LEADERSHIP SERIES · NO. 05

Leading Where It's Hardest

Rural and community health asks for the most complete executives in American healthcare, offers them the fewest resources, and pays them the least. Then we wonder why the seats sit empty.

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6 min read · From the boardroom to the bedside

1. The map is quietly shrinking

Rural hospitals have been closing and converting for more than a decade, and the ones still standing have been shedding services to stay standing. Obstetrics usually goes first, because it is expensive to staff around the clock and impossible to run at low volume. Then surgery, then behavioral health, then the specialty clinics.

A community rarely loses its hospital in one announcement. It loses it a service line at a time, until the nearest place to have a baby is ninety minutes away and nobody can point to the day it happened.

2. A rural executive job is not a smaller version of an urban one

This is the misunderstanding that drives most failed hires. In a large health system, a chief operating officer runs operations and hands finance to the CFO, strategy to the strategy office, and payer negotiations to a contracting team. In a critical access hospital, the chief executive does all of it. They negotiate the payer contracts, manage the medical staff, sit on the chamber of commerce, answer to a board of local business owners rather than professional directors, take the call from the newspaper, and know a good number of the patients by name. There is no vice president of anything. The job asks for a complete generalist in an industry that has spent thirty years rewarding specialists.

3. The math nobody wants to say out loud

The organizations with the thinnest margins, the oldest plant, the heaviest public payer mix and the least room for error need the most capable and most versatile executives in the country. And they compete for them against systems that can pay considerably more for a narrower job with a deeper bench underneath it. This is not a recruiting problem that better advertising solves. It is a structural mismatch between what the work demands and what the market rewards.

> **"We ask the least-resourced organizations in American healthcare to find the most complete executives, and we pay them less to do it."**

4. The career path actively prepares people for the wrong job

A conventional health system career runs deeper and narrower every year. Fifteen years in, an executive has genuine mastery of one function and a support structure that handles everything adjacent to it. Rural leadership asks that person to do all of it at once with almost none of the structure, and many find out too late that depth in one lane is not the same as competence across all of them. The leaders who do thrive tend to have come up in smaller organizations, or through community health,

or they came home to a place they already understood. Very few of them arrived by promotion from a large system, and almost nobody is deliberately trained for it.

5. You are not recruiting an executive, you are recruiting a life

A rural chief executive search is also a decision about a spouse's career, a school district, aging parents several states away, and living somewhere the job never really ends because everyone in the grocery store knows who you are. Compensation cannot carry that on its own, and the candidates who accept mainly for the money tend to leave within two years, which is worse than not hiring them. The ones who stay almost always have a reason to be there that predates the offer. Finding those people takes a search that goes looking, because they are not scanning job boards for a move to a town they have never heard of.

6. A vacancy here costs more than anywhere else

When a large system loses an executive, an interim steps across from another division and the machine keeps running. When a twenty-five bed hospital loses its chief executive, it loses its strategy, its payer relationships and its standing with the medical staff in a single afternoon. Recruitment takes longer because the candidate pool is smaller, the interim market is thinner, and meanwhile the decisions that determine whether the hospital survives its next three years simply do not get made. Service lines get deferred rather than fixed. Affiliation conversations stall. That is how an organization that could have made it does not.

7. What the ones who hold their leaders do differently

They stop treating each search as an emergency and start building a pipeline from within their own region, because someone already living there has cleared the hardest hurdle before the interview begins.

What the systems that keep their leaders get right

1. They build a pipeline from within their own region, because someone already living there has cleared the hardest hurdle before the interview begins.
2. They hire against the specific problem, since stabilizing a hospital, turning one around and preparing one for affiliation are three different jobs that suit three different people.
3. They tell candidates the truth about the condition of the balance sheet, having learned that the ones who accept an honest picture stay and the ones who accept a polished one leave.
4. They use interim leadership deliberately as a bridge rather than as a response to panic.
5. They compete on the things they can actually win on, which are scope, autonomy and the visible consequence of the work, because a leader in a small community can see what they changed, and almost no large system can offer that.

8. This is a distribution problem

America does not have a shortage of healthcare leaders in the aggregate. It has them concentrated in metropolitan systems that can pay for them, and thinning out precisely where the need per capita is highest and the margin for error is smallest. Every rural board that fills its seat well buys its community another decade of local care. Every one that gets it wrong, or leaves it open too long, moves the nearest hospital another county away. From the boardroom to the bedside, access in rural America is decided by who is willing to lead there, and by whether anyone went looking for them.

ABOUT THE AUTHOR

Lee Fossey leads healthcare executive search at WDP Healthcare, advising health systems, behavioral-health and post-acute platforms, and healthcare investors on confidential leadership search, from the boardroom to the bedside. This is part of the WDP Healthcare Leadership Series on the leadership questions shaping healthcare.

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