improve physician relations and operational accountability, as well as create new revenue-generating programs. One tactic used by the leadership team was to begin qualifying payor status before the patient was admitted; this allowed the CAH to categorize patients efficiently and apply to any programs needed for payment assistance. Financially, the CAH is in a much better position, with its Earnings Before Interest, Depreciation, and Amortization hitting $1 million in 2024 compared to $182,000 in 2004 (Community Hospital Corporation, 2018).

Case Example 4: Northeastern Rural Clinic Using Technological Innovations

A clinic serving a rural region in the northeast faced major financial and quality-of-care challenges when their clinical workforce dropped by 43% in one year, leading to long waits for patients and burnout among the staff they retained. Instead of closing beds, the leadership of this clinic created a virtual, team-based system of nurses with a centralized command center.

This model allowed for an expanded reach into the rural communities it was serving. At the center, remote nurses used TV screens to have "face-to-face" interactions with patients and their in-person care teams. These virtual nurses provide 24/7 support to the in-person care teams by documenting patient history and providing an extra layer of observation. This program saved $7 million in labor costs, improved the clinic's safety grade, and decreased the number of infections associated with catheters and central lines. The program also fostered a mentorship relationship between the veteran virtual nurses and the in-person nurses, who were often newer to the profession (American Hospital Association, 2024).

THE NEXT DECADE IN RURAL HEALTH

The next ten years will be pivotal. Telehealth has expanded potential access but requires increased broadband investments for that potential to be fully realized. The rapid growth of telehealth during the COVID-19 pandemic proved that distance does not have to be a barrier to care. But without reliable broadband and affordable devices, telehealth becomes another form of inequity, widening the gap between those who are connected and those left behind. Investment in digital infrastructure is not simply about convenience—it is about survival, ensuring that no community is isolated from care.

AI will begin to support triage and diagnostics, but only if rural providers can afford it. These tools will reach rural America only if providers can afford the technology and trust that it will complement—not replace—the human relationships that define rural care. For patients who already feel overlooked by the health system, AI must be rolled out with transparency, affordability, and safeguards against bias.

No innovation will matter if there are not enough people to provide care. Many rural communities already struggle with a shortage of doctors, Advanced Practice Providers (APPs)—such as NPs and PAs—, nurses, and behavioral health professionals. Promising "grow-your-own" workforce pipeline programs are beginning to change this—training local residents as medical assistants,

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community health workers, or nurses, and creating career paths that keep talent in the community. These training programs are showing success in regional public colleges and universities, where the local residents' ties to the community ignite a unique and understanding passion for rural health (Milbank Memorial Fund, 2025). When a high school student from a small town sees a pathway to becoming a nurse practitioner or other health professional that can serve their own community, the benefits ripple for decades. These are the investments that turn health care into an engine of both health and economic opportunity.

Policy shifts around 340B, Medicaid, and value-based models will continue to define the financial viability of rural providers. For rural hospitals already operating on razor-thin margins, predictability and fairness in policy are as important as any medical breakthrough. Policymakers must recognize that financial stability in rural health is not about profit—it is about whether families can deliver babies close to home, whether farmers can manage chronic illness without losing a day's wages, and whether seniors can live with dignity because care is nearby.

RECAP: THE CHALLENGES FACING RURAL HEALTH

As detailed above, rural health faces substantial challenges moving forward. CHCs and RHCs struggle with staffing shortages that are even more severe than those in non-rural facilities, disrupting continuity of care and straining the providers who remain. These shortages are exacerbated by an aging workforce and limited training or pipeline programs to replenish it. At the same time, patient demand in CHCs, RHCs, and CAHs consistently exceeds both facility capacity and staff availability, leaving many communities underserved.

Infrastructure challenges further complicate the picture. Limited broadband access restricts the reach of telehealth and slows the adoption of innovative care models that could otherwise bridge access gaps. Financial pressures pile on, with shrinking reimbursements and the threat of Medicaid cuts making it harder for clinics and hospitals to keep their doors open. And because rural communities are so spread out, the kind of partnerships and shared resources that might ease these burdens are harder to build.

As rural health providers face their own unique, demanding struggles, the solutions we build must be narrowly tailored to the realities of rural health.

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THE THRIVE FRAMEWORK FOR RESILIENCE

THRIVE has seen firsthand the challenges rural health faces. From our work with CHCs, RHCs, and CAHs, we have developed a five-part framework for resilience:

1. **Workforce Strategies**
    a. Identify core "survival staff" to protect continuity of care.
    b. Develop care team models that maximize every provider's role.
    c. Expand the use of community health workers and telehealth.
    d. Strengthen recruitment and retention strategies tailored to rural realities.
2. **Financial Resilience**
    a. Diversify revenue streams beyond Medicaid.
    b. Prepare for value-based care and evolving payment models.
    c. Build cash flow and recovery plans to keep facilities open.
    d. Improve revenue cycle processes that address rural payer mix challenges.
3. **Leadership and Governance**
    a. Equip boards with contingency frameworks and decision-making tools.
    b. Facilitate nimble, data-driven governance structures.
    c. Support executives with real-time planning and scenario modeling.
    d. Provide interim leadership solutions during times of transition.
4. **Collaboration and Partnerships**
    a. Connect health centers, hospitals, and social service agencies.
    b. Design whole-person care systems integrating health and social supports.
    c. Build regional networks that multiply impact with limited resources.
    d. Guide cross-sector partnerships to strengthen long-term sustainability.
5. **Integrated Care**
    a. Recognize the unique needs of rural communities and incorporate solutions tailored to those needs.
    b. Treat the whole person through the introduction of social services.
    c. Utilize community health workers to reach into the community and connect patients with medical, behavioral, and social care.
    d. Partner with community foundations, state associations, and private funders to achieve this multi-layered approach to care.

CONCLUSION

People living in rural areas must overcome many challenges to receive care, and CHCs, RHCs, and CAHs are holding rural health care together under extraordinary strain. These entities face persistent financial, staffing, and operational challenges, yet they also stand at the center of rural communities with unmatched opportunities to transform care. The broader health care industry is in constant motion—policies shift, payment models evolve, technologies emerge, and patient needs grow more complex.

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For rural health systems, flexibility and quick-thinking are not optional—they are the difference between resilience and erosion. Those that can anticipate industry shifts, diversify revenue, and reimagine how care is delivered will be best positioned to weather fluctuations in funding, policy, and demand. The organizations that endure will be those willing to adapt and act boldly. At THRIVE, we walk alongside providers, helping them survive the storm and build a sustainable, more equitable future for health care.

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REFERENCES

American Hospital Association. (2024). *Medical informatics case study: Guthrie Clinic*. https://sponsors.aha.org/rs/710-ZLL-651/images/Medical_Informatics_Guthrie_CaseStudy_final.pdf

Becker's Hospital Review. (2025). *760 hospitals at risk of closure, state by state*. Becker's Hospital Review. https://www.beckershospitalreview.com/finance/760-hospitals-at-risk-of-closure-state-by-state/?origin=CFOE&utm_source=CFOE&utm_medium=email&utm_content=newsletter&oly_enc_id=4624A4623090A0I

Center for Healthcare Quality & Payment Reform. (CHQPR, 2025). *Rural hospitals at risk of closing*. https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

Centers for Medicare & Medicaid Services. (CMS, 2023). Critical Access Hospitals. https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals

Chartis Center for Rural Health. (2025). 2025 rural health state of the state. https://www.chartis.com/insights/2025-rural-health-state-state

Commonwealth Fund. (2024). Community Health Centers' Progress and Challenges in Meeting Patients' Essential Primary Care Needs. https://www.commonwealthfund.org/publications/issue-briefs/2024/aug/community-health-centers-meeting-primary-care-needs-2024-FQHC-survey?

Commonwealth Fund. (2020). *Building partnerships to improve health in rural South Carolina*. Commonwealth Fund. https://www.commonwealthfund.org/publications/case-study/2020/jan/building-partnerships-improve-health-rural-south-carolina

Community Hospital Corporation. (2018). *Yoakum Community Hospital: Rural Texas Hospital is a Model of Success* [Case study]. CHC. https://chc.com/wp-content/uploads/2018/05/CHC_CaseStudy_YCH_0625LO2.pdf

Health Resources & Services Administration. (HRSA, 2025). Second Quarter of Fiscal Year 2025 Designated HPSA Quarterly Summary. https://data.hrsa.gov/default/generatehpsaquarterlyreport

Kaiser Family Foundation. (KFF, 2019). Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained. https://www.kff.org/medicaid/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained/

Kaiser Family Foundation. (KFF, 2025a). *Health provisions in the 2025 Federal Budget Reconciliation Bill.* https://www.kff.org/medicaid/tracking-the-medicaid-provisions-in-the-2025-budget-bill/

Kaiser Family Foundation. (KFF, 2025b). Community Health Center Patients, Financing, and Services. https://www.kff.org/medicaid/community-health-center-patients-financing-and-services/#:~:text=A%20majority%20of%20health%20center,under%20200%25%20FPL%20in%202023.

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Lumeris. (2024). *Leveraging value-based care to empower rural health organizations*. https://www.lumeris.com/insights/leveraging-value-based-care-to-empower-rural-health-organizations

Milbank Memorial Fund. (2025). *Opportunities for rural transformation: Regional public colleges and universities*. Milbank Memorial Fund. https://www.milbank.org/2025/09/opportunities-for-rural-transformation-regional-public-colleges-and-universities/

Modern Healthcare. (2025a). *HHS opens applications for $50B rural health fund*. https://www.modernhealthcare.com/politics-regulation/mh-rural-health-transformation-program-fund-applications-hhs/

Modern Healthcare. (2025b). *What to know about the tax law's $50B fund for rural providers.* https://www.modernhealthcare.com/providers/mh-rural-health-transformation-program-explained/?utm_source=modern-healthcare-alert&utm_medium=email&utm_campaign=20250915

National Association of Community Health Centers. (NACHC, 2025). *America's Health Centers: September 10, 2025*. https://www.nachc.org/wp-content/uploads/2025/08/Americas-Health-Centers-Sept-10-2025.pdf

National Association of Community Health Centers. (NACHC, 2023a). Community Health Center Chartbook.

National Association of Community Health Centers .(NACHC, 2023b). Federal Funding Deadlock Costs Safety Net Clinics. https://www.nachc.org/federal-funding-deadlock-costs-safety-net-clinics/

National Association of Rural Health Clinics. (NARHC, 2023). Sixty Percent of Rural Americans Served by Rural Health Clinics. https://www.narhc.org/News/29910/Sixty-Percent-of-Rural-Americans-Served-by-Rural-Health-Clinics#:~:text=According%20to%20the%20National%20Association%20of%20Rural,more%20than%2011%25%20of%20the%20entire%20population

National Rural Health Association. (NRHA, 2023). Rural Health Clinic Policy Brief.

Pillai A., et al, Kaiser Family Foundation. (2025) Community Health Center Patients, Financing, and Services: 2023 Update. https://www.kff.org/medicaid/community-health-center-patients-financing-and-services/

Rural Health Information Hub. (RHIhub, 2024a). Healthcare Access in Rural Communities. Retrieved from https://www.ruralhealthinfo.org/topics/healthcare-access

Rural Health Information Hub. (RHIhub, 2024b). Healthcare Workforce in Rural Communities. https://www.ruralhealthinfo.org/topics/health-care-workforce

Winnie-Stowell Hospital District. (n.d.). *Winnie-Stowell Hospital District Special meeting and Workshop 10/29/2021*. https://wshd-tx.org/meetings/

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