



# Merging Ahead: Case Studies in Clinic Consolidation

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## Introduction

Many of California's community health centers (CHCs) have cooperative relationships with organizations in their field and region. However, deeper or more permanent forms of partnership—such as administrative consolidation, joint venture, or merger—are still fairly uncommon. This issue brief looks at the experience of CHCs and consortia that have considered or entered into such partnerships, in order to help inform the field of potential benefits and challenges. Building on earlier research presented in June 2009, it is based on continuing conversations with clinic executives, board members, and other experts in the field.<sup>1</sup> Three useful stories—one of them an amalgam based on several actual situations—follow.

- Southside Coalition of Community Health Centers in South Los Angeles engages eight CHCs in a continuing partnership that involves joint funding opportunities and shared access to specialty services. It is exploring other types of joint programming to enhance services to the community. This case study highlights a decisionmaking tool that groups can use to weigh collaborative options, taking into account their own unique and shared strategic priorities, limitations, and other criteria.
- A fictionalized composite profile of “West Haven Free Clinic” and “Hope Clinic” explores a merger negotiation that failed.<sup>2</sup> It draws from several real-life examples to highlight some common risks and opportunities that may bring clinics to the

merger negotiation table, then push them away. It emphasizes the importance of the due diligence process in exchanging key information and establishing the level of trust needed to create a successful partnership.

- The merger of Miners Family Health Center and Western Sierra Medical Clinic in rural Northern California illustrates how incremental forms of collaboration over time can pave the way for more permanent alliances in the future. This case study also highlights the importance of remaining true to the local community and its unique culture after a consolidation.

Each of these stories describes different benefits and challenges that CHCs can find helpful to consider as they assess various types of strategic restructuring opportunities.

## SOUTHSIDE COALITION OF COMMUNITY HEALTH CENTERS

### COLLABORATION AS A COMPETITIVE STRATEGY

The Southside Coalition is a collaborative of eight CHCs providing safety-net services in South Los Angeles, a large urban neighborhood working to overcome high levels of poverty, gang violence, and extreme health disparities. Several of the clinics first came together in 2003 to share ideas and experience on how to respond to these challenges. In 2006, the clinic leaders became concerned about the impending closure of the county hospital then serving the community, which could cause critical funding to be diverted away from South Los Angeles. This threat was exacerbated by

disproportionate allocations of Public-Private Partnership (PPP) funds that left South Los Angeles poorly covered relative to its high level of need.<sup>4</sup>

By the following year, in response to these pressures, the clinics established the Southside Coalition, obtaining separate nonprofit status and hiring a director to staff

### What is Strategic Restructuring?<sup>3</sup>

Strategic restructuring takes collaboration to a deeper level, formalizing the partnership with some type of contractual commitment to share or transfer decisionmaking power. This type of relationship may take several forms:

- **Administrative consolidation.** The sharing, exchange, or contracting of administrative functions to increase the administrative efficiency of one or more of the organizations. For example, one CHC might contract with another to provide it with financial management services.
- **Joint programming.** The joint launching and managing of one or more programs to further the programmatic mission of the participating organizations. An example might be a centralized disease management system.
- **Management services organization.** The creation of a new organization in order to integrate administrative functions.
- **Joint venture corporation.** The creation of a new organization to further a specific administrative or programmatic end of two or more existing entities, where partners share governance of the new organization. An example might be a jointly established group purchasing organization.
- **Merger.** The integration of all programmatic and administrative functions of two or more existing organizations in order to increase both administrative efficiency and program quality. Examples might be two CHCs merging into one legal entity or a CHC incorporating a previously independent private practice into its organizational structure.

For more about strategic restructuring, including a graphic representation of the Partnership Matrix, see [www.chcf.org](http://www.chcf.org).

the organization. Its first order of business was to secure resources to ensure that safety-net services would continue to be readily accessible to the community, which is largely contained within Los Angeles County's Service Planning Area 6.<sup>5</sup>

The members jointly applied to receive a special allocation of state funds designed to help stabilize the provision of essential health services in the absence of the failed hospital.<sup>6</sup> This joint application for SB 474 funds was key to the coalition's later success. It helped ensure that community needs would be met, and it was also the first time that the clinics had partnered so closely on a funding request, setting the stage for the Southside Coalition's future.

In the short time since the Southside Coalition was founded, its members have engaged in joint efforts to expand access to services—particularly specialty services—in South Los Angeles. Today, the coalition is identifying and pursuing additional partnership opportunities to help address the most pressing health needs of the community.

### Specialty Care and Health IT

With uninsured patients facing wait lists of six months and more to see specialists at county facilities, Southside Coalition members felt a pressing need to develop their own capacity in high-demand specialties. They began with podiatry, establishing clinical capacity at two member clinics, and ophthalmology, supporting retinal screening programs at all clinics. This work—made possible by funding from the Kaiser Permanente Specialty Care Access Initiative—will continue into 2012, as member clinics seek solutions for additional specialties such as cardiology, gastroenterology, and orthopedics.

Ultimately, Executive Director Nina Vaccaro explained, the Southside Coalition hopes that its efforts with this initiative will yield “systemic changes,” such as improvements in the county referral process. In the

meantime, the specialty initiative has helped the member clinics develop their health information technology capacity, establishing telemedicine programs for retinal screening and dermatology, and creating a shared Web-based system for intraclinic podiatry and teledermatology referrals.

### All for One?

In researching collaborative options for Southside Coalition members to consider, the consultants looked at the work of California's 14 regional consortia of community health centers, similar networks in other states, and clinic collaboratives funded by the Health Resources and Services Administration (HRSA) as Health Center Controlled Networks (HCCNs). The research found that while such partnerships may coalesce around a sense of shared opportunity, developing the deeper levels of trust required to engage in more highly integrated forms of collaboration takes time. For example, most clinic consortia include in their charge a policy/advocacy role and a commitment to sharing best practices, but only a few (typically, the most long-standing) have developed services requiring greater commitment, such as managed care entities, joint purchasing programs, or shared administrative services.

Said Sherry Hirota, CEO of Asian Health Services and member of the Alameda Health Consortium, "There are a lot of things you can do [as a consortium], but there's a trust factor." Often, the only way for organizations to build this trust is to work with one another over a period of time, at incrementally higher levels of integration.

This process can be challenging among networks or consortia made up of organizations of varying size and capacity. Inevitably, some member clinics are already fairly well off, and these may not be as interested in infrastructure-related or capacity-building efforts from which smaller clinics would be the most likely to gain. At the same time, the clinics that are newer or less well developed may have the advantage in other areas, such as greater flexibility or openness to innovation.

It is by leveraging the complementary strengths that all partners bring to the table that a collaboration can ultimately result in better access to higher quality health care services.

In addition to its specialty access work, the coalition decided in 2009 to seek out other ways member clinics might partner with one another to realize operational efficiencies and enhance services to the community. With assistance from the Blue Shield of California Foundation, the coalition engaged in a facilitated assessment of its strategic restructuring options.

It is important to note that all of the member clinics had been in "growth mode"—expanding services or facilities—and came to this effort with a perspective of seeking opportunities rather than simply ameliorating problems. Thus, it quickly became clear in the course of working with the consulting team that instead of pursuing a merger, an administrative consolidation, or a management services organization (MSO), the clinics wanted a less formal shared services arrangement or shared programming effort. Through a process of mapping each clinic's needs and interests, discussing these findings, and looking at ways in which other collaboratives have addressed similar issues, the Southside Coalition identified two priorities: expanding diabetes care and preparing for health care reform.

### Taking on Diabetes at the Community Level

South Los Angeles, historically an African American community, is now more than 50 percent Latino. Both populations are disproportionately affected by diabetes, which has become a virtual epidemic in the community. The disease poses a costly challenge to clinics. After reviewing models of community-based prevention, education, and disease/lifestyle management programs implemented by collaboratives elsewhere, coalition members decided to look into developing a joint effort. In weighing this initiative, the members referred to decisionmaking criteria (see Table 1 on page 4) that they developed and agreed upon during the interest mapping process to help them choose from among many collaborative options.

## Table 1. Decisionmaking Criteria

- **Interest.** What issue or opportunity is there “critical mass” around?
- **Common Benefit.** What would be beneficial to all clinics?
- **Common Impact.** What would positively affect the South Central area?
- **Sphere of Influence.** What can Southside members realistically influence or control?
- **Sustainable.** Can this effort be made self-sustaining over time? Can it be pursued independent of external factors like health reform, etc.?
- **Fund Development Opportunity.** What is there funding for?
- **Visibility.** What would help bring Southside clinics greater visibility?
- **Capacity.** What is realistic, given member clinics and Southside staff capacity?

The joint diabetes project met the coalition’s criteria as to common interest, potential for community impact, appropriate scale, and opportunity to increase its visibility in the community as a key provider and health partner.

Said Carl Coan, president and CEO of Eisner Pediatric & Family Medical Center, “We could partner and do a lot more in diabetes prevention (education, outreach, screening), and it would have an enormous impact on the community. But it would take all of us doing it.”

Diabetes care could also serve as a testing ground and model for how member clinics could collaborate on future programming. Unlike the coalition’s more limited specialty care collaborations, a diabetes initiative could require members to pool and mobilize a diverse range of resources and expertise and also to forge a shared brand identity under which to market the joint program to the public. This might represent an opportunity for the coalition to identify itself as a “family” of providers dedicated collectively to the South Los Angeles community, while still retaining the individuality of each member clinic apart from the campaign.

A diabetes program could be a good fit because it addresses a critical community need while allowing the Southside Coalition to more visibly assert its identity

in South Los Angeles. Competing providers have been entering the area, motivated by growing demand and attractive funding opportunities through state set-aside allocations made after the county hospital closure and through private foundation initiatives.

## Positioning for Health Care Reform

Health care reform promises an even more profound shift in the health care marketplace. Along with \$11 billion in funding over the next five years to implement the legislation will come greater competition, as providers vie for a share of the new dollars and the millions of patients who will gain access to health care coverage.

The member clinics recognize that the opportunities posed by health care reform also present the challenge of how to position themselves as providers of choice in a changing market. Using the lens of health care reform, the clinics are analyzing their individual and collective strengths and weaknesses to determine competitive strategies. Like many collaborating clinics in other regions, the partners are also close competitors. They must decide in which areas to put aside individual interests and band together to better compete against external threats. Organizations that are able to submerge their individual interests often succeed in not only remaining relevant but in exceeding their original goals.

While the Southside Coalition’s strategic restructuring assessment and decisionmaking process has been led primarily by a board composed of the CEOs of each member clinic, the diabetes program and competitive positioning efforts will involve a broader range of stakeholders. Clinic staff representatives will serve in an advisory capacity as the coalition determines its role in community-based diabetes programming. This involvement of medical directors, outreach workers, and others will lend additional perspective on the impact of diabetes on South Los Angeles residents and the best options to meet specific community needs and clinic capacity. Similarly, groups of staff from each clinic will

help the coalition develop strategies for positioning itself for health care reform. The boards of each member clinic may also be involved in educational opportunities and forum discussions. The strategy of bringing together non-CEO staff members and the boards of member clinics should develop stronger relationships between the partner organizations.

### Key Takeaways

In addition to their commitment to serving their communities, the coalition members are characterized by a strong competitive spirit, which can make it difficult to build the level of trust required for deep collaboration. By taking on mutually beneficial low-risk efforts, such as shared access to specialty care, Southside Coalition reaped early successes and gained the confidence to take the partnership to the next level. The selection of diabetes programming and strategic positioning as the two next areas of collaborative effort to explore indicates the members are ready to take on more complex initiatives. By combining forces in significant undertakings they hope to achieve higher impact that will enable them to thrive in their increasingly competitive environment.

### WEST HAVEN FREE CLINIC AND HOPE CLINIC

#### TOO LITTLE, TOO LATE DERAILS NEGOTIATIONS

“West Haven Free Clinic” and “Hope Clinic” are amalgams of a several actual clinics and other organizations. Their fictionalized experiences in merger negotiations are based on actual situations at various organizations.

West Haven has proudly served the city of West Haven and its neighboring communities for 40 years. Established at the height of the free clinic movement, the clinic successfully responded to changing community health needs over the years, building a reputation for high-quality services and cutting-edge health technologies, while maintaining its “by the people, for the people” culture and identity. However, it has increasingly struggled to sustain a strong patient base, forcing its

board and staff leadership to pursue ideas to attract more patients and have a broader impact in the community.

Hope Clinic was established in the early 1980s with a primary focus on chronic disease care and mental health therapy. During its first few years, it benefited from strong community support and a charismatic director, but it never developed the professional staffing or infrastructure to sustain this success. It has since struggled financially, lost its founding director along with key board members, and hired and fired three new directors in as many years. It nonetheless continues to labor along, filling a critical niche as one of the only resources for affordable mental health care in the county. It is also one of the few that has the cultural and linguistic capacity to effectively serve the community’s growing newcomer populations of Southeast Asian and Latino immigrants.

In 2009, West Haven and Hope Clinic began to engage in serious conversations about how a merger of the two might help address their respective organizational challenges and leverage their complementary strengths. The two clinics assembled a negotiation committee, composed of representatives of both organizations, that spent four months identifying and discussing many of the key issues and concerns that would need to be addressed before they could bring a merger recommendation to their respective boards. Although this well-planned and thoughtful approach enabled them to formalize agreements in several key areas, the two clinics encountered sticking points during their due diligence phase that delayed the process almost three months and ultimately led to abandonment of the merger negotiations for the foreseeable future.

### Setting the Stage

No stranger to merger, West Haven had absorbed a small walk-in clinic through consolidation in the late 1990s in an effort to preserve services in the city’s aging downtown neighborhood. However, board and staff were disturbed to discover financial shortfalls and administrative systems

gaps that didn't fully come to light until after the merger. It took West Haven two to three years to resolve and move past these difficulties, an experience that taught it much but also left it somewhat wary of mergers.

Hope Clinic had a different set of issues with respect to merger. Although its cultural competency in serving the Asian community, in particular, had drawn the interest of two midsized federally qualified health centers (FQHCs), neither made a formal overture toward a merger or other strategic alliance that might help leverage this strength to greater effect. This wariness on the part of the FQHCs was partly due to the chronic turnover in leadership at Hope Clinic, but it also reflected a perception of the organization as insular, "closed," or somewhat hard to work with.

Despite these challenges, 2009 brought changes in leadership at both West Haven and Hope Clinic, putting discussion of a possible merger on the table. West Haven saw a changing of the guard among the top ranks of its board, with two long-time members, including the board chair, cycling off. With the addition of two new members, one a seasoned entrepreneur and the other an up-and-coming young community leader, the political balance on the board shifted. Memories of the past merger began to fade, opening up thinking about organizational strategy. Meanwhile, Hope Clinic announced that it was once again losing an executive director, this time due to a serious health issue that would soon render the current leader unable to work full-time.

The conversation that put these pieces together came about in a chance encounter between two board members of the respective organizations. Seated together at a local fundraising luncheon, they soon began to share the challenges and opportunities they were seeing from their vantage point as board members of the county's only two free clinics. This discussion led the clinics to enter into serious conversations about a possible merger.

## An Apparent Match

When Hope Clinic opened up shop 1.5 miles from West Haven 28 years ago, West Haven had already established itself as a "go-to" community resource. The chronic disease and mental health focus of the newer clinic made it a welcome complement to the local health care landscape, rather than a competitive threat. Since then, the two clinics have developed on more or less parallel, but very different, paths.

Hope Clinic relied heavily on RNs, certified disease management educators, and mental health clinicians. Its patients often lacked ready access to physicians, nurse practitioners, or physician assistants. One benefit of a partnership with West Haven would be the opportunity to bring Hope Clinic patients under the care of MDs. Conversely, although West Haven had a strong complement of physicians and nurse practitioners, it lacked sufficient midlevel medical staff to round out its team and pursue its vision of a patient-centered medical home model. It thus saw a merger as way to attain that needed depth. Hope Clinic's culturally competent staff and strong track record of serving an increasingly multicultural community would also be a tremendous asset to West Haven.

There were compelling reasons to merge nonmedical staff as well. West Haven had established a strong administrative and operations team, whereas Hope Clinic was still making do with a small team of committed but undertrained office staff and a costly human resources and payroll contractor. The impending departure of Hope Clinic's director lent urgency to this need, signaling that the beleaguered organization must again engage in a time-consuming executive recruitment and transition process. The joint negotiations committee quickly determined that both organizations considered West Haven's current director an ideal candidate to provide leadership to the newly merged entity, and she indicated preliminary interest in taking on the job.

Because West Haven and Hope Clinic each brought different strengths to the table in their respective medical staffing, a combination of the two would allow for a more robust range of options for meeting patient needs. Administrative and operational staffing for the merged organization, however, would require a solution other than simply combining the two staffs. Here, notable efficiencies and some small cost savings could be realized by consolidating functions and/or eliminating duplication. In their negotiation discussions, both clinics agreed to delay any layoffs until after the merger, when a more comprehensive assessment could be made.

The strongest motivator for West Haven to engage in the merger was the opportunity to significantly expand its patient base. It was very eager to add 1,000 patients from Hope Clinic's roster to its own 2,500 unduplicated patients annually, viewing this as the linchpin of a key goal in its strategic plan: to double its current level of

service by 2011. To West Haven, the merger may have appeared more like an acquisition than a true "marriage of equals." This attitude seemed to be reflected in West Haven's initial proposal to carry over its full board to the new entity, but only a portion of Hope Clinic's board.

West Haven was eager to take on the new patient load, but did not consider very seriously the cultural component of working with a large patient population of Southeast Asian families. This important oversight boded poorly for West Haven's readiness to engage in a successful integration of its own organizational culture with that of Hope Clinic.

Hope Clinic's readiness for merger was also called into question when, early in the due diligence process, it was late in providing key financial and other documents for review. Even after requesting and receiving more time, it finally submitted documentation that turned out to

## Favorable and Unfavorable Factors

### Paving the Way to Merger...

- **Common mission/structure.** Organizations that share the same purpose, are run in much the same way, and/or have similar philosophies of care (such as two free clinics) are likely to have an easier time forging a partnership than more disparate entities, such as a free clinic and an FQHC, or an FQHC and a private practice. It is also true that mergers between different kinds of complementary organizations can sometimes yield great benefits, so long as there is a common mission, vision, or purpose bringing them together.
- **Complementary services/capacity.** Successful mergers leverage the assets of all partners. They enable partners to attain a higher level of operational expertise and/or service delivery than they would have been able to independently.
- **Executive transition.** Because merger raises the question of who will lead the new organization—whether that means a "surviving" executive director or a new leader from outside—it may get recognized as a viable option only when an executive transition is already on the horizon. Merger should not be used in place of thoughtful succession planning, but it can help meet multiple strategic needs when one of those needs is to secure new leadership.

### Making Merger More Difficult...

- **Lack of preparedness.** A merger process entails a thorough review of organizational finances and key data. Organizations that cannot provide complete and accurate reporting may stand to benefit from a merger, but they could have a harder time meeting the requirements of the process. Strong communication with potential partners is important so that lack of preparedness is not interpreted as a failure to commit to the process.
- **Lack of transparency.** The line between lack of preparedness and lack of transparency may be indistinguishable to a potential partner. The due diligence process tests the level of trust between organizations considering merger, and any real or perceived lack of honesty or transparency can be a deal breaker.

be incomplete and partially outdated. West Haven had expected that the smaller clinic could have some difficulty producing reports, with its less sophisticated staffing structure and systems, but the delays in communication and the lack of quality seemed to suggest that Hope Clinic was hard to work with. West Haven came to doubt Hope Clinic's credibility and its commitment to the process.

### The Deal Breaker

West Haven's confidence in its potential partner broke down entirely when the discovery process led to questions about the reliability of Hope Clinic's data on numbers of patients served. West Haven's interest in merger hinged on expanding its patient base by 1,000 unduplicated patients in the first year. When doubt arose on how Hope Clinic had arrived at its patient count, it threatened the whole process.

The critical question was whether some of these patients were eligible to receive free services. If Hope Clinic was found to have failed to follow appropriate processes for screening and accounting for its patients, the merged entity could be at risk of losing funding. Even the implication of impropriety or lack of transparency made Hope Clinic a less attractive partner.

Hope Clinic initially reported that 95 percent of its patient census, or 950 patients, had been screened in the past year. The remaining 5 percent, it maintained, included individuals for whom a decision had been made to serve temporarily. When Hope Clinic was not able to provide adequate documentation to quell concerns, West Haven requested that it conduct an audit of its data. The audit revealed that the number of patients who had been screened was much smaller than originally reported.

The sharing of sensitive information in the due diligence process represents a critical time in a merger negotiation because the partners have made themselves vulnerable. Mistakes can be perceived as a betrayal of trust, whether

intentional or not. West Haven's director, in retrospect, characterized the problem as perhaps Hope Clinic's overenthusiasm:

“They were very willing to share positive things—to say ‘we’re in great financial shape, serving hundreds of patients, etc.’—but lots of questions came up. We got along well... the only part of our conversations that hasn't gone as well is their tendency to ‘sell’ things at times where maybe what we’re looking for is plain old clarity. When we finally got to the facts of the matter, it was a pretty unattractive package for us.”

Hope Clinic's leadership did not feel that the difference in numbers revealed by the audit warranted a halt to the negotiations. By that point, however, West Haven believed that the costs of continuing were greater than the benefits. For now, a merger is off the table.

### Key Takeaways

Even mutually advantageous alliances on paper can be derailed in practice. The way that the partners go about working through problems is at least as important as the content of the issues, if not more so. Any sticking points are likely to emerge in a detailed due diligence process. This is “where the rubber meets the road” in terms of sharing information that organizations typically hold close to their vests—especially liabilities. The question then becomes whether these issues can be resolved to the satisfaction of all parties.

In this case, it appeared that the merger would not be able to deliver the benefits that West Haven most valued. Had Hope Clinic been more candid from the outset about its potential limitations, and less intent on “selling” itself as a partner, the negotiations may have weathered these difficulties.



## WESTERN SIERRA MEDICAL CLINIC AND MINERS FAMILY HEALTH CENTER

### BUILDING ON SMALL SUCCESSES

When Western Sierra Medical Clinic in Downieville, California, was established in the mid-1970s, it was staffed by a single nurse practitioner assigned by the U.S. Public Health Service. Today it has a staff of 20, including nine nonmedical personnel, and is designated as an FQHC. With the nearest hospital 50 miles away along a two-lane highway, Western Sierra is the sole medical and dental resource serving its rural Gold Country community.

Miners Family Health Center in Grass Valley, an hour's trip to the south, was established in 2001. The larger of the two clinics, it plays a very different role in its immediate service area, where it is one of a number of providers available to residents. After finding itself in serious financial trouble within its first few years of operation, Miners was able to pull itself back from the brink by aggressively expanding its Medicare patient base and adding pediatric services. It now has a staff of 80 and treats 18,000 patients a year.

Although the two health centers are situated some 50 miles apart in different counties, they share responsibility for the health care of residents living in and around the western portion of Tahoe National Forest. Cognizant of this responsibility, and seeking to strengthen their organizations' abilities to meet current and future needs, the two clinics have nurtured a collaborative relationship over the past several years. A full merger was made official in January 2010.

### A Shared Vision of Sustainability

Community health care has historically been a family affair at Western Sierra. Frank Lang, the lone nurse practitioner on staff when the clinic opened more than 30 years ago, directed the facility until 2007 and is still deeply engaged. His son Mark took over as CEO prior to the merger and currently serves as COO of the merged entity, while Frank Jr. served as medical director at both

Western Sierra and Miners concurrently. The Langs embrace the long view and are committed to preparing Western Sierra for a future independent of them.

Mark Lang explained, "We have been grappling with how to create continuity of care (beginning with my dad's retirement from his work with the facility) and how to structure the system for that continuity to occur so it will survive into the future."

For rural clinics like Western Sierra, sustainability cannot depend on continual growth, as in communities with high and/or growing populations. Patient fees alone are insufficient to keep rural providers in business because there aren't enough patients, a situation that makes grants and subsidies essential. At the same time, government funding brings technical and reporting requirements that are often cumbersome, particularly for small clinics.

As Mark described it, "There's a need to build a more permanent infrastructure to handle all of those tasks. To do that alone would be very difficult; it can take up all your resources just to comply with all the regulations—resources that you'd be better off putting toward patient care." Therefore the clinic's board and staff leadership explored ways of working with partner clinics to maximize resources and create a stronger and more seamless system of care.

Miners was equally motivated by a desire to create a stronger, more stable system that the community could rely on for years to come. Its challenges were mainly related to funding and reimbursement issues. Having been instrumental in turning around the struggling clinic since his hire in 2005, CEO Scott McFarland and his board saw collaboration as a way to mitigate the vulnerabilities common to community health clinics. McFarland explained, "The community health clinic is a system that can fail at any time (like we're seeing now with the loss of funding for dental services). In order to

have a truly sustainable model, you need to collaborate, expand, partner.”

Together, the two clinics engaged in a series of successful collaborations that paved the way for an eventual merger.

### Iterative Collaboration Sets the Stage

At the time that merger negotiations began, Miners was losing its medical director to illness, leading to an agreement to share Frank Lang Jr.’s leadership among both facilities. Subsequent collaborative ventures built upon this initial link.

Western Sierra’s attainment of FQHC status in 2007 opened the door to new sources of federal funding, which it leveraged to support collaborative efforts with Miners, as well as with Sierra Family Medical Clinic in Nevada City.<sup>7</sup> For example, it obtained a grant in 2008 to hire a quality assurance nurse manager who now oversees administrative and patient management improvements at all three facilities.

With Western Sierra and Miners already sharing key personnel, it seemed natural that when Miners began looking at electronic medical records (EMR) systems, it would adopt the same system Western Sierra was already using. Mark Lang encouraged Miners to piggyback on his clinic’s system, as both a cost-sharing measure and an opportunity to make working together more seamless. McFarland welcomed the chance, and for a time the two clinics shared EMR and practice management systems while maintaining a firewall between the two data sets to comply with Health Insurance Portability and Accountability Act (HIPAA) standards. Soon the distinction between clinics appeared less important. “After a while, it seemed like a no-brainer to just combine the two facilities,” recalled Mark Lang.

McFarland views the EMR experience as a prime example of how, by beginning with modest collaborative projects offering results without high risk to either party, Western

Sierra and Miners were able to smooth the way for an eventual merger. They front-loaded a solution to a systems issue that otherwise would have cropped up in the post-merger integration phase. “We had already built an infrastructure, so when we finally pulled the trigger, we just merged them together,” McFarland recalled.

Foreseeing and planning for challenges played a big part in the early collaborative efforts. Not only did the growing partnership benefit from board members already having seen the value of various modest types of collaboration, but efforts to keep the board involved and engaged enabled a successful transition. These efforts included social events and other opportunities for the two boards to get to know one another.

### Overcoming Challenges Through Communication

Challenges to the merger process included concerns about maintaining each partner’s unique community identity. Western Sierra wanted to be sure that its small-town culture and values would not be subsumed by Miners’ more aggressive business model. “There’s always a fear that the bigger community will swallow the more rural one,” said Mark Lang. While Western Sierra was focused on being all things to all people in its small community, Miners had to compete with other providers in Grass Valley and served a much higher volume of patients in the process. To ameliorate concerns, a provision was added to the merger agreement stipulating that services at each facility will continue in perpetuity—for example, that 24-hour care will always be provided in Downieville.

At the same time, it was essential to the partnership that each organization think beyond its own parochial interests and see how a merger could enable broader regional impact. Mark Lang explained, “We needed to get everyone to recognize we’re more of a regional community than we are defined by just the town one happens to live in. That was a complicated part of the whole mix, how to do that.” The unique thing about community health

centers, he said, “is that they’re run by the community. It’s not just a business decision that can be justified by the numbers alone; you’re dealing with communities that are different in some ways.”

The process was made easier by the fact that the leaders of both health centers were engaged in the conversations and already knew how to work well together. McFarland wryly described the role the shared medical director played during this process as “a fun job,” as Frank Lang Jr. was frequently pulled in two directions. Because he was raised in Downieville, he understood its perspective and was trusted by the residents. At the same time, he was also well respected for the years of work he had put in at Miners and was ultimately able to use his influence with both communities to assuage concerns and facilitate closer collaboration.

Board members, particularly the two board presidents, also helped champion the effort. From the beginning, both clinics intentionally created opportunities for the boards to interact socially, recognizing that informal relationship-building helps pave the way for good working conditions at the board level.

Fostering buy-in among staff was another essential component. Here, communication played a key role. Mark Lang described endeavoring to abide by the rule of “no surprises,” by providing frequent updates to staff, keeping them informed of how the process was moving along, and providing opportunities for input. He said that now, during the integration process, staff are contributing many of their own ideas and solutions.

Because of careful preparation and committed leadership on both sides (as well as Mark Lang’s own legal experience and that of a Miners board member), Western Sierra and Miners were able to negotiate the merger agreement without assistance from external consultants. However, as Mark Lang learned, the biggest challenge is typically in the implementation, after an agreement has been reached.

“The merger paperwork itself isn’t really complicated at all,” he said. “It’s figuring out how to meld retirement systems together, personnel policies, benefits, etc.” He noted that Western Sierra and Miners have relied on their own resources and know-how to navigate the postmerger integration, without benefit of any special funding, but conceded that having a little support for some of this work would have been helpful. McFarland added that with such external assistance, “the outcome would have been the same, but it could have saved us some time and effort.”

Although Western Sierra and Miners worked hard to smooth the transition for community members, McFarland said there was a point at which they had to decide whether to wait for their stakeholders to buy in or to just do it. They decided to go for it. The commitment was not without its risks. For example, no one knew what form health care reform would take and what the implications would be for independent health care centers as opposed to FQHCs. It was a calculated risk for the two clinics to join forces.

### Creating Short- and Long-Term Benefits

Recruiting medical staff to rural clinics is difficult. Mark Lang described this problem as a key motivator for Western Sierra, especially given the dearth of providers willing to assume responsibility for 24/7 care as demanded in Downieville. Combining forces also helped to attract specialists. “We need to share those providers because we can’t keep them busy all the time, with our small patient base alone. Aligning with other facilities makes this more feasible,” he said.

By working together, Western Sierra and Miners have also been able to move toward greater specialization and professionalization among administrative functions. The ability to spread the work among a larger pool of staff means that instead of one person trying to perform several functions at a time, he or she can now develop deeper mastery over a primary area of responsibility. This would

not have been true had the merger resulted in layoffs, but Western Sierra and Miners made a commitment to keep all current staff and are now reaping the benefits, along with the efficiencies gained by eliminating duplication. Another added capacity attributable to the collaboration is the creation of a shared dental system.

For Western Sierra, the merger has opened up a new pool of ideas and innovation. Said Mark Lang, “Collaboration helps us figure out how to better meet needs by tapping into new and better ideas. . . . They may have ways to bring better care to my community that wouldn’t be possible if we didn’t work together.” This collegial philosophy is borne out in the leadership structure of the newly merged entity, with Mark Lang as COO and McFarland as CEO. McFarland noted that the arrangement suits both because it plays to each of their complementary strengths and interests.

### Key Takeaways

Western Sierra and Miners were experiencing challenges that motivated their collaboration and eventual merger, but they did not wait until they had reached crisis mode. Rather than come to the table at their most stressed, each approached the merger from a position of strength. Said Mark Lang, “You need to come to it with an open mind—no preconceived notions about how ‘it’s always worked this way,’ because as we all know, the economy has completely changed and it’s a new playing field. We need to adapt.”

The leaders’ foresight and planning were also great assets to the process, as they started with small collaborative efforts and gradually built on those successes and the trust engendered between the two clinics. The merged organization is the Western Sierra Medical Clinic, doing business in Grass Valley as Miners Family Health Center.

### Conclusion

Organizations often come to strategic restructuring as an option of last resort because perceived stigma, concerns about loss of autonomy, and other barriers persist. But lack of information is also a key factor. Interviewees consistently stated that wider availability of assessment tools, case studies, and other materials was needed to help prepare CHCs for more open and proactive conversations about strategic restructuring.

The case studies illustrate how CHCs have engaged in strategic restructuring of different kinds and with varying degrees of success. Although each story is unique, all speak to some of the most common challenges and benefits that clinics are likely to experience.

- The concerns felt by stakeholders at Western Sierra about merging with the larger Miners clinic are common. Organizations and staff often fear that merger would mean losing their unique community spirit. Communication and trust-building, achieved in part through an incremental approach to collaboration, were required to overcome this fear. Helping to quell such concerns was the fact that both clinics had come to the partnership from a position of strength. What each brought to the table was recognized and valued.
- The Southside Coalition is exploring collaborative opportunities short of administrative consolidation or merger, focusing on programmatic efforts that pose little risk to the autonomy of member clinics. Many clinics are likely to find themselves in a similar position, wanting to reap the benefits of joining forces while not yet reaching the comfort level necessary for deeper forms of collaboration. Seeking opportunities that allow for incremental trust-building over time is one way clinics can set the stage for future success.
- The fictional West Haven and Hope Clinic example highlights the importance of a sound

process, as well as organizational readiness for strategic restructuring. The due diligence phase of negotiations, when partners must disclose sensitive financial and operational information, is where the truth comes out, potentially making or breaking the deal. Being prepared for this kind of openness and data-sharing is crucial. A readiness assessment can help position organizations going into an exploration or negotiation process.

If any one theme echoes through all three case studies, it is the importance of trust. Miners and Western Sierra had it and succeeded. West Haven and Hope Clinic failed to establish trust, and their strategic restructuring effort foundered. Southside Coalition continues to cultivate trust among its members as it deepens its collaborative capacity. As more CHCs share their collaborative experiences, the field will gain practical lessons about the potential value of strategic restructuring in the clinic environment. New thinking and new conversations will emerge about strategic restructuring as an option to address organizational challenges and opportunities.

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## **ABOUT THE AUTHOR**

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## **ABOUT THE FOUNDATION**

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at [www.chcf.org](http://www.chcf.org).

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## ENDNOTES

1. *Strategic Restructuring for Community Clinics: Options and Examples*, California HealthCare Foundation, June 2009, [www.chcf.org](http://www.chcf.org).
2. The organizations and circumstances described in this case study represent an amalgam of how a merger or partnership may be explored but, ultimately, not completed. While the researchers encourage organizations to share their setbacks as well as their successes in strategic restructuring—as both offer valuable lessons to the sector—they respect the anonymity of those organizations (clinics and otherwise) from whose stories the fictionalized case study was drawn.
3. Adapted from Kohm, A., and La Piana, D. *Strategic Restructuring for Nonprofit Organizations: Mergers, Integrations, and Alliances*. Westport, CT: Chapin Hall Center for Children, 2003.
4. The Public-Private Partnership Program is an organized system of L.A. County's primary care clinics that complements the delivery of care through DHS. First established with a Medicaid 1115 waiver, it is now funded by the county, at a lower overall level.
5. Los Angeles County is divided into eight Service Planning Areas for health care planning purposes. Originally composed of seven members drawing the majority of their patients from Service Planning Area 6 (SPA6), the Southside Coalition recently added one more to its ranks, after refining the definition of its geographic area to include communities where SPA6 meets with other service areas. Today, participating clinics are Central City Community Health Center; Eisner Pediatric & Family Medical Center; St. John's Well Child & Family Center; South Bay Family Health Care; South Central Family Health Center; T.H.E. (To Help Everyone) Clinic; UMMA (University Muslim Medical Association) Community Clinic; and Watts Healthcare Corporation.
6. The Martin Luther King Jr. Hospital was shuttered in 2007 after failing to meet federal standards. Recognizing that its closure would have a serious impact on the local safety net, the State passed SB474, establishing a \$100 million annual fund to help stabilize health services in the hospital's absence. A modest portion of these funds was made available to community health centers serving residents in the immediate area.
7. Although not a featured player in this merger-focused case study, Sierra Family Medical Clinic remains a valued partner that Western Sierra Medical Clinic continues to collaborate with in various other ways.