

Shared Resource Models in Rural Healthcare: Intermountain Health's Approach and Lessons for Scaling Rural Care

Introduction: The Rural Healthcare Challenge

Rural communities across the United States face severe healthcare access challenges. Roughly **60 million Americans** (about one in five) live in rural areas, yet in 2024 alone **at least 25 rural hospitals closed**; over **700 more** – about **one-third** of all rural U.S. hospitals – are **at risk of shutting down**¹. These closures and service cutbacks lead to long travel distances for care, specialist shortages, and worsening health outcomes in rural populations (for example, rural cancer mortality far exceeds urban rates)^{2 3}. Recognizing this crisis, health systems and policymakers are seeking scalable ways to “**keep care close to home**” for rural patients while **stabilizing the finances** of rural hospitals. One promising strategy is the “**shared resource**” model, in which larger health systems **partner with** or **support smaller rural hospitals** by sharing clinical services, technology, and operational infrastructure. This report examines how **Intermountain Health** – a large nonprofit health system in the Mountain West – has delivered shared resources to rural hospitals in its network and periphery. We will explore what has worked well for Intermountain (especially in **clinical support** and **supply chain efficiencies**), what is showing promise, and how these efforts could serve as a model for other rural health systems. Comparative examples from other health systems are included to illustrate key points. Both **commercial partnerships** (driven by private-sector innovation) and **public collaborations** (e.g. federal grants) will be highlighted, with an emphasis on market-driven models likely to appeal to conservative state leadership.

¹<https://www.healthleadersmedia.com/innovation/can-telemedicine-solve-rural-healthcare-crisis>

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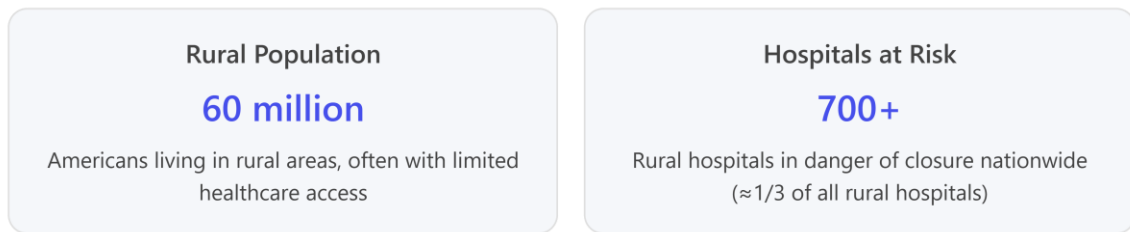


Figure: The rural healthcare crisis in numbers. Persistent financial instability has put hundreds of rural hospitals in jeopardy⁴, threatening access for tens of millions of Americans.

Against this backdrop, Intermountain Health’s initiatives demonstrate how **shared resource models** can bolster rural healthcare. Intermountain operates 33 hospitals (as of 2025) across Utah, Idaho, Nevada, Montana and other states – many in rural or frontier areas⁵ – and has **partnered with dozens of additional rural hospitals outside its system** to extend critical services^{6 7}. Below, we detail Intermountain’s approach in two key domains: **clinical telehealth support** and **centralized supply chain services**, along with specialized programs addressing rural needs. We then evaluate outcomes and extract lessons, before comparing similar models from other health systems.

Intermountain’s Shared Resource Initiatives for Rural Hospitals

1. “Virtual Hospital” Telemedicine Network (Clinical Support)

One of Intermountain’s flagship efforts is its extensive **hub-and-spoke telemedicine platform**, essentially a “virtual hospital” that connects urban medical expertise with rural facilities. Intermountain has built an enterprise-wide telehealth network linking its large tertiary hospitals (as hubs) with **small rural hospitals (spokes)** across several states^{8 9}. This platform supports critical care, emergency medicine, stroke neurology, neonatal care,

⁴<https://www.healthleadersmedia.com/innovation/can-telemedicine-solve-rural-healthcare-crisis>

⁵<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

⁶<https://www.aonl.org/news/Health-system-uses-telemedicine-to-strengthen-rural-health-care>

⁷<https://www.aonl.org/news/Health-system-uses-telemedicine-to-strengthen-rural-health-care>

⁸<https://www.healthleadersmedia.com/innovation/can-telemedicine-solve-rural-healthcare-crisis>

⁹<https://medcitynews.com/2025/02/intermountain-rural-healthcare/>

behavioral health and more via virtual connections. Key features of Intermountain's telehealth network include:

- **On-Demand Specialty Consultation: Small critical access hospitals** in remote areas are equipped with secure video links and monitoring tech that connect to specialists at Intermountain's "**virtual command center**". For example, rural ER or ICU staff can summon an Intermountain intensivist, cardiologist, neurologist, or other specialist on video within minutes, 24/7^{10 11}. Intermountain began this program with tele-ICU services (260 tele-enabled ICU beds across 12 hospitals by 2014) and has since expanded to 35+ telehealth service lines including ED, neonatal ICU, stroke, and psychiatric crisis consults^{12 13}.
- **Broad Network Coverage:** As of 2025, the network connects **33 Intermountain hospitals and ~40 affiliated rural hospitals outside the system** that **contract for telemedicine access**¹⁴. In total, **70+ hospitals** across Utah, Idaho, Montana, Wyoming, Nevada and other states are part of this shared telehealth network¹⁵. Notably, Intermountain opened this service to **non-Intermountain facilities** (about 40 so far) on a subscription basis¹⁶. These external rural partners pay a "**very small fractional fee**" to access Intermountain's virtual specialists¹⁷, making it an affordable lifeline for hospitals that could never recruit or retain such expertise on their own.
- **Hub-and-Spoke Model in Action:** Intermountain's **specialists and subspecialists** (e.g. critical care physicians, neonatologists, trauma surgeons, cardiologists, pharmacists) **work shifts in a centralized telehealth hub** (often referred to as a virtual hospital)

¹⁰<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

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¹²<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

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rather than solely seeing in-person patients^{18 19}. From this hub, they can instantly “beam into” a rural hospital’s patient room via telemedicine. For the rural “spoke” hospitals, this effectively **puts an expert in the room** alongside their local providers during critical cases – **without transferring the patient**. For example, an emergency physician at a 10-bed frontier hospital can consult a neurologist at the hub to guide stroke thrombolysis on the spot, or a community hospital labor-and-delivery unit can get a neonatologist’s assistance during a high-risk birth via video. Intermountain calls this integrated telehealth approach a way to create “**what we call a virtual hospital**” spanning many locations²⁰.

- **Reducing Unnecessary Transfers:** A major goal is to **treat more patients locally** and avoid sending them on long ambulance or air transports to distant tertiary centers whenever possible. Before telehealth, small rural hospitals often had to **transfer patients by default** if a specialist consult or ICU-level monitoring was needed. With the telemedicine network, **up to 13–18% of cases that previously would have been transferred can now be managed locally** at the rural hospital^{21 22}. Intermountain’s Chief Strategy Officer, , noted that keeping “an extra 13% to 18% of their patients” in local facilities has been feasible thanks to virtual specialty support^{23 24}. This is a **huge win** for rural hospitals – these retained cases boost their inpatient volumes (helping their finances) and allow patients to stay near home. In fact, Intermountain reports rural partners are “**keeping up to 18% more of their patients**” who would otherwise be sent away²⁵. This translates into **capturing more revenue locally** (patients who

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stay generate billing for the rural facility) and often better patient outcomes (avoiding high-risk transports and treatment delays)²⁶.

- **Clinical Outcomes and Safety:** The telemedicine collaboration has measurably improved care quality. Intermountain noted that even in early phases, **smaller rural hospitals saw remarkable benefits** – for example, in the first few years of tele-ICU use the system observed a **33% lower risk-adjusted mortality rate** among participating hospitals and reduced lengths of stay^{27 28}. Rapid specialist intervention via telehealth has saved lives (e.g. stroke patients getting clot-busting treatment faster, critical infants kept stable) and prevented many transfers. In one specific initiative, tele-neonatology access for 18 rural hospitals (including two outside Intermountain) resulted in at least **50 newborns who avoided transfer to a big NICU**, yielding an estimated **\$1+ million in cost savings** and keeping those infants and mothers in their community^{29 30}. Such outcomes demonstrate that virtual expertise, when well-coordinated, can **match the quality of in-person care** and even provide a safety net that **boosts overall care consistency and patient safety** across rural and urban sites^{31 32}.
- **Technology and Integration:** Underlying this program is a significant **investment in technology integration**. Intermountain built a common telehealth technology platform and installed it in over 1,000 patient rooms systemwide (covering all ICUs, EDs, and many other units)^{33 34}. This standardization means any given room in a rural affiliate hospital can connect to Intermountain’s specialists with the push of a button. Intermountain also emphasizes **integrated electronic health records (EHR)** and data sharing so that remote consultants can see patient data in real time. (In general, many rural hospitals struggle with outdated IT, and programs like Epic

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³⁴<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

Community Connect could give them access to modern EHRs^{35 36}. Ensuring **seamless data flow** has been key to Intermountain’s telehealth scaling^{37 38}.) The system’s partnerships with tech companies like **Microsoft and Epic** are aimed partly at solving these integration challenges – e.g. creating single sign-on workflows for Intermountain doctors to access multiple hospitals’ records quickly^{39 40}. High-quality video infrastructure and analytics support (e.g. teleICU monitors) further enhance the “virtual hospital” capabilities.

- **Coalition and Expansion:** To amplify this model, Intermountain in late 2024 launched a **national coalition** with major partners – Microsoft, Epic, **Gates Ventures** (the investment arm of Bill Gates focusing on health innovation), and **West Health** (a nonprofit focused on senior and rural care)^{41 42}. The coalition’s aim is to “**reverse the trajectory of rural healthcare**” by scaling hub-and-spoke telemedicine networks across the country⁴³. By combining Intermountain’s on-the-ground experience with the technology and funding clout of these partners, the group plans to pilot the model in more regions and **prove out a sustainable business case** for rural

³⁵<https://content.presspage.com/uploads/2804/05dd57e6-ee19-453d-a709-3171854d4726/intermountainhealth-ruralhealthwhitepaper.pdf?10000>

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telehealth networks^{44 45}. Early analyses have indicated the hub-and-spoke model can be **financially accretive** for both the hub system and the rural hospitals, meaning it's not just a charitable endeavor but a win-win economic model if done right^{46 47}.

Intermountain's Liljenquist actively evangelizes that **other large health systems should adopt this approach**, suggesting "**seven to 10**" other big systems in the US are well-positioned to create similar rural partnerships⁴⁸. In other words, the Intermountain telehealth network is being positioned as a **national example or template** to "**help stabilize rural healthcare nationwide**"⁴⁹.

In sum, Intermountain's shared telemedicine initiative has effectively created a **distributed care network** where rural hospitals share the **centralized specialist pool** and clinical protocols of a major system. This **clinical support hub** has helped **bridge critical gaps** (ICU care, neurology, high-risk OB, etc.) that often plague rural providers. As we will see in the outcomes section, this model is keeping patients in their communities and **preventing rural hospital closures** by improving their capabilities and finances^{50 51}. It exemplifies a **commercially driven partnership** (a not-for-profit health system leveraging its resources for a fee to others) that aligns incentives for all parties.

2. Centralized Supply Chain and Shared Logistics (Operational Support)

In addition to clinical telehealth, Intermountain has a long history of **delivering shared operational resources** that benefit its network of hospitals, including those in rural areas. A prime example is Intermountain's **Supply Chain Organization (SCO)** – an in-house supply chain and distribution enterprise that is considered one of the most advanced in healthcare.

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By **centralizing purchasing, warehousing, and distribution** for its hospitals, Intermountain has achieved **major cost savings and efficiency gains**, allowing even small rural facilities to get affordable and timely supplies that they might struggle to procure on their own.

- **Central Supply Chain Center:** Intermountain operates a massive centralized **Supply Chain Center**, originally a 327,000 sq. ft. warehouse and logistics hub in Midvale, Utah⁵². This facility (built around 2012 after a consulting study) consolidates **purchasing, contracting, and distribution** for the entire system⁵³. Uniquely, Intermountain **owns and manages its own warehouses and trucking**, rather than relying purely on third-party distributors – a rare approach in healthcare^{54 55}. The center uses advanced Warehouse Management Systems, automation (e.g. voice-picking, conveyors), and data analytics to optimize inventory and deliveries⁵⁶. By standardizing products and buying in bulk directly from manufacturers, Intermountain leverages **economies of scale** that drop unit costs for all its hospitals^{57 58}.
- **Cost Savings and Efficiency:** The results have been striking. When Intermountain centralized its supply chain a decade ago, it was tasked with saving \$20 million in the

⁵²<https://www.scmr.com/article/intermountain-healthcare-how-to-become-a-supply-chain-driven-organization>

⁵³<https://www.scmr.com/article/intermountain-healthcare-how-to-become-a-supply-chain-driven-organization>

⁵⁴<https://news.intermountainhealth.org/intermountain-healths-supply-chain-organization-celebrates-major-expansion-allowing-for-cost-savings--expanded-storage-for-vital-medical-supplies/>

⁵⁵<https://news.intermountainhealth.org/intermountain-healths-supply-chain-organization-celebrates-major-expansion-allowing-for-cost-savings--expanded-storage-for-vital-medical-supplies/>

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first 4 years – it **delivered \$80 million in savings** instead⁵⁹. Over about 8 years, the system cumulatively **saved over \$400 million** through better supply management⁶⁰. These savings come from bulk purchasing, elimination of waste and duplication, and improved contract pricing. For instance, by purchasing supplies directly and consolidating vendors, Intermountain’s fill rates went from 93% to over 99%, reducing expensive last-minute orders⁶¹. Every dollar saved on supplies is a dollar that can be redirected to patient care or to shoring up finances of facilities – a crucial benefit for low-margin rural hospitals. Intermountain’s model became so successful that it was nationally recognized (ranked #4 in Gartner’s Top 25 Healthcare Supply Chains, alongside giants like Cardinal Health)⁶². In fact, Intermountain’s supply chain prowess was *commercialized*: in the 2010s the system acquired a group purchasing organization (Intalere, formerly Amerinet) and offered its supply chain services to other hospitals nationwide⁶³ ⁶⁴. (Intermountain later sold Intalere to Vizient in 2021 to refocus on core operations⁶⁵ ⁶⁶, but this illustrates how a health system’s supply chain can itself be a **shareable resource** beyond its own walls.)

- **Shared Distribution for Rural Facilities:** For rural and remote hospitals, a centralized supply chain means **guaranteed access to essential supplies** and medications, even in challenging circumstances. Intermountain’s warehouse ships out **daily deliveries**

⁵⁹<https://www.scmr.com/article/intermountain-healthcare-how-to-become-a-supply-chain-driven-organization>

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⁶⁴<https://www.healthcarediver.com/news/intermountain-sells-supply-chain-management-business-to-vizient-intalere/588525/>

⁶⁵<https://www.healthcarediver.com/news/intermountain-sells-supply-chain-management-business-to-vizient-intalere/588525/>

⁶⁶<https://www.healthcarediver.com/news/intermountain-sells-supply-chain-management-business-to-vizient-intalere/588525/>

to all its hospitals and clinics across Utah, Idaho, Nevada, Colorado, etc.⁶⁷, ensuring that even far-flung clinics get what they need promptly. The organization recently expanded its main warehouse by 40,000 sq. ft. (a **30% increase in storage capacity**) specifically to meet growing needs and improve emergency stockpiles^{68 69}. By consolidating inventory that was previously kept in **rented satellite storage** into the expanded center, Intermountain will **save \$12+ million annually** in rental and logistics costs^{70 71}. Eliminating those external storage sites also cuts “thousands of unnecessary trucking miles,” improving efficiency and disaster readiness (having all critical supplies under one roof)^{72 73}. *For smaller rural hospitals within Intermountain’s system, this means they do not have to maintain large, costly inventories or deal with multiple suppliers on their own – the system’s logistics arm buffers them.* During the COVID-19 pandemic, this central warehouse “**played a major role**” in ensuring personal protective equipment and ventilators were

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available system-wide, including at rural sites that could have easily run out on their own⁷⁴.

- **Regional Logistics Hubs:** As Intermountain has expanded geographically (merging with SCL Health in 2022 and adding new regions like Montana), it is replicating its supply chain model in those areas. A **case in point is Montana**, a predominantly rural state. Intermountain is developing a **Montana Consolidated Services Center (CSC)** in Billings – a first-of-its-kind hub in that state to centralize **medical supply distribution, laundry services, and specimen transport** for facilities across Montana^{75 76}. This central hub will manage **over 500,000 medical supply items annually** and handle **25,000+ delivery stops per year**, bringing supplies and lab samples to even faraway community hospitals efficiently^{77 78}. Crucially, by storing supplies *in-state* (rather than relying on shipments from distribution centers 500+ miles away), the Montana hub will **mitigate delays from weather or distance** – e.g. avoiding situations where winter storms cut off rural hospitals for days^{79 80}. **Local courier teams** and delivery trucks will operate from the Billings center, covering an estimated 325,000 miles a year to reach hospitals and clinics across Montana’s vast expanse^{81 82}. The CSC is

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⁷⁵<https://healthpoint.com/business/how-will-montanas-new-medical-hub-transform-healthcare/>

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slated to open in late 2026 and is expected to improve resilience (quicker access to critical items) for remote facilities like those in Butte or Miles City that currently wait on far-off suppliers^{83 84}. This investment also brings economic benefits (70 new jobs in Billings) and reflects a **holistic approach**: pairing supply chain improvement with the construction of a new regional medical center (the 14-story St. Vincent Hospital replacement by 2029) to comprehensively uplift healthcare in Montana^{85 86}.

- **Medication and Pharmacy Support:** Another shared resource tied to supply chain is **pharmacy services**. At the expanded Utah warehouse, Intermountain runs a centralized **pharmacy fulfillment center** that fills nearly **1 million prescriptions annually** for its hospitals and patients^{87 88}. This kind of central pharmacy can help rural hospitals by providing 24/7 pharmacy coverage and medication compounding that a small hospital pharmacy could never staff continuously. (In a parallel example, Avera Health’s ePharmacy program in the Upper Midwest provides remote pharmacist review for dozens of rural hospitals, ensuring meds are dispensed safely around the clock^{89 90}.) Moreover, Intermountain has taken a leadership role in ensuring **affordable medication supply** through initiatives like **Civica Rx** – a nonprofit generic drug company it co-founded in 2018 to address chronic drug shortages and high costs. While Civica Rx is national in scope (60+ health systems participating) and not specific to rural hospitals, it exemplifies the **commercial partnership approach** to solving supply issues: health systems banding together (essentially sharing

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resources) to manufacture essential drugs and keep prices down. Stable medication supply is particularly beneficial for rural facilities that often struggle with drug shortages.

Overall, Intermountain's supply chain and logistics strategy shows how **operational efficiencies can be shared** across a network. By **centralizing back-end functions** (purchasing, distribution, pharmacy) and **investing in infrastructure** (warehouses, IT systems) at a scale individual rural hospitals could never afford, Intermountain creates a **rising tide that lifts all boats** – the entire system benefits from lower costs and dependable supply lines. Importantly, this has been achieved largely through **private-sector management techniques and capital investments** (with some local public-private cooperation for new facilities), aligning with a business-friendly narrative. Intermountain's approach could serve as a blueprint for other states or hospital alliances to form **shared services centers** that support multiple rural providers.

3. Community-Based Rural Health Programs

Beyond system-wide telehealth and supply chain, Intermountain has also piloted **targeted programs** to reach rural populations through creative shared-resource models. Two examples illustrate this, both of which blend **virtual care, community partnerships, and external funding** to extend services in hard-to-reach areas:

- **Maternal Health Connection (MHC):** This is an **innovative tele-maternity program** launched by Intermountain to support **expectant mothers in rural communities**. Many rural areas in Intermountain's footprint lack local obstetricians or maternal-fetal specialists (a nationwide problem contributing to poor maternal outcomes). MHC uses a **hybrid care model**: local clinics and community health workers coordinate with **Intermountain OB/GYNs and maternal-fetal medicine specialists via telehealth**, combined with **remote patient monitoring devices** deployed in the patient's home^{91 92}. Starting at 28 weeks of pregnancy, participants are given kits including Bluetooth fetal monitors, blood pressure cuffs, pulse oximeters, scales, etc., so that much of their prenatal care (check-ups, vitals monitoring, even certain diagnostics) can be done **from home with data transmitted to specialists**^{93 94}. In addition, patients have periodic in-person visits at local clinics and home visits from community health nurses, creating a **comprehensive "shared care" structure**. This program, supported by a **\$3.9 million federal grant from HRSA** (Health Resources &

⁹¹<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

⁹²<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

⁹³<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

⁹⁴<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

Services Administration), has allowed pregnant women in places like Evanston, Wyoming and rural Southwest Montana to receive high-quality maternal care **without traveling hours to an urban center**^{95 96}. **Outcomes have been encouraging:** MHC reports **reduced travel distances** (and associated safety risks) for maternity care, **decreases in postpartum depression rates**, and **improved continuity of care** for mothers and babies^{97 98}. Essentially, this is a *public-private shared resource model*: federal funding and Intermountain’s clinical expertise were combined to close a service gap in rural health. It shows that **grant-funded partnerships** can jump-start valuable programs that, if effective, might later be sustained by insurers or other commercial means due to the cost savings of avoiding complications.

- **COMPASS (Tele-Addiction Support):** Another program is **Community Outreach Medication-Assisted Therapy and Peer Support Services**, called COMPASS. Launched in 2022 with grant support (SAMHSA), COMPASS extends **addiction treatment and behavioral health services into rural areas** of Utah and even the Arizona strip^{99 100}. It works by **equipping local clinics** (including Federally Qualified Health Centers) with training, funding, and telehealth links to **Intermountain addiction medicine specialists and psychiatrists**¹⁰¹. Patients in remote communities can receive medication-assisted therapy for opioid or alcohol use disorder via telehealth visits, and local peer support organizations collaborate to provide on-the-ground recovery support^{102 103}. This is a model of **shared clinical expertise** (Intermountain’s specialists make virtual “rounds” to multiple rural clinics) combined with local partnership for implementation. By **partnering with existing rural clinics and nonprofits**, Intermountain scaled out addiction care far beyond its own

⁹⁵<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

⁹⁶<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

⁹⁷<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

⁹⁸<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

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¹⁰¹<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

¹⁰²<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

¹⁰³<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

hospitals. Early results include expanded access to care in counties that previously had little to none, contributing to broader goals like reducing overdose deaths^{104 105}.

These programs, while smaller in scale than the system-wide telehealth and supply chain initiatives, demonstrate a **flexible shared-resource approach**: leveraging technology and partnerships to deliver specialized care in communities that would otherwise go without. They highlight that **public grants** (HRSA, SAMHSA, etc.) can be effectively used by a private health system to innovate in rural care delivery. A key insight from Intermountain's community programs is that **meeting rural needs often requires listening to those communities and co-designing services**. *"These programs don't just deliver care — they reshape how care is delivered,"* observed , Intermountain's VP of Community Health. *"They're proof that when we listen to communities and invest in solutions to meet people where they are, access to treatment improves and so do health outcomes, regardless of rural location."*^{106 107}. In other words, successful shared-resource models are **grounded in local context** – whether that's tailoring a telehealth program for frontier mothers or setting up a mobile clinic rotation.

Having outlined Intermountain's major initiatives, we turn next to **what results have been achieved** and **why these models are working**. We will then consider how these approaches might generalize to other systems, including comparisons with similar efforts elsewhere.

Outcomes and What's Working Well at Intermountain

Intermountain's shared resource strategy for rural health has yielded **tangible improvements** in clinical outcomes, access to care, and operational efficiency. Below we summarize key outcomes and "promising signs" from the initiatives above:

- **More Patients Cared for Locally:** Perhaps the headline result is that **rural hospitals in Intermountain's telehealth network are keeping significantly more patients in their local facilities** rather than transferring out. As noted, the telemedicine hub has enabled rural partners to retain an **additional 13–18% of patients** who previously

¹⁰⁴<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

¹⁰⁵<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

¹⁰⁶<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

¹⁰⁷<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

would have been sent to referral hospitals^{108 109}. For the patient, this means receiving care in a familiar setting close to family; for the hospital, it means capturing revenue and maintaining services. By *reducing out-transfers*, Intermountain's model directly combats the vicious cycle that drives rural hospitals out of business (losing patients -> losing revenue -> cutting services -> losing more patients). **Keeping even 10–20% more volume local can be the difference between viability and closure**, according to Intermountain leaders¹¹⁰. For example, in Louisiana's Ochsner Health telestroke network (a comparable hub program), one critical access hospital went from transferring almost every stroke patient to keeping **over 60% of stroke cases in-house** after establishing tele-neurology support^{111 112}. Intermountain is seeing similar shifts for emergency and ICU cases – a real sign of success.

- **Improved Patient Outcomes:** Quality metrics have improved alongside access. In the early tele-ICU implementation, rural hospitals in Intermountain's system saw a **one-third reduction in ICU mortality** versus baseline¹¹³. Timely specialist input has likely improved adherence to best practices (as Intermountain noted, the tele-ICU team ensures consistency of care and provides decision support that standardizes treatment^{114 115}). Patients managed via telehealth consults also avoid the risks of long-distance transfers; for instance, critical babies or stroke patients treated locally had outcomes comparable to those who would have been moved, with faster intervention time. Intermountain's telestroke program has treated over 1,000 patients, bringing neurologists to bedside in minutes and undoubtedly mitigating stroke disability by speeding up tPA administration^{116 117}. Outside evaluations echo these improvements: Mercy Virtual's teleICU, for example, resulted in patients spending less time in ICU and showed lower mortality by enabling earlier

¹⁰⁸<https://www.aonl.org/news/Health-system-uses-telemedicine-to-strengthen-rural-health-care>

¹⁰⁹<https://medcitynews.com/2025/02/intermountain-rural-healthcare/>

¹¹⁰<https://medcitynews.com/2025/02/intermountain-rural-healthcare/>

¹¹¹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹¹²<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹¹³<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹¹⁴<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹¹⁵<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹¹⁶<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹¹⁷<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

interventions^{118 119}. Additionally, Intermountain's Maternal Health Connection reports **lower postpartum depression rates** for participants, indicating that remote support and keeping care local has mental health benefits as well¹²⁰. All these data points reinforce that **shared resource models can maintain or even raise the standard of care** in rural settings.

- **Financial and Operational Gains:** On the operations side, Intermountain's shared resource approach has clearly paid off. The **supply chain integration** has **saved hundreds of millions of dollars** overall¹²¹, translating into a lower cost base for each hospital in the system (savings which can be passed on as lower expenses to payers like Medicare/Medicaid). A concrete example is the **\$12 million/year saved** by consolidating warehouse space in 2024¹²² – these are dollars that can help offset rural hospitals' thin margins. Similarly, by avoiding patient transfers, rural hospitals and Medicare save on costly transport bills. (Air ambulance flights can cost \$20,000–\$50,000 each; avoiding even a handful through telemedicine yields substantial savings.) Rural facilities in the network also benefit from **better reimbursement** potential: With virtual specialist help, they can treat more complex cases and bill for higher-acuity diagnosis-related groups (DRGs) than they otherwise could^{123 124}, improving their payer mix. In short, **economies of scale** (through central purchasing) and **economies of scope** (through shared clinical services) are improving the financial sustainability of rural care in Intermountain's orbit.
- **Hospital Viability and Avoided Closures:** While it is early to measure long-term survival, Intermountain explicitly believes this model will **prevent rural hospital closures**. By offering rural hospitals a way to **"thrive" rather than be subsumed**, the hub-and-spoke partnership gives independent community hospitals an alternative to

¹¹⁸<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹¹⁹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹²⁰<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

¹²¹<https://www.scmr.com/article/intermountain-healthcare-how-to-become-a-supply-chain-driven-organization>

¹²²<https://news.intermountainhealth.org/intermountain-healths-supply-chain-organization-celebrates-major-expansion-allowing-for-cost-savings--expanded-storage-for-vital-medical-supplies/>

¹²³<https://www.healthleadersmedia.com/innovation/can-telemedicine-solve-rural-healthcare-crisis>

¹²⁴<https://www.healthleadersmedia.com/innovation/can-telemedicine-solve-rural-healthcare-crisis>

shutting down or being bought out^{125 126}. Intermountain itself has not had a rural hospital closure among those participating. In fact, several of its own small rural hospitals were recently named to the Top 100 Critical Access Hospitals list nationally, attributed in part to the support they receive (four Intermountain-affiliated rural hospitals made the list in 2023). The **value proposition** is clear: a rural hospital with telehealth support can provide more services and keep patients (hence revenue), which strengthens its bottom line and community support, decreasing the likelihood of closure. Intermountain's Liljenquist has stated that this platform *"could serve as a model to improve care and prevent hospital closures throughout rural America"*¹²⁷ – a strong indication of observed success.

- **Community Benefits and Patient Satisfaction:** Patients and communities have responded positively. Rural patients now have **access to specialty care that simply didn't exist locally before**, whether it's a psychiatric visit or a high-risk pregnancy consultation. For many, the **alternative to virtual care was no care at all**, as one Sanford Health physician noted^{128 129}. Patient satisfaction with telehealth options is high; Sanford Health reports *"overwhelming feedback: do not take this away"* from rural patients regarding virtual visits¹³⁰. Intermountain's programs likewise note increased patient engagement when care is convenient. Communities benefit from avoiding the disruptions of travel – one Sanford specialist in North Dakota found that telehealth saved each patient an average of **176 miles of driving** (plus lodging and time off work) for a consultation that can now be done online¹³¹. Such metrics underscore the **quality of life improvements** that accompany shared-resource care models.

¹²⁵<https://medcitynews.com/2025/02/intermountain-rural-healthcare/>

¹²⁶<https://medcitynews.com/2025/02/intermountain-rural-healthcare/>

¹²⁷<https://www.aonl.org/news/Health-system-uses-telemedicine-to-strengthen-rural-health-care>

¹²⁸<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

¹²⁹<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

¹³⁰<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

¹³¹<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

- **Scalability and Replicability:** What is especially promising is that Intermountain's results are not a one-off – they appear **replicable by others**. The existence of analogous successes (detailed in the next section) at Avera Health, Mercy, Sanford, and Ochsner indicates that the **hub-and-spoke telehealth model scales** across different regions and health systems. Likewise, group purchasing and centralized supply chains are proven in other industries and are being copied by other hospital consortia (for example, Midwest hospitals forming supply collaboratives). The Intermountain case adds real-world validation, which is persuasive to policymakers: these are **practical, businesslike solutions** rather than theoretical pilot projects. The involvement of major private partners (like technology companies and philanthropies) also suggests a **broad coalition of support** that can be mobilized, reducing reliance on government alone. For state medical directors and Medicaid/Medicare directors, these outcomes signal possible **policy levers** – e.g., encouraging the formation of telehealth networks via grants or favorable reimbursement, or supporting regional supply hubs through public-private partnerships – that could propagate the Intermountain effect statewide.

In summary, Intermountain's shared resource initiatives are **showing concrete benefits**: more care delivered locally (with high quality), significant cost savings, and improved stability for rural healthcare providers. The strategy aligns well with the goals of **value-based care** (improving outcomes while reducing unnecessary costs like transfers or duplicated infrastructure). It's also attractive to *conservative, market-oriented thinkers* because it harnesses **private sector efficiency and entrepreneurship**: a large nonprofit health system, acting almost like a healthcare "service provider," extends its resources to smaller players for mutual gain, rather than relying on a new government program or ongoing subsidy. Intermountain's experience thus far suggests that **with the right partnerships, rural healthcare gaps can be addressed at scale**.

More Care, Closer to Home

Intermountain's telehealth hub lets rural hospitals treat up to **18% more patients locally** instead of transferring them to distant centers. This means patients get care in their community, and small hospitals retain revenue – a key factor in preventing closures.

Efficiency = Sustainability

Through supply chain consolidation, Intermountain saved **\$400 million** over 8 years. Group purchasing and centralized logistics cut costs for every hospital in the system, bolstering the finances of rural facilities and ensuring supplies reach remote sites without delay.

Win–Win–Win Partnerships

Shared-resource models create a virtuous cycle: rural providers gain specialist support and stay viable, patients avoid travel and get timely care, and hub systems optimize their capacity. As Intermountain's CSO put it, it's "great for the rural hospital... great for the patient, and it also helps us" better utilize big-city hospitals.

Figure: Key outcomes of Intermountain's shared resource approach. By sharing clinical and operational resources, Intermountain has improved local care delivery (fewer transfers), achieved major cost savings, and created partnerships where everyone benefits – the rural hospital, the patient, and the larger health system¹³².

The table below summarizes Intermountain's major rural-focused initiatives, their outcomes, and the types of partnerships enabling them:

Intermountain Initiative	Approach & Shared Resource	Outcomes / Impact	Partnership Model
"Virtual Hospital" Telemedicine Network	Hub-and-spoke telehealth platform linking ~73 hospitals (33 Intermountain + ~40 outside) ¹³³ . Centralized specialist teams	– Up to 18% fewer transfers of patients; those patients now treated locally ¹³⁴ . – Improved outcomes (e.g. 33% lower ICU mortality; faster stroke treatment) ^{135 136} . –	Commercial/Tech Partnership: Built and run by Intermountain (nonprofit health system) with support from Microsoft, Epic, Gates Ventures, West Health for technology

¹³² <https://medcitynews.com/2025/02/intermountain-rural-healthcare/>

¹³³ <https://www.aonl.org/news/Health-system-uses-telemedicine-to-strengthen-rural-health-care>

¹³⁴ <https://www.aonl.org/news/Health-system-uses-telemedicine-to-strengthen-rural-health-care>

¹³⁵ <https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹³⁶ <https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

	provide 24/7 ICU, ER, stroke, neonatology, and other consults via video.	Rural hospitals grow service capabilities and revenue (more complex cases retained) ^{137 138} . – Model identified as a blueprint to prevent rural hospital closures nationwide ¹³⁹ .	and funding ^{140 141} . External rural hospitals participate via service contracts (subscription fee model) ¹⁴² .
Centralized Supply Chain & Logistics	357,000 sq ft system-owned Supply Chain Center (Midvale, UT) and new regional warehouse hubs (e.g. Billings, MT) serving all Intermountain	– \$12+ million/year saved by consolidating warehouses and reducing inefficiencies ¹⁴⁵ ; over \$400 million total supply cost savings in 8 years ¹⁴⁶ . – >99% supply fulfillment rate system-wide (reliable access to meds and supplies even for	Internal Investment / Shared Services: Intermountain funds and operates central supply chain as a system asset (no direct public funding). Public-Private Element: Local economic development support for new Montana logistics center (70 jobs). Previously extended via a commercial GPO

¹³⁷<https://medcitynews.com/2025/02/intermountain-rural-healthcare/>

¹³⁸<https://medcitynews.com/2025/02/intermountain-rural-healthcare/>

¹³⁹<https://www.aonl.org/news/Health-system-uses-telemedicine-to-strengthen-rural-health-care>

¹⁴⁰<https://www.aonl.org/news/Health-system-uses-telemedicine-to-strengthen-rural-health-care>

¹⁴¹<https://www.healthleadersmedia.com/innovation/can-telemedicine-solve-rural-healthcare-crisis>

¹⁴²<https://medcitynews.com/2025/02/intermountain-rural-healthcare/>

¹⁴⁵<https://news.intermountainhealth.org/intermountain-healths-supply-chain-organization-celebrates-major-expansion-allowing-for-cost-savings--expanded-storage-for-vital-medical-supplies/>

¹⁴⁶<https://www.scmr.com/article/intermountain-healthcare-how-to-become-a-supply-chain-driven-organization>

	facilities ^{143 144} . Bulk procurement, internal distribution fleet, and integrated pharmacy services.	remote clinics) ¹⁴⁷ . – Localized logistics in Montana will cut delivery times during weather disruptions ¹⁴⁸ and support rural hospitals with faster restocking ¹⁴⁹ . – Economies of scale enable smaller hospitals to get pricing and resources on par with large centers.	(Intalere) to other systems ¹⁵⁰ .
Maternal Health Connection (Rural Tele-OB)	Community-based maternal telehealth program. Rural clinics + home monitoring devices connect expectant mothers with Intermountain OB/GYNs and	– <i>Reduced travel distance</i> and safer, timely prenatal care for women in at least 3 rural regions (WY, MT) ¹⁵² . – ↓ Postpartum depression rates; ↑ continuity of prenatal to postnatal care ¹⁵³ . –	Public-Private Partnership: Seeded by a \$3.9M HRSA federal grant ¹⁵⁴ . Implemented by Intermountain's team in collaboration with local community clinics. Ongoing operations integrate with Intermountain

¹⁴³<https://news.intermountainhealth.org/intermountain-healths-supply-chain-organization-celebrates-major-expansion-allowing-for-cost-savings--expanded-storage-for-vital-medical-supplies/>

¹⁴⁴<https://healthpoint.com/business/how-will-montanas-new-medical-hub-transform-healthcare/>

¹⁴⁷<https://www.scmr.com/article/intermountain-healthcare-how-to-become-a-supply-chain-driven-organization>

¹⁴⁸<https://healthpoint.com/business/how-will-montanas-new-medical-hub-transform-healthcare/>

¹⁴⁹<https://healthpoint.com/business/how-will-montanas-new-medical-hub-transform-healthcare/>

¹⁵⁰<https://www.healthcaredive.com/news/intermountain-sells-supply-chain-management-business-to-vizient-intalere/588525/>

¹⁵²<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

¹⁵³<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

¹⁵⁴<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

	specialists virtually ¹⁵¹ . Includes in-person, telehealth, and home care hybrid model.	Enabled high-risk pregnancies to be managed locally with remote specialist input (keeping mothers near family).	telehealth services and community health workers.
COMPASS Tele-Addiction Program	Hub specialists (addiction psychiatrists) support rural clinics via telehealth for Medication-Assisted Treatment (MAT). Partnerships with local FQHCs and recovery organizations to deliver services ¹⁵⁵ .	– Expanded opioid use disorder treatment to multiple rural counties in UT/AZ that lacked local providers ^{156 157} . – Part of strategy contributing to reductions in overdose deaths and improved behavioral health access in target areas ^{158 159} .	Public Grant + Collaboration: Funded by SAMHSA (HHS) grant ¹⁶⁰ . Intermountain provides clinical staff via telehealth; local clinics and nonprofits share in delivery. Example of a shared manpower model across organizations.

Table: Intermountain Health’s key shared-resource initiatives serving rural hospitals, with their outcomes and partnership structure.

Intermountain’s experience underscores that **multiple facets** of healthcare can be successfully shared or centralized – from specialist physicians to supply chain infrastructure to care programs – to benefit rural populations. Each initiative required thoughtful partnerships: technology companies to provide platforms, federal agencies or philanthropies to jumpstart funding in some cases, and importantly, **buy-in from rural providers** to participate. Intermountain has managed to align these pieces into a cohesive strategy. Next, we will look at how other health systems have implemented similar models, and what lessons emerge for scaling these approaches more broadly.

¹⁵¹<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

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¹⁶⁰<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

Comparative Examples: How Other Systems Share Resources with Rural Hospitals

Intermountain is not alone in pursuing shared resource models for rural health. Several other health systems – both non-profit and public – have developed analogous strategies, reinforcing the viability of these approaches. Below are a few illustrative examples from around the country:

- **Avera Health’s eCARE (South Dakota) – Telehealth Services at Scale:** Avera Health, based in Sioux Falls, SD, was a **pioneer in telehealth for rural areas**. Beginning in the 1990s, Avera built a comprehensive telemedicine program called **Avera eCARE**, which created a **virtual hospital hub (“eHelm”)** in 2012 to support rural facilities¹⁶¹¹⁶². Through eCARE, Avera offers *24/7 tele-ICU, emergency tele-triage, tele-pharmacy, and other services* to remote hospitals and clinics, both within and beyond its own system. By 2017, Avera eCARE had expanded to **serve over 200 facilities across 8 states**, including many **outside the Avera network** that contract for these services¹⁶³¹⁶⁴. For example, a tiny critical access hospital in North Dakota can use Avera’s tele-pharmacists at night to review medication orders, or a rural Minnesota ER can call Avera’s tele-critical care team if a trauma patient arrives at 2 AM. Avera eCARE’s impact has been significant: its **tele-pharmacy alone handled 1+ million medication orders for 95 client sites**, preventing thousands of potential adverse drug events¹⁶⁵¹⁶⁶. Overall, Avera’s model has *improved emergency response* (by getting virtual clinicians on scene within minutes), *avoided many patient transfers*, and *relieved overburdened rural providers* by sharing the load¹⁶⁷¹⁶⁸. A key enabler was **philanthropy** – the Helmsley Charitable Trust provided major grants to help Avera scale its telehealth to hundreds of sites¹⁶⁹. Today, Avera has spun off this business as **Avel eCare**, a commercial telehealth services company, demonstrating a

¹⁶¹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁶²<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁶³<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁶⁴<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁶⁵<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

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¹⁶⁸<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁶⁹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

successful transition from a health system program to a scalable **commercial partnership model**.

- **Mercy Virtual (Missouri)** – *Dedicated Virtual Care Center*: Mercy, one of the largest Catholic health systems (based in St. Louis, MO), made headlines by investing \$300 million over a decade to create the **Mercy Virtual Care Center**, an entire **hospital without beds** devoted to telehealth^{170 171}. Opened in 2015, this 125,000 sq. ft, four-story center is staffed by **600+ clinicians and technicians around the clock** and serves as the nerve center for Mercy’s telehealth operations^{172 173}. Mercy Virtual provides teleICU monitoring, telestroke and tele-specialty consults, remote patient monitoring for chronic diseases, and even “engagement at home” programs for patients with complex conditions^{174 175}. The teleICU program is the **largest single-hub E-ICU in the nation**, covering **30 hospitals across 7 states** (not only Mercy’s own hospitals, but also some affiliates)^{176 177}. The outcomes: Mercy Virtual has reported reductions in ICU lengths of stay and mortality through proactive monitoring¹⁷⁸, and it has solved critical staffing issues – for example, rural Mercy hospitals that struggled to recruit specialists can now rely on virtual intensivists and neurologists based at the hub^{179 180}. Mercy’s model is a **fully internal, enterprise-funded approach**, but it shows that a large system can justify such investment by spreading the service across dozens of hospitals. Notably, Mercy also partners with other hospitals (outside its system) to provide telehealth services, effectively **commercializing its virtual care capacity**. Mercy Virtual exemplifies a shared

¹⁷⁰<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁷¹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁷²<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁷³<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁷⁴<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁷⁵<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁷⁶<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁷⁷<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁷⁸<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁷⁹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁸⁰<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

resource model that is *entirely privately funded*, aimed at achieving the “Triple Aim” (better care, better health, lower cost) through technology¹⁸¹.

- **Sanford Health (North & South Dakota) – Embedded Virtual Care in a Rural Network:** Sanford Health serves a huge rural region (the Dakotas, MN, IA) with many frontier communities. Sanford has **integrated telemedicine into 78 specialty areas** across its network, making virtual visits a routine part of care for rural patients^{182 183}. This includes everything from primary care e-visits to eICU and eEmergency similar to the models above. One area Sanford highlights is **behavioral health**: about **40% of all behavioral health consultations system-wide are now done via telehealth**, a shift that greatly expanded access in rural towns where stigma or lack of providers was a barrier^{184 185}. The benefit was illustrated by a Sanford doctor: a physician in a small town sought mental health care but didn’t want to sit in the local waiting room; through Sanford’s virtual behavioral health service, he connected privately to a psychiatrist out of region¹⁸⁶. Sanford’s approach shows how telehealth, once novel, has become an **expectation** for rural patients – one leader noted patients now want virtual visits to be “as easy as ordering off Amazon”^{187 188}. Critically, Sanford emphasizes **policy advocacy** to preserve telehealth reimbursement and licensure

¹⁸¹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁸²<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

¹⁸³<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

¹⁸⁴<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

¹⁸⁵<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

¹⁸⁶<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

¹⁸⁷<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

¹⁸⁸<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

flexibilities, since many of these gains rely on supportive regulations^{189 190}. While Sanford's model is mostly used within its integrated system, it could be extended to partnerships. It underscores that **even highly rural health systems can transform care delivery with digital tools**, improving convenience and potentially outcomes (Sanford has seen reduced no-shows and earlier interventions, preventing costly complications down the line).

- **Ochsner Health's Telestroke Network (Louisiana)** – *Regional Specialty Sharing*: A specific example of a **public-private partnership** enabling a hub-and-spoke model is Ochsner Health's telestroke program. In 2011, Ochsner (a large health system in New Orleans) partnered with multiple small hospitals across Louisiana and Mississippi to provide 24/7 stroke neurologist coverage via telemedicine^{191 192}. The start-up was aided by a federal grant (CDC) that funded telehealth equipment for rural hospitals¹⁹³. The result: **34 rural hospitals ("spokes") now have round-the-clock access to Ochsner's stroke experts**¹⁹⁴. Before, many stroke patients at those hospitals were simply transferred out; now **over 60% are treated locally at the spoke** with the neurologist guiding care remotely^{195 196}. The program significantly increased the use of clot-busting therapy (tPA) in those communities and reduced stroke mortality/morbidity by bringing specialist care to the patient^{197 198}. This is a narrower scope than Intermountain's full platform, but it's an excellent **proof of concept** that a single tertiary center can **extend life-saving expertise** to dozens of community hospitals with relatively low cost and high impact. It also illustrates how **government support (grant funding)** can catalyze such networks, which then

¹⁸⁹<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

¹⁹⁰<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

¹⁹¹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁹²<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁹³<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁹⁴<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁹⁵<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁹⁶<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁹⁷<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

¹⁹⁸<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

become self-sustaining through improved outcomes and payer support (in stroke, better outcomes save costs for insurers too).

These examples, summarized in the table below, reinforce several themes. First, **telehealth-first models** have been widely adopted as the mechanism to share clinical resources (specialists, ICU monitoring, etc.) across distance. Second, **scale and partnerships** vary: some programs are an internal service of one health system (Mercy), others form a network of independent hospitals (Ochsner’s case, or Intermountain’s inclusion of external hospitals, or Avera’s service-for-fee model). Third, **outcomes universally point to improved access and often cost avoidance** (fewer transfers, fewer adverse events). Finally, funding sources blend **private investment, operational revenue, philanthropic grants, and federal grants**, indicating that both commercial and public capital have roles to play.

Health System & Region	Shared Resource Model	Scale & Outcomes	Model Type
Avera Health (SD) Avera eCARE ¹⁹⁹ ²⁰⁰	Virtual hospital hub (“eHelm”) providing tele-ICU, tele-ER, tele-pharmacy, tele-specialists to rural sites. Established 24/7 command center in 2012.	– Serves 200+ facilities in 8 states (many independent of Avera) ²⁰¹ . – Tele-pharmacy covers 95 sites, 1+ million patient orders reviewed (improved med safety) ²⁰² . – Avoided unnecessary transfers and improved emergency response times system-wide ²⁰³ . – Enabled small hospitals to meet compliance (e.g. pharmacy oversight) and offer higher-level care locally.	Nonprofit health system initiative , scaled via philanthropic grants (Helmsley Trust) ²⁰⁴ and service contracts (Avera sells telehealth services to partner hospitals). Now spun off as a commercial entity (Avel eCare) .
Mercy (MO and multi-	Dedicated telehealth	– 30 hospitals in 7 states connected to tele-ICU	Private health system investment (Mercy funded

¹⁹⁹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²⁰⁰<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²⁰¹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²⁰²<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²⁰³<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²⁰⁴<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

<p>state) Mercy Virtual Care Center²⁰⁵ ²⁰⁶</p>	<p>hospital (125k sq ft facility) with 600 staff, serving Mercy's system and partners. TeleICU, telestroke, remote patient monitoring, etc., all run from this "virtual care center."</p>	<p>hub (largest single-hub eICU in U.S.)^{207 208}. – Improved ICU outcomes (shorter LOS, lower mortality) by having intensivists on-duty remotely 24/7²⁰⁹. – Facilitated specialist coverage in rural Mercy hospitals (e.g. no need for on-site neurologist for stroke care – virtual consults fill the gap)^{210 211}. – High patient satisfaction and lower overall costs by treating patients in place when possible^{212 213}.</p>	<p>~\$300M internally)²¹⁴. Now operates as an internal shared service and also contracts with non-Mercy hospitals. Emphasizes technology and workforce innovation as a competitive strategy.</p>
<p>Sanford Health (ND/SD) Network-Wide</p>	<p>Embedding telehealth across a large rural delivery network (no separate hub center, but robust virtual offerings in many specialties).</p>	<p>– Virtual care in 78 specialties; telehealth integrated into primary and specialty care visits²¹⁷. – ~40% of behavioral health visits across Sanford are now</p>	<p>Integrated network approach – telehealth treated as standard care modality. No separate commercialization, focus is on serving Sanford's own rural communities. Relies on favorable</p>

²⁰⁵<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²⁰⁶<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²⁰⁷<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²⁰⁸<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²⁰⁹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²¹⁰<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²¹¹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²¹²<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²¹³<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²¹⁴<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²¹⁷<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

Telehealth 215 216		virtual ²¹⁸ , greatly expanding mental health access in rural towns. – Telehealth saves the average rural patient 176 miles of travel for specialty consults, plus time and cost savings ²¹⁹ . – Strong patient demand for continued telehealth (rural patients voice that it's essential to access) ²²⁰ 221.	reimbursement policy (advocacy to keep telehealth pay parity post-pandemic) ²²² .
Ochsner Health (LA) TeleStroke Program ²²³ 224	Tertiary hub (Ochsner Medical Center) linking with rural hospital ERs for on-demand stroke	– 34 spoke hospitals (mostly rural/community hospitals) connected in LA and MS ²²⁵ . – Before: nearly all stroke patients at spokes were	Public-initiated partnership – funded by federal grant for equipment ²³⁰ , executed by a private health system (Ochsner). Functions as a

²¹⁵<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

²¹⁶<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

²¹⁸<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

²¹⁹<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

²²⁰<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

²²¹<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

²²²<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

²²³<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²²⁴<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²²⁵<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²³⁰<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

	specialist consultation via telemedicine.	transferred out. After program: 60%+ of stroke patients can be treated locally (not transferred) with neurologist guidance ^{226 227} . – Increased use of tPA clot- buster from ~3% of eligible patients to significantly higher, thanks to rapid specialist evaluation ^{228 229} – improving outcomes and survival. – Program seeded by a CDC grant; now sustained as part of Ochsner’s telehealth services (with reimbursement for tele- consults).	regional network with a mix of independent hospitals and Ochsner- affiliated sites. Demonstrates a <i>niche specialty telehealth service</i> as a shared resource.
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Table: Examples of shared resource models in other health systems, showing various telehealth “hubs” and partnership structures that echo Intermountain’s approach.

These case studies bolster the argument that **shared resource models are scalable and adaptable**. Whether led by an integrated delivery network (like Intermountain, Mercy, Sanford) or as a consortium model (like Avera expanding to many partners, or Ochsner teaming with peers), the core idea is the same: use **connectivity and centralization to overcome the limitations of small, remote facilities**. Across these examples, **commercial models** have played a dominant role – most of these initiatives were spearheaded by the health systems themselves as strategic innovations, sometimes later supported by business arrangements (e.g. telehealth service contracts or spin-off companies). Public funding often acted as a **catalyst** (through grants or policy changes) rather than ongoing operation subsidy, which may appeal to conservative policymakers who prefer one-time investments over new entitlement programs.

²²⁶<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²²⁷<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²²⁸<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²²⁹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

Lessons and Implications for Scaling Rural Healthcare Through Shared Resources

The success of Intermountain Health and its peers in delivering shared resources to rural hospitals offers several key lessons for state medical directors, Medicare/Medicaid directors, and healthcare leaders seeking to improve rural health outcomes:

- **“Hub-and-Spoke” Networks Can Strengthen Rural Care Nationwide:** A well-designed hub-and-spoke model – where a regional center (hub) shares its specialists, care protocols, and technical infrastructure with smaller community hospitals (spokes) – can **dramatically expand access** to quality care in rural areas. Intermountain’s telehealth platform and others like Avera eCARE and Ochsner’s telestroke show that **geography need not be destiny**: rural patients can receive advanced care locally by virtually bringing the experts to them. Large health systems in other states could replicate this by partnering with rural hospitals in their catchment area. In fact, Intermountain’s strategy is deliberately being packaged as a **replicable model for other systems**^{231 232}. This could be encouraged via state policies that incentivize regional hub agreements or **certificates of need that favor collaborative ventures** rather than duplication of services.
- **Commercially Sustainable Approaches Exist:** Importantly, these models are not about permanent charitable support – they aim to be **win-win business arrangements**. Rural hospitals pay modest fees for telehealth or join group purchasing programs, but the **value they receive (avoided transfers, cost savings, more revenue)** far exceeds the cost. Intermountain noted the cost for a small hospital to join its telehealth network is very low relative to its benefits. This means states can promote these partnerships as **market-based solutions** rather than handouts. For example, encouraging state Medicaid programs to reimburse **telehealth consultations** at reasonable rates will make it financially viable for hub systems to offer those services broadly (since they can recoup the cost of a virtual specialist consult). Likewise, supporting **multi-hospital purchasing coalitions** can drive savings without ongoing government intervention, because hospitals have a natural incentive to save money once the structure is in place. The takeaway is that **initial investment (by a health system or via a grant) can lead to a self-sustaining program** that continues based on mutual benefit.
- **Public-Private Partnerships Can Catalyze Innovation:** While the ongoing operations can be sustained by partners, the **startup phase often benefits from public**

²³¹<https://www.healthleadersmedia.com/innovation/can-telemedicine-solve-rural-healthcare-crisis>

²³²<https://medcitynews.com/2025/02/intermountain-rural-healthcare/>

partnership. Intermountain’s maternal and behavioral health programs used federal grants to launch^{233 234}; the telestroke network in Louisiana used a CDC grant for initial setup²³⁵; Avera’s telehealth expansion was accelerated by foundation grants²³⁶. State directors should look at leveraging **existing federal rural health grants (HRSA telehealth network grants, USDA distance learning grants, etc.)** or public funds (e.g. opioid settlement funds for programs like COMPASS) to seed shared resource projects. Those funds can underwrite technology, broadband improvements, or training, after which the program can transition to commercial operation. Moreover, **policy support** is crucial – for instance, extending Medicare’s telehealth reimbursement flexibilities for rural services (which during COVID were expanded) is fundamental to keep these models viable. Ensuring state licensing allows **cross-hospital telemedicine practice** (or joining interstate compacts) is another area where government action enables private innovation to flourish^{237 238}.

- **Shared Services Beyond Clinical Care:** While telemedicine grabs headlines, other back-office or support services can also be shared to great effect. Intermountain’s supply chain success could be emulated via **state or regional cooperative purchasing** initiatives. State hospital associations or coalitions might negotiate with a proven supply chain leader (like Intermountain or Vizient) to manage supply distribution for multiple rural hospitals in that state, achieving bulk pricing that a single small hospital could never get. Similarly, rural hospitals could share resources like **IT systems** (cloud-hosted EHRs), **labs** (use a reference lab network), **specialty equipment** (mobile MRI units rotating among sites), or even **administrative personnel** (for example, **shared staffing models** where one team of healthcare CFOs or quality improvement experts serves multiple hospitals). Community Hospital Corporation (CHC) offers a model where a central entity provides management services to numerous rural hospitals, illustrating that **shared management and consulting resources** can also help keep facilities viable. State leaders can encourage such arrangements by reducing regulatory barriers to outsourcing or resource sharing across facilities.

²³³<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

²³⁴<https://intermountainhealthcare.org/blogs/delivering-care-in-rural-areas>

²³⁵<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²³⁶<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

²³⁷<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

²³⁸<https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/the-health-system-safeguarding-rural-telehealth-access/>

- Data and Accountability:** To persuade stakeholders, robust data on outcomes and savings should be collected and shared. Intermountain and others have begun publishing outcomes (e.g., patient retention %, cost savings, clinical improvements) and framing the narrative that these models save not only lives but money – which appeals to both health plans and conservative budget watchdogs. For example, if a telehealth network prevents X medevacs and Y hospital closures, what is the **Medicare cost avoidance**? Those metrics can justify continued support. As one insight, **Medicare could explore pilot programs** where it shares in the cost of setting up telehealth hubs, on the expectation that Medicare will save on transfer costs and higher-cost tertiary care episodes. Private insurers could do similarly if presented with evidence of total cost reduction. The more success stories are documented (like Intermountain’s 50 babies kept local, saving \$1M²³⁹, or Ochsner’s dozens of stroke patients who avoided disability), the stronger the case for scaling up.
- Local Engagement and Trust:** A softer lesson is that successful resource-sharing requires **building trust with rural providers and communities**. Intermountain did not impose its telehealth on others overnight; it built it internally, proved its worth, and gradually invited outside hospitals to join. Rural hospitals understandably fear losing autonomy or business to big systems. The narrative must be **“keeping care local”** and truly partnering (not funneling patients away). Intermountain’s approach of charging only a token fee and *empowering* the local staff (the tele-specialist works **with** the rural clinicians, not over them) has been important. Similarly, supply sharing works when all parties feel they have a voice and realize mutual benefits (e.g., shared formulary decisions). For state officials, facilitating dialogues between big urban hospitals and rural ones can help forge these partnerships. In many cases, rural providers will welcome support if it’s framed as helping them serve their community better *and* remain independent.

In conclusion, **Intermountain Health’s example provides a compelling proof of concept** that rural healthcare can be uplifted through strategic sharing of resources. Advanced telehealth networks and centralized services have enabled small hospitals in Utah, Idaho, Montana and beyond to offer care once thought unsustainable outside big cities. The approach combines the strengths of **private enterprise (efficiency, innovation, capital)** with the mission of **public health (equitable access, community well-being)**. For US state medical directors and Medicare directors, the implications are clear: supporting and scaling such shared resource models could be a highly effective strategy to **improve rural health outcomes, reduce disparities, and ensure financial viability** of rural providers without simply resorting to permanent subsidies or watching hospitals close. By championing policies that encourage **commercial partnerships in rural healthcare delivery** – from telemedicine collaborations to joint supply chain ventures – leaders can help replicate

²³⁹<https://www.aha.org/system/files/media/file/2025/07/telehealth-case-examples.pdf>

Intermountain's success in other regions. The end goal is a future where rural Americans enjoy health services on par with urban residents, delivered through innovative networks that make the **best use of limited resources**. Intermountain's story shows that this vision is not only aspirational but achievable, and already happening today in places once considered too remote to reach.