



FROM NICE-TO-HAVE TO NEED-TO-HAVE

The Evolving Role of Strategic Partnerships for Critical Access Hospitals

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THE MATH OF RURAL HEALTHCARE HAS CHANGED.

For 30 years, many CAHs survived through local grit and incremental operational improvement. The environment that rewarded that strategy is gone.

Policy & Reimbursement

OBBBA / HR1 effects, Medicare sequestration, Medicaid instability, RHTP uncertainty

Payer Leverage Imbalance

MA growth, narrow networks, opaque private payer rates, eroding negotiating position

Workforce Scarcity

Clinical and executive recruitment, provider burnout, behavioral health gaps

Capital & Infrastructure

Aging plant, IT modernization, cybersecurity risk, depreciation outpacing reinvestment

Rising Expectations

Care coordination, value-based readiness, transparency, compliance complexity

Community Risk Concentration

Single-hospital communities, uncompensated care, fragile referral economies

No single rural hospital can sustainably build all the capabilities now required.



THE STRATEGIC QUESTION HAS CHANGED.

THE OLD QUESTION

“Should we partner?”

Partnership framed as optional. Local control protected through independence. Collaboration viewed as a hedge -- pursued selectively for purchasing or shared services, mostly transactional.

THE NEW QUESTION

“What collaboration infrastructure will let us preserve independence?”

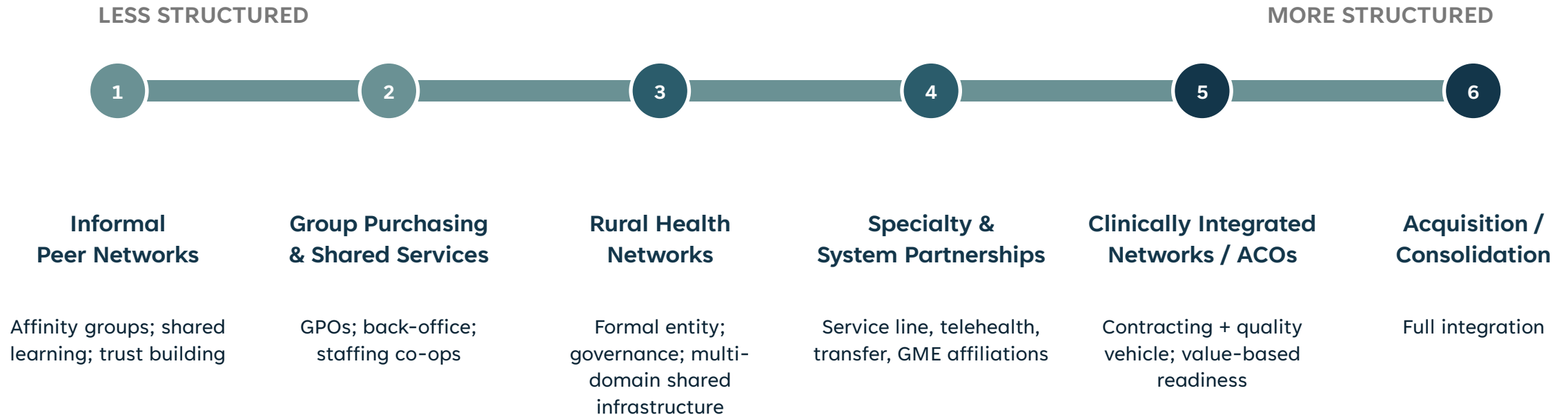
Collaboration framed as foundational. Local governance protected through structured interdependence. Networks, shared services, and strategic alliances treated as survival infrastructure, not a fad.

Independence and collaboration are not opposites. Independence is not isolation. Interdependence is the key.



THERE IS NO SINGLE 'RIGHT' MODEL. THERE IS A SPECTRUM.

Each model fits different geographies, governance maturity, and strategic intent. Greater integration is not greater virtue.



CIN is one possible expression of collaboration. It is not the centerpiece. The network is the substrate.

The network matters more than the CIN.

Rural health networks have existed for decades—through NCHN, statewide alliances, regional cooperatives, and shared-services collaboratives. CINs and ACOs are sometimes downstream products of strong networks. They are rarely the foundation.

Governance + Trust

The foundation. Built, not installed.

Shared Capability

What collaboration produces operationally.

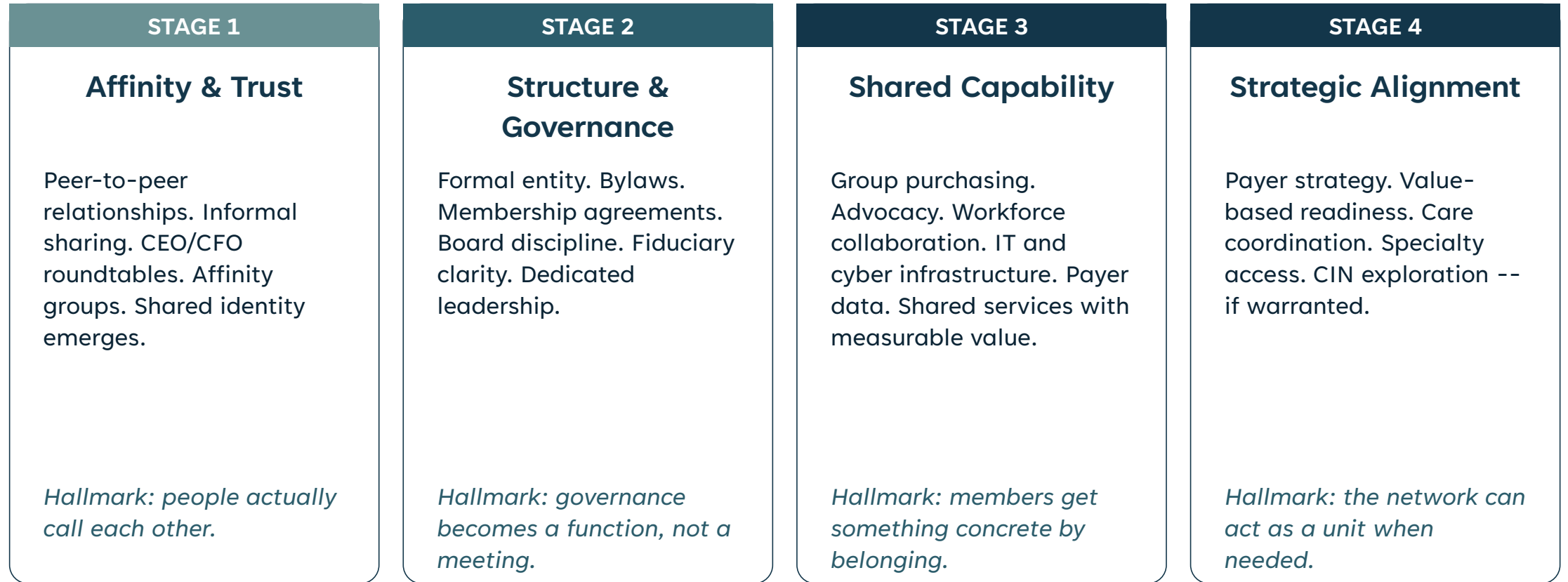
Contracting Vehicles

CIN, ACO, MSO—optional downstream products.

"Sustainable collaboration must be built, not installed."

FROM INFORMAL RELATIONSHIPS TO FORMALIZED PARTNERSHIPS.

A maturity pathway. Skipping stages is the most common cause of failure.



Networks that try to start at Stage 3 or 4 without doing the work of Stages 1 and 2 tend to fail. Sequencing matters.



SHARED SERVICES INCREASINGLY CREATE SURVIVABILITY—NOT JUST EFFICIENCY.

What collaboration is actually for—across six capability domains, no individual rural hospital can sustain alone.

Workforce & Recruitment

Executive search, provider recruitment, GME pathways, retention programs, shared training—and protection from talent poaching across the region.

Payer Strategy & Data

Payer transparency dashboards, underpayment recovery, contract benchmarking, COPA non-economic negotiation, and value-based readiness.

Shared Services & Purchasing

Group purchasing, back-office consolidation (IT, RCM), swing-bed optimization, vendor at-risk arrangements.

Advocacy & Policy Influence

Coordinated state and federal voice. Coalitions with SORHs, hospital associations, governors. Larger than any one CAH could manage alone.

Care Coordination & Specialty Access

Transfer center coordination, specialty consult pathways, telehealth infrastructure, referral integrity, network-wide care navigation.

Capital, IT & Cybersecurity

Shared cyber posture, IT staffing pools, joint infrastructure investments, USAC pathways, vendor consolidation, capital-pooling exploration.

The case for collaboration is no longer efficiency. It is survivability.



WHAT THIS LOOKS LIKE IN PRACTICE: EPHC.

EASTERN PLAINS HEALTHCARE CONSORTIUM

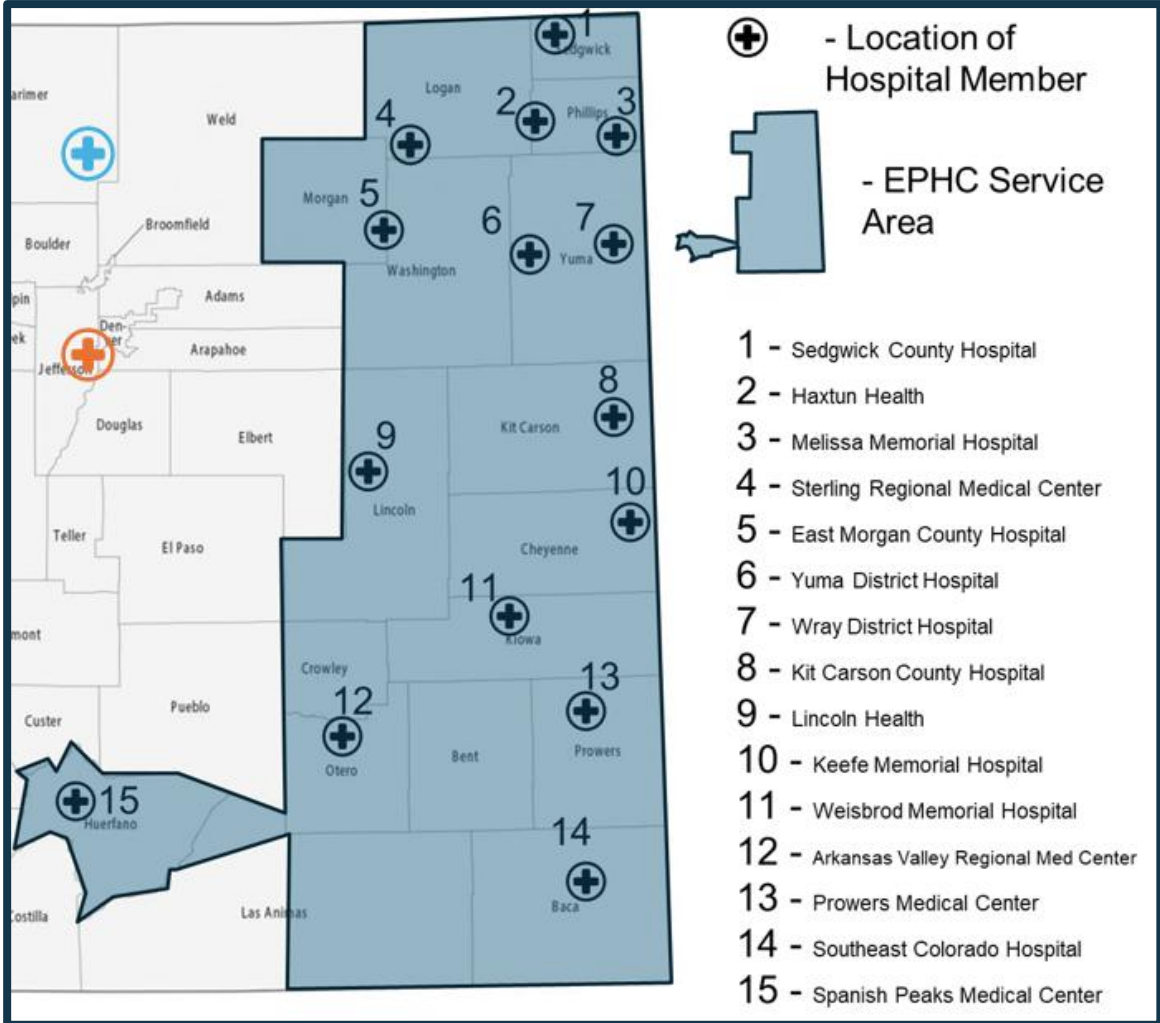
EPHC's Strategic Focus – 2026 & 2027

Grow Volumes at EPHC Member Hospitals - Expanding access, strengthening local referrals, and keeping care on the Plains.

- Rural Migration Report & CHA Data Investments
- Swing Bed Optimization
- Case Management & Swing Bed Affinity
- UNC Rural Residency Program
- Rural Hospital Revitalization Act
- Network Integrity and EPHC Referrals & Transfer Center

Improve Payment at EPHC Member Hospitals - Advancing payer relationships, value-based readiness, and cost-report optimization to improve reimbursement and sustainability.

- COPA Non-Economic Payer Negotiations
- Payer Transparency & Accountability Programs
- Cost-Report Improvement Partnership
- Finance & Revenue Cycle Affinity
- State-Wide Clinically Integrated Network



ENGAGE HEALTH SYSTEMS STRATEGICALLY. PROTECT GOVERNANCE LOCALLY.

Most rural hospitals will need some form of health-system relationship. The strategic question is structural design—not whether to partner.

WHAT TO LEVERAGE

- **Specialty access & transfer pathways**
Cardiology, oncology, behavioral health, complex transfer coordination
- **Telehealth & e-consults**
ED, hospitalist, specialty -- where appropriate
- **Workforce + GME partnerships**
Residency rotations, recruitment pipelines, retention support
- **IT & cybersecurity infrastructure**
Shared cyber posture, EHR support, vendor consolidation
- **Service line co-management**
Surgery, oncology, women's health support models
- **Capital partnership—in select cases**
Joint ventures with explicit governance boundaries

WHAT TO PROTECT

- **Local governance & board authority**
Decisions that affect the community remain local
- **Community accountability**
Mission, identity, charity care commitments
- **Operating discipline & budget control**
Independent P&L; no operational substitution
- **Brand & identity**
Local trust is not transferable
- **Network / affiliation flexibility**
Avoid exclusivity clauses that foreclose future options
- **Right to walk away**
Clear off-ramps; renegotiation clauses; sunset windows

Act like a system without becoming one.



Collaboration is governance work.

Not marketing. Not branding. Not vendor logos. Discipline.

- Is governance clear, or is collaboration drifting?
- Are expectations contractual, or aspirational?
- Are we building capabilities, or buying logos?
- Is local accountability protected by structure rather than goodwill?
- Are we sequencing—or skipping—stages?

The hospitals most likely to remain independent long term may be the ones most willing to collaborate.





COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

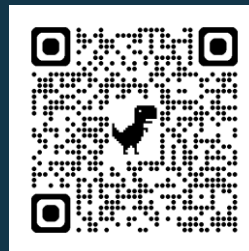
Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.



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