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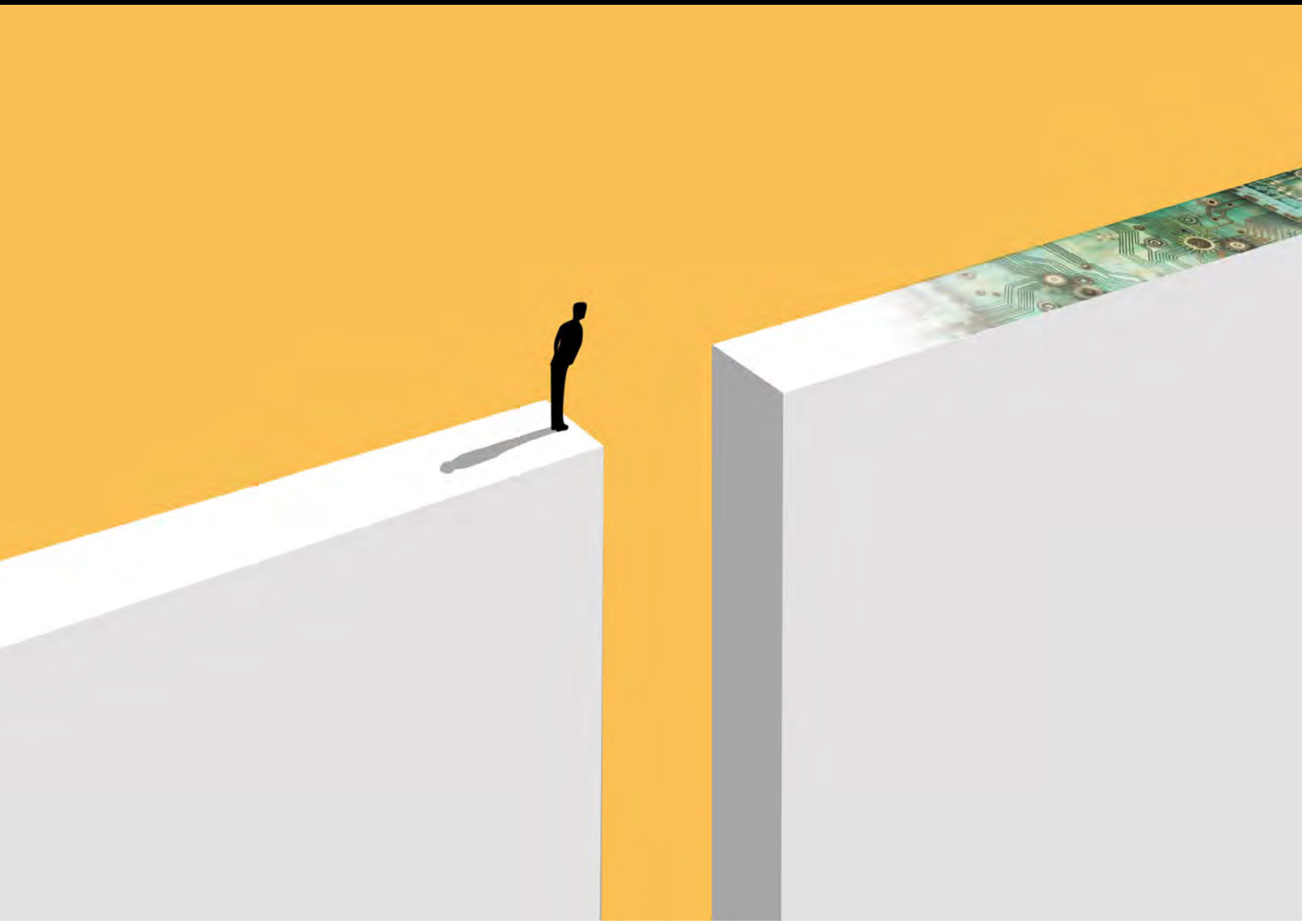

KNOWLEDGE EXCHANGE

Closing the Digital Divide: AI Governance for Rural Hospitals

Realizing the promise of AI in rural communities

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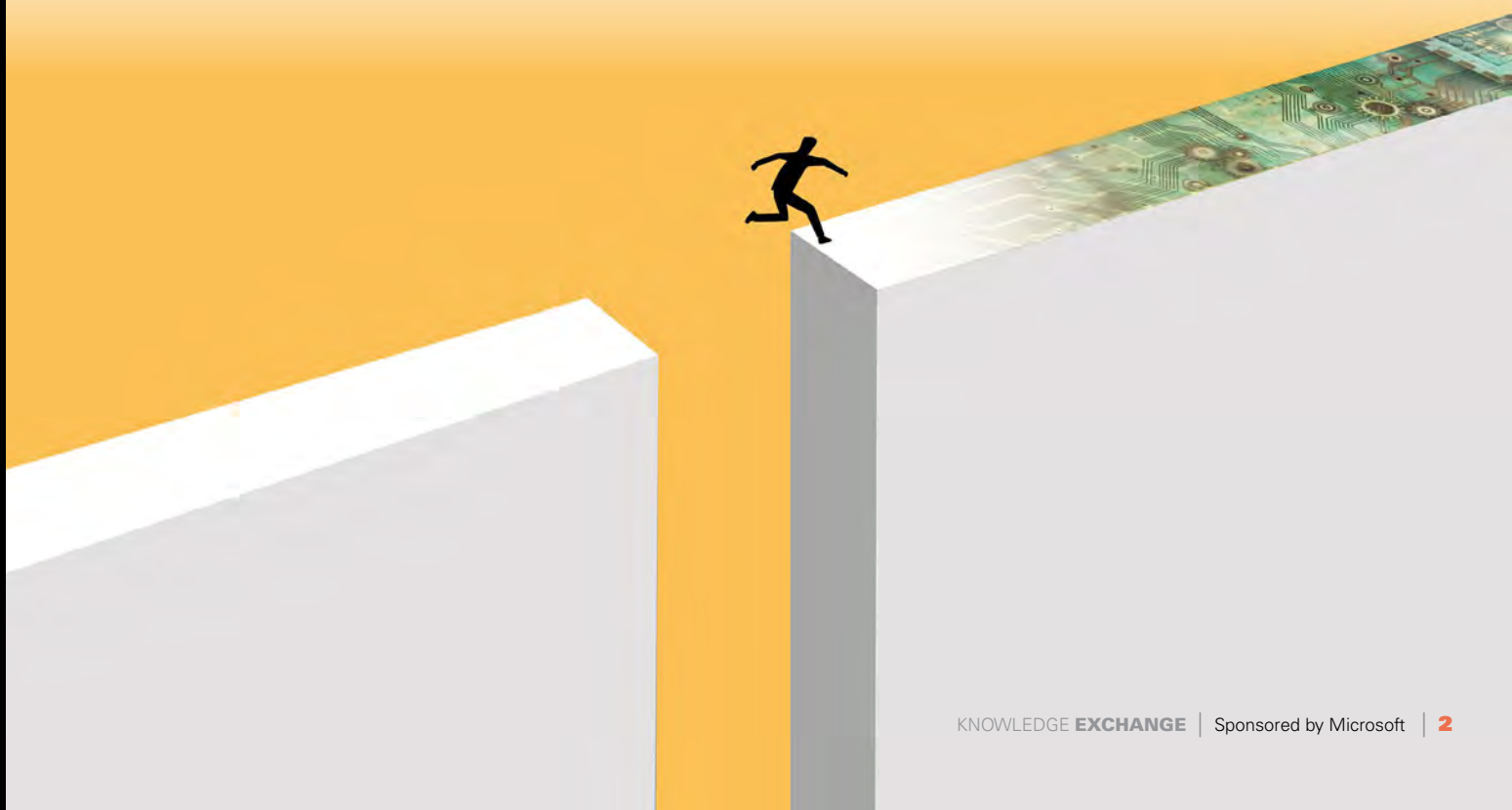
Introduction

Closing the Digital Divide: AI Governance for Rural Hospitals

Realizing the promise of AI in rural communities

As artificial intelligence (AI) becomes a standard tool in health care, rural hospitals are at risk of a deepening digital divide. Compounding this challenge is the reality that rural hospitals often lack the patient volume, technical staff and resources needed to localize externally developed models, train their own, or maintain them over time. New data reveals smaller, independent and critical access hospitals struggling to keep pace with peers to adopt AI technology. Without intentional governance and tailored implementation strategies, rural communities may miss out on AI's potential to improve outcomes and operational efficiency. This Knowledge Exchange e-book explores how rural health care leaders can design AI governance frameworks that reflect the realities of rural care, ensuring access, sustainable deployment and long-term impact.



Action Items

7 high-impact AI governance best practices for rural health care leaders

1 MULTIDISCIPLINARY TEAM

Build multidisciplinary governance that includes clinical, operational, legal, cybersecurity, informatics and patient voices to strengthen trust and decision-making.

2 FOCUS

Start with a governance model focused on safety, privacy, risk-tiering and clear vendor expectations and iterate over time as needed.

3 GUIDANCE

Shift from restrictive "don'ts" to clear safe-use pathways that guide staff on how to use AI responsibly in daily workflows.

4 PRESSURE-TEST

Pressure-test vendor claims, understand how models were trained, ensure data-use agreements protect rural populations and pilot before scaling. Require annual revalidation of all AI tools.

5 CHECK DATA

Address rural data underrepresentation by assessing model fit, monitoring for bias and ensuring community benefit in partnerships.

6 PRIORITIZE

Prioritize education for clinicians, leaders, and patients, including how tools work, their limitations, how to communicate AI use to patients and how to avoid unsafe or unapproved tools.

7 LEAD

Lead with trust and transparency, especially as early wins, such as ambient documentation, improve workflows; clearly communicate to patients how and why AI is used in their care.

Participants

Mark Boucot, MBA, FACHE
President and CEO
WVU Medicine
Potomac Valley Hospital and Garrett Regional Medical Center
Keyser, W.Va.

Andrea Cooley, DO, FACOS
Assistant dean, clinical experience, and assistant professor, Medical Education
University of Texas at Tyler School of Medicine
Tyler, Texas

Jeremy P. Davis, MHA
President and CEO
Grande Ronde Hospital
La Grande, Ore.

Eric Fish, M.D., MBA
President and CEO
Schneck Medical Center
Seymour, Ind.

Tara Gellasch, M.D., MBA
Chief medical officer
RRH United Memorial Medical Center
Batavia, N.Y.

Aaron Grigg, M.D.
Medical staff president
Grande Ronde Hospital
La Grande, Ore.

Laura Kreofsky, MHA, MBA, PMP, CDH-E
National director, rural health resiliency
Microsoft Elevate
Redmond, Wash.

Amy McDaniel
CEO
Iowa Specialty Hospital
Belmond, Iowa

Gratia Pitcher, M.D.
Chief medical officer
Essentia Health
Duluth, Minn.

Rachelle Schultz, EdD
President and CEO
Winona Health Services
Winona, Minn.

MODERATOR
Chris DeRienzo, M.D.
Senior vice president and chief physician executive, American Hospital Association
President, AHA's Health Research and Educational Trust
Chicago

MODERATOR CHRIS DERIENZO (*American Hospital Association):* **How does your organization define the core building blocks of artificial intelligence (AI) governance? Those could include structure, policies, processes, principles and tools. And how does that definition shape your approach to AI strategy and oversight?**

ERIC FISH *(Schneck Medical Center):* We have an executive AI oversight committee responsible for AI decision-making. That group connects directly with our clinical steering committee, nurse informatics council and our fiscal and operations teams to ensure alignment across clinical, technical and operational domains. Our governance is anchored in five guiding principles: patient safety, human-in-the-loop, transparency, privacy and security, and value-driven application. We classify all AI use cases using a risk-based framework — low, medium or high. Anything that directly affects patient care is categorized as high.

We've standardized our intake and approval process and require annual revalidation of all AI tools. Given the cybersecurity landscape, we also maintain strict vendor and data-handling expectations to ensure that any partner meets our security, privacy and data-protection standards. This structure gives us a consistent, disciplined way to evaluate AI, manage risk and ensure safe, responsible deployment across the organization.

RACHELLE SCHULTZ *(Winona Health):* We're still early in this work. As a small rural hospital, AI falls under our existing information technology (IT) governance. We don't yet have a separate AI structure. We recently created our first AI policy, focused heavily on risk and liability, because so much about AI is still unknown. We're essentially building the plane as we fly: beginning to use AI tools while putting guardrails in place as new products emerge and as physicians are approached by outside vendors. Nothing external is allowed in without going through our governance process. We're committed to using AI because we see its potential, but we know we have to be intentional and cautious as we establish boundaries and learn our way forward.

GRATIA PITCHER (*Essentia Health):* Eighty-five percent of our footprint is rural, so we rely on a responsible AI framework supported by a multidisciplinary governance committee within our IT structure. Like others, we use a risk-based profile and evaluate both the technology itself and the expectations we place on vendors. Because our legal and compliance teams are conservative, we recently added a small group that conducts a focused go/no-go review to help us manage risk while still pushing innovation where appropriate.

Data stewardship is central. We set clear expectations for how vendors handle our data and how much we're willing to share, especially given cybersecurity concerns. Our chief medical informatics office rigorously assesses clinical use cases to ensure the technology solves real problems. Vendors often present polished solutions that don't fully match real-world performance, so we pilot everything first and only scale once we've validated the use case.

MODERATOR: We've just heard perspectives from small independents to large multi-state systems, and despite the differences, the themes are strikingly similar. What stands out to me is how much alignment there is around the core elements of AI governance — alignment that I'm not sure would've surfaced a year ago. Is anyone else seeing that same shift?

LAURA KREOFSKY *(Microsoft Elevate):* The tone of this conference has shifted dramatically in just a year. You can hardly get through a sentence without mentioning AI. We're all trying to keep up. A year ago, much of our work with hospitals focused on cybersecurity, but one of our early partners told us their bigger need was AI governance because they didn't even know where to start. Since then, interest and activity have scaled rapidly, though we still have a long way to go.

AMY MCDANIEL *(Iowa Specialty Hospital):* We're a small independent rural hospital, and right now our AI oversight largely sits within our cybersecurity

team. Yesterday's discussion really highlighted the need to bring physicians more formally into that process. From a policy and procedure standpoint, we're essentially at square one and looking for models that we can replicate. I'm also serving on an Iowa Hospital Association steering group focused on AI adoption, where we're working to help rural hospitals build the policies and structures they need to move forward safely.

AARON GRIGG *(Grande Ronde Hospital):* We created our first AI policy almost two years ago, and we're now revisiting it. As a Community Connect site that receives our EHR from a larger institution, one of our challenges is navigating shared governance. Our host system has its own policies and processes, and we have ours. We rely on them for enough information to make informed local decisions, yet there are times when tools are deployed without a process for input, or when we are interested in an AI solution and need their approval to move forward. Our governance approach has to account for this dual-authority environment in a collaborative, constructive way.

JEREMY DAVIS *(Grande Ronde Hospital):* We were early adopters. We put an AI policy in place and brought it through our board, along with initial board education. Our governance is overseen by our Information Management Oversight Committee, which includes executives, IT and informatics.

Our policy has mostly been a list of "don'ts" — don't do this, don't use that. Now we're shifting toward defining what we do want people to do. That's the evolution we're working through.

ANDREA COOLEY *(University of Texas at Tyler School of Medicine):* It's remarkable how quickly AI governance has evolved. A year or two ago, our focus was mostly on cybersecurity and data. Now governance covers much more: whether tools actually work as promised, whether they perform safely in our rural populations, how we vet vendors, where our data goes and who benefits from it. We also need to understand who in our system is using these tools and whether they're using them appropriately. It's encouraging to see teams building layered frameworks and risk-stratified processes, because we can't simply copy what large centers do; we have different needs and resources.

TARA GELLASCH *(RRH United Memorial Medical Center):* We're part of Rochester Regional Health, which implemented an AI policy back in 2024. We've started rolling out tools like ambient digital scribes and Copilot, and what we're really missing now is personalized education to ensure our teams and leaders know how to use these tools effectively and safely. With a new VP of Innovation and AI Strategy in place, we're well-positioned to build a strong AI governance structure and continue advancing this work.

MARK BOUCOT *(WVU Medicine Potomac Valley Hospital and Garrett Regional Medical Center):* As part of WVU Medicine, we're fortunate to have a strong, forward-thinking approach to AI, especially in our physician practices. A multi-stakeholder group has developed systemwide policies, but each hospital can decide how far to implement. We're already using AI-powered ambient clinical documentation across our practices and have seen major improvements in documentation compliance and physician adoption.

Our governance is anchored in our Epic-standardization, which provides clear guardrails for add-on tools. Technology also changes how conversations happen: People are more mindful knowing visits are

ERIC FISH | SCHNECK MEDICAL CENTER

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recorded, and patients need clear, transparent explanations about why we're using these tools, especially in rural settings.

MODERATOR: **There's a degree of intentionality required to get it right. The goal of bringing ambient technology into practice was to improve the experience for clinicians and patients, and the productivity gains were simply a byproduct.**

It's Q1 of 2026, and many rural hospitals are still two years behind where you are today. If you had to define a minimum viable AI governance model for a rural hospital just getting started, what is the one essential element that absolutely must be part of that framework?

BOUCOT: A multi-stakeholder group of legal, physician, administrative and clinical teams is essential. We can't do this work in a vacuum. The more inclusive and collaborative we are, and the more transparent and honest our conversations are, the stronger our governance will be. The human side of our culture really determines how well we figure this out together.

FISH: A core pillar is privacy and security. We need to ensure every AI tool is truly secure, because each one increases our exposure to threat actors.

COOLEY: I'd add the patient voice. The trust clinicians build with patients and the transparency that comes with it should guide every decision. Even at a small scale, including a basic education component, whether through a hospital educator or in-service training, ensures the team understands how AI affects patient care.

MODERATOR: **Boards play a crucial role. One of their biggest challenges is deciding how to engage with AI: whether to build models in-house, act as an early-alpha partner while tools are still buggy and experimental, or purchase mature, off-the-shelf solutions. That discussion has to start with the CEO and the board, because without clear direction, organizations get pulled into all those very different sandboxes at once.**

GRIGG: We need a centralized process to evaluate and catalog AI tools, especially because so much shadow AI is already in use without our knowledge. We must educate staff on why off-the-shelf tools aren't acceptable when they risk exposing patient information. The challenge is that heavy governance can slow us down — and the slower we move, the more shadow AI will spread as clinicians find their own workarounds. We have to provide safe, supported options, or people will adopt unsanctioned tools on their own.

MODERATOR: **As you move from designing your AI governance model to putting it into practice, what are your next steps for execution? How are you preparing your processes to assess quality and detect issues like hallucinations? Is that something you're already planning for?**

PITCHER: We created a protected internal ChatGPT sandbox early on to prevent staff from putting business or, more importantly, patient data into external AI tools. We communicated clearly that this was a safe place to experiment, and it's become part of the daily workflow. I use it myself to summarize notes or dashboards because it's so efficient. That comfort with technology ties directly to education.

We've also seen real patient-experience benefit from ambient listening. Clinicians say it's been a game-changer, and our data shows that visits using ambient

GRATIA PITCHER | ESSENTIA HEALTH

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listening have significantly higher patient-experience scores. Patients feel more heard because clinicians can focus on them rather than getting distracted by the record.

GELLASCH: We need education to be a core part of governance, teaching both clinicians and leaders how to use AI safely and effectively so it can augment their work rather than add to it. Many of our leaders are slow adopters and don't feel confident using these tools, and the same is true for many physicians who need one-on-one support. Clinicians who use AI are seeing strong results, but others are hesitant or still rely on older tools. With one in five of our physicians over 60, helping them adopt AI is essential to bringing everyone along and may even extend how long they choose to practice.

SCHULTZ: Education has to be central to how we approach AI, because its use spans everything from clinical care to administrative work, and some areas carry more risk than others. This isn't just about learning how to turn on ChatGPT or Copilot; it's a new way of thinking that will reshape workflows and expectations. As we adopt these tools, we need to stay actively engaged in evaluating how they're changing the work, not just celebrating that things are faster. The real task is to understand what we're trying to accomplish and to make sure technology supports it.

Physicians at a recent conference noted that ambient documentation is more accurate because it captures what was said rather than what they remember after a long day. That improves documentation quality and reduces the "memory test" of seeing many patients.

MODERATOR: Given that many AI models are trained on datasets that underrepresent rural populations, how are you ensuring your data reflects your community's needs, protects its value, and structures partnerships to deliver meaningful benefits back to your organization and patients?

MCDANIEL: We've launched ambient listening for our providers, and they've really embraced it. As a Community Connect site, we benefit from the University of Iowa's oversight and vendor evaluation, and we lean on those relationships, especially to identify vendors who are genuinely interested in developing rural-focused tools, which consistently lead to better outcomes for us. Because we're smaller, Epic often pilots new features with us first. We can move quickly, work through issues, and then the larger system adopts what's been refined.

COOLEY: There's a major knowledge gap among developers and regulators about rural needs, workflows and data realities. The insights we're generating are incredibly valuable. When we can articulate that value and negotiate around it, we're in a better position to secure the resources and support our communities need. The real opportunity is recognizing how powerful our implementation experience is and using it to shape the tools being built.

GRIGG: After using ambient listening for about a year and a half, my main concern is over-reliance. We need visibility into how much of each transcript or summary is being edited so we can target education. For example, if a provider signs off without any changes, that's a signal they may not be reviewing it closely, which leads to potential note quality concerns.

Ambient tools are also a useful model because they're less of a black box than many newer AI products. We need transparency into what data trained the model, how much of our data is being used, and how the model continues to learn. One of the best ideas

JEREMY DAVIS | GRANDE RONDE HOSPITAL

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I've seen is a standardized "AI nutritional label" that clearly outlines training data, usage and key details so users understand what's behind the model.

PITCHER: As we move toward more agent-like and clinical-facing AI, lagging data becomes critical, especially in rural settings where the risk of reinforcing existing biases is high. We need to monitor documentation quality closely and stay alert to where these tools can fail, because what feels routine to us is never routine for the patient.

Clinicians need simple, clear guidance on the top risks to watch for, so they stay engaged rather than overly trusting the tool. And at both small and large systems, we must ensure our data isn't propagating equity gaps or misinformation as these models evolve.

MODERATOR: What barriers are limiting AI adoption in rural health care, and what best practices or lessons learned have helped your organization overcome resource constraints, build trust and achieve measurable impact?

DAVIS: If an organization hasn't started these conversations yet, governance doesn't need to feel overwhelming — just get people in a room and begin. If leadership isn't talking about AI, your staff and physicians will be, and they may head in directions you don't want, creating rework and inefficiency.

Sometimes the simplest starting point is a basic set of questions: Do we have a policy? What do we want our guardrails to be? How will we make decisions? Once you begin that blocking-and-tackling, the rest starts to take shape, and the connections follow.

KREOFSKY: We're in a unique moment: rural health transformation funding has suddenly made every vendor interested in rural markets, putting rural organizations in a rare position of influence. That makes it the right time to have honest conversations with vendors, not just about bias and models that don't fit, but also about insisting that models be built for rural communities and finding partners willing to do that work.

MODERATOR: We're not perfect at baseline; a gold standard of perfection can become its own barrier. We've raised concerns about how AI models are trained, the trust issues that follow and the operational challenges that come with implementation.

COOLEY: In rural health care, we innovate out of necessity. We don't have the luxury of waiting for perfection. That's why we're well-positioned to lead in this moment. But we also have to recognize the value of our insights and data. As vendors rush into rural markets because of rural health transformation funding, we need to protect that value and structure partnerships carefully. When we safeguard our data and use it strategically, everyone can benefit.

BOUCOT: I'm looking forward to the day when all this work in the rural space translates into fewer missed diagnoses and more conditions caught early. At the end of the day, AI is a tool to help us deliver better care — one that gives us more insight, more knowledge and ultimately better outcomes for our patients.

GRIGG: My biggest concern as we move forward with AI is making sure it strengthens, not weakens, the patient-provider relationship. Vendors don't always grasp that clinicians can't juggle a patchwork of

LAURA KREOFSKY | MICROSOFT ELEVATE

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RACHELLE SCHULTZ | WINONA HEALTH

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disconnected tools; we need a unified, simple interface that reduces complexity so we can stay present with patients.

Ambient has shown what's possible: stepping away from the keyboard and being able to hold a child while talking to a parent creates a completely different kind of interaction. That's the kind of relationship-building we can't afford to lose.

DAVIS: In rural health care, we're used to being creative and figuring out hard problems with limited resources. That's why we're uniquely positioned to lead in this space. It's simply the power of rural.

PITCHER: We need to look at this from both the patient's and the clinician's perspectives and focus on what truly creates value. Patients are already using these tools, and we've seen cases where they trust an AI-generated diagnosis over an accurate clinical one. That means we have a responsibility to educate both patients and clinicians about what these tools can and can't do, and to keep safety and quality at the center of how we use them every day.

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