Rural and Independent Hospitals: Going It Alone or Teaming Up?

Independent hospitals must face hard choices to prosper in an era of consolidation.

By Beth A. Nelson

There is an unmistakable trend in health care toward partnering and consolidation. Some rural hospitals in particular, however, choose to remain independent — for the good of their patients, staff and community, they argue. It's about preserving the mission, which is a nice notion.

But is there a business case to be made for "going it alone"? Can it remain a viable strategy? If not, is there a degree of creative partnering that affords local facilities independence and control, yet also access to broader services and lower costs?

These are questions that rural and independent hospitals and medical centers are asking themselves almost daily. They are fiercely debated at the annual Rural Health Care Leadership Conference and other gatherings.

To get a flavor of current thinking, I conducted some informal surveys of several successful chief executives at independent hospitals. While all remain steadfastly committed to mission and serving their particular constituencies and communities, they also will candidly acknowledge that remaining independent is tenuous and can change with the shifting legislative and reimbursement landscape.

No Margin, No Mission?

Why stay independent? It's mostly about the mission of serving local residents and the community, says Tim Putnam, president and CEO of Margaret Mary Health, a critical access hospital in Batesville, Ind., between Indianapolis and Cincinnati. "When independent hospitals join larger systems, the mission to the local community first and foremost goes away," he says. The new system's mission may be admirable, but it portends a potential loss of voice for the community's core needs, he says. Executives and their boards should understand that.

Independent hospitals tend to be nimble and can adapt easily to local needs, says John Solheim, CEO of Cuyuna Regional Medical Center, a CAH in Crosby, Minn., north of Brainerd. It's important to have local control regarding the scope and quality of services, and this goal becomes challenging at the system level, he believes.

The best way to provide a community with the level and type of health care it requires is through independence, concurs Steven Long, FACHE, president and CEO of Hancock Regional Hospital in Greenfield, Ind., outside Indianapolis. In addition, he says, citizens look at the local hospital as their hospital and maintain a strong sense of ownership and commitment to it.

The Business Case

That said, the decision whether to remain independent usually comes down to finances. Long cites the well-worn phrase of the late Sister Irene Kraus of the Daughters of Charity: "No margin, no mission." Hancock has strived to avoid debt, to maintain financial reserves and to keep short-term revenue flowing. If a hospital starts down a path of "cutting its way to success, it is bound to
fail," Long says. When the decision comes down to having a hospital affiliated with a larger system or no hospital at all, it’s an easy one for the community to make.

Many solo facilities are pursuing some of the same initiatives as the largest systems — population health, clinical integration and operational excellence, for example, albeit on a different scale. It is important to be perceived as a “destination of choice” for health care [and not just “hospital care”) for people in the service area, Long notes. “This means low-cost, high-quality, local access when, where and how the patient desires,” he says.

The trick to staying local and “going it alone” is often through configuring creative but limited partnerships with larger systems. For Hancock, that has meant relationships with large systems in the Indianapolis metropolitan area for cardiac, cancer and even primary care physician services. To suppress costs, the hospital is also part owner of a shared services company.

Margaret Mary Health strives to provide “outstanding and affordable care close to home,” which Putnam hopes will remain a recipe for success. But reimbursement changes may prevent it. “Offering outstanding and affordable care close to home may not be enough in the future,” he says. “One of the biggest threats comes from the possibility that our hospital and physicians could be locked out of a government or private insurance product.” Such a scenario, he said, would force hospitals to band together so that they can have a stronger position in negotiating insurance terms.

Though independent, Cuyuna Regional strives for regional and even statewide influence, Solheim says. Its staff and physicians have bought into this model of outreach and, as a result, patients come from all corners of the state.

Alone but Not Lonely

Cuyuna is another example of how no independent hospital is an island. It maintains a strong bond with other nearby CAHs to keep roughly 20 surgeons on staff, and it provides excellent cancer and cardiology services through alliances with Allina Health’s Minneapolis Heart Institute and Virginia Piper Cancer Institute.

Cooperative agreements, when they are practical and mutually advantageous, foster Cuyuna’s independence. “Our cancer and cardiology partnerships are two excellent examples which helped to instill patients’ confidence in the quality of care and continuity of service provided,” Solheim notes. “Our approach to remaining independent has been very successful and could be a model for others if organizations and physicians are open to a broader view of collaboration and codependence.”

Margaret Mary in Batesville has created partnerships for cardiac, neurology, trauma and other programs, Putnam says. “Like many rural hospitals, we were quick to realize that we cannot offer the full complement of therapeutic care patients require,” he says. Clinical partnerships with regional tertiary care facilities have helped Margaret Mary coordinate state-of-the-art care for the organization’s most complex cases.

Only the Strong Survive

What’s the fate of independent hospitals? Will the pendulum swing back in their favor? Probably not, says Putnam. “Given the current reimbursement system, we will continue to see small hospitals close or significantly cut services to survive.” The strongest rural hospitals will stay independent unless they are given no option but to join an insurance network, he predicts. Other hospitals will team with larger systems out of absolute necessity. “Losing their independence is far from the worst-case scenario for many rural hospitals,” he adds. The trick is to try, as much as possible, “to keep decision-making local to ensure the mission stays intact.”

With the reimbursement landscape changing, “margins will continue to be squeezed and only the most financially robust, forward-thinking and geographically favored hospitals will be able to remain independent,” Long says.

Wanted: Progressive Leaders

Whether independent hospitals can continue to go it alone is a moot question without capable executives, and recruiting exceptional leaders must be a priority for boards and communities. There is a real need for leaders who are fiercely committed to mission but not so inflexible that they ignore opportunities available through strategic collaborations with other organizations small and large.

There is also great demand for executives who get creative about financing and are proactive about reimbursement models. Today’s independent hospital is still going strong but — as the CEOs make clear — the wisest independent hospital leaders are taking nothing for granted.

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