Strategic Restructuring for Community Clinics:
Options and Examples

California HealthCare Foundation

ISSUE BRIEF

Introduction

The weakened economy has brought the entire nonprofit sector to a moment of profound reflection. Some predict that 10 percent of all nonprofits will go out of business in this recession,[1] while others view the worsening economic storm as an opportunity to restructure the sector by focusing on options for organizational consolidation.[2] Nonprofits around the country are looking for ways to survive the downturn, maximize efficiencies, continue to serve those in greatest need, and increase their social impact.

Community health centers (CHCs), which rely heavily on state and federal reimbursements and are coping with other significant challenges, are especially vulnerable. Although the federal economic stimulus package approved in February offers clinics immediate short-term support to enhance technical capacity, facility development, and care delivery, funds will not be available to help shore up reserves or otherwise sustain organizational operations.[3]

The prospects for survival among California clinics depend in part on how they answer two critical questions: 1) "How can we best compete for the resources we need to do our work?" and 2) "In what ways could we be stronger by working together?" Strategic restructuring—establishing formal partnerships ranging from administrative consolidation to fully integrated mergers—could help answer both questions. It is an approach that has long been used in the for-profit sector and is becoming increasingly common among nonprofits.

California is home to over 264 licensed primary care clinics. It also has a state primary care association (the California Primary Care Association) and a network of over a dozen regional clinic associations, or consortia, that represent community clinics and health centers at the local level. Some of these consortia provide technical support, such as centralized human resource management, practice management, group purchasing, electronic health records management, and back-office administration.

This issue brief will explore CHCs' and regional consortia's experience with various types of partnerships, including administrative consolidation and merger, and examine what opportunities strategic restructuring might offer clinics seeking to strengthen their positions now and remain viable and vital in the years to come.

What Is Strategic Restructuring?

There are many ways for nonprofit organizations to work together, from the most basic forms of collaboration all the way to fully integrated mergers. The partnership matrix (Figure 1 on page 2) presents the range of options available.

Most CHCs have extensive experience collaborating with others in their field and community, and much of the consortia's efforts focus on fostering collaboration among the clinics in their regions. These often transient forms of partnership are regarded in the matrix chart as basic collaboration rather than strategic restructuring.

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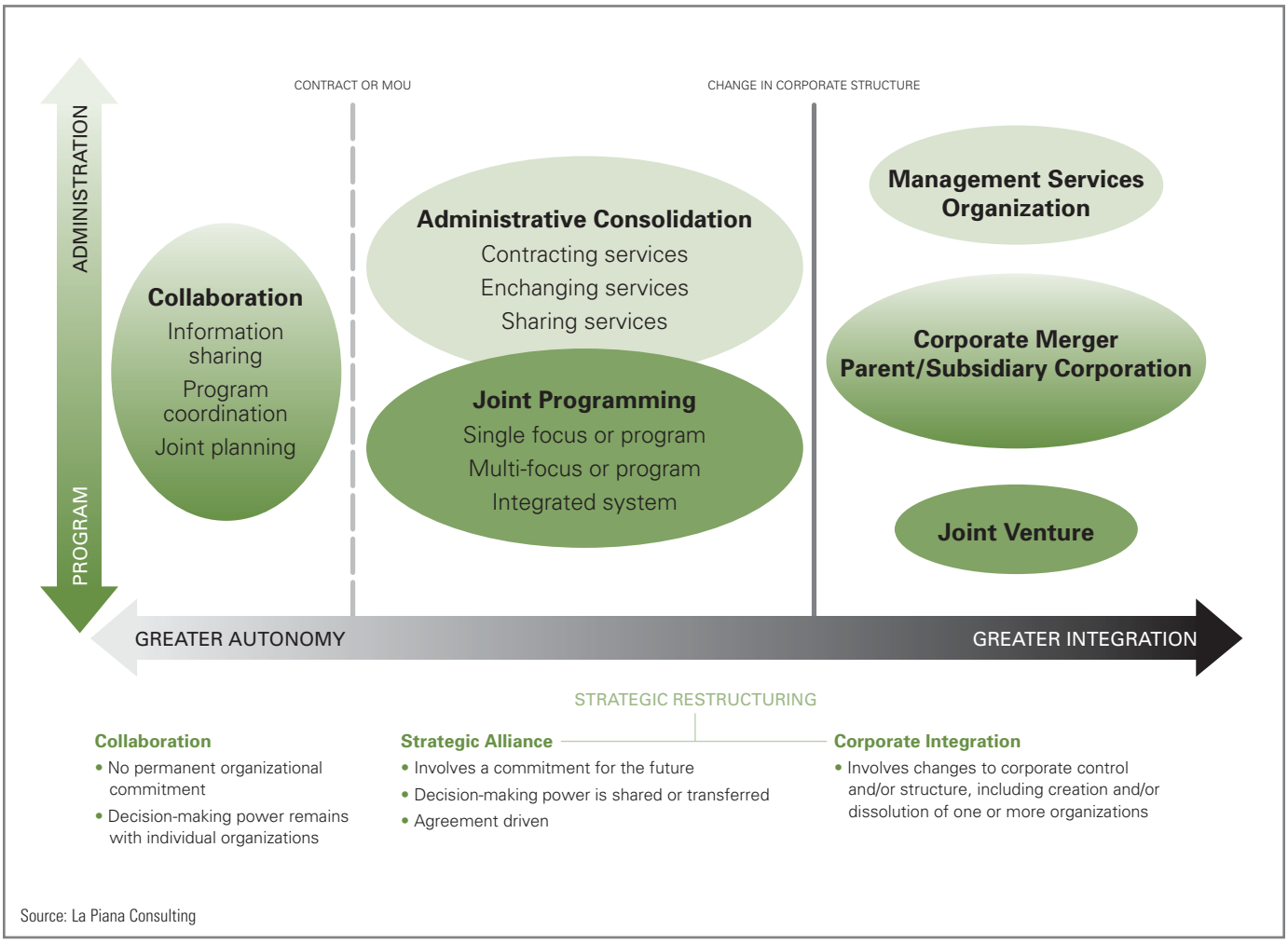
Figure 1. The Partnership Matrix



Source: La Piana Consulting

Once a partnership becomes more formalized—involving a commitment to continue, for the foreseeable future, shared or transferred decision-making power, as well as a formal agreement—it can be described as strategic restructuring. With strategic restructuring, two or more independent organizations establish an ongoing relationship to increase the administrative efficiency and/or further the programmatic mission of one or more of the participating organizations through shared, transferred, or combined services, resources, or programs. Examples include:[4]

- **Administrative consolidation.** The sharing, exchange, or contracting of administrative functions to increase the administrative efficiency of one or more of the organizations (e.g., one CHC contracts with another to provide financial management services);
- **Joint programming.** The joint launching and managing of one or more programs to further the programmatic mission of the participating organizations (e.g., a centralized disease management system);
- **Management services organization.** The creation of a new organization 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 organizations, with partner organizations sharing governance of the new organization (e.g., a jointly established group purchasing organization); and

- **Merger.** The integration of all programmatic and administrative functions of two or more existing organizations to increase both administrative efficiency and program quality (e.g., two CHCs merge into one legal entity, or a CHC incorporates a previously independent private practice into its organizational structure).

Asset transfers, while not shown in Figure 1, are another type of partnership common among CHCs, county health providers, and private practices. A typical example would be the transfer of a county-run specialty clinic, such as dental or prenatal care, into the local CHC. These are not represented on the partnership matrix because they are more transactional than ongoing.

While most nonprofits enter into strategic restructuring to enhance efficiencies or address financial pressures, they often end up with expanded services, improved administrative capacity, and greater market share.[5] It is clear that the practical value of strategic restructuring as a way to respond to both challenges and opportunities has become increasingly accepted and embraced throughout the nonprofit sector. What is less clear is the extent to which CHCs—specifically those in California—have considered or welcomed it as a means of addressing their specific needs.

Challenges and Opportunities for CHCs

In addition to the various pressures experienced by all nonprofit organizations, CHCs face unique challenges and opportunities, both nationally and in California.[6] Some of the most pressing include, but are not limited to:

- **Financial survival and competition.** Dependence on public funding, lack of adequate reserves, complex financial management, and increasing competition;
- **Changes in patient mix.** Growing numbers of uninsured and underinsured patients, more managed care patients, an increasingly diverse population, and aging baby boomers;
- **Workforce and leadership shortages.** Shortage of health care professionals and administrative staff, founding CEOs and other leaders approaching retirement;
- **Inadequate facilities.** Buildings requiring renovation or expansion, limited access to capital to finance improvements;
- **Pressure to demonstrate outcomes.** Information management and quality improvement tools becoming more sophisticated, costly technology upgrades; and
- **Uncertainties of health care reform.** How health reform efforts might affect clinics is still unclear.

As they grapple with these challenges, clinics have earned a reputation for shoring up gaps in the health care safety net by efficiently providing a wide range of quality care and health education to diverse populations. With every challenge comes the opportunity for clinics to strengthen and own this niche and prove themselves as innovators in the marketplace.

Some clinics have already started to explore ways in which various forms of partnership can help them respond to challenges and opportunities. Sharing financial expertise or other administrative functions is one way in which CHCs have sought to strengthen their capacity in these areas and/or reduce overhead costs. Consortia have also played a role in making pooled resource opportunities such as shared information technology and electronic records management available to member clinics. Joint programming or shared facilities are other ways clinics can combine expertise and resources to better serve their communities. Finally, some CHCs have engaged in mergers to add services (such as pediatric, dental,

or mental health), expand their reach (through school-based or mobile clinics, for example), and/or ensure uninterrupted access to critical health care services for those most in need.

Strategic Restructuring among CHCs

Mergers among CHCs appear to be more common in California than in other states. However, other states may take greater advantage of opportunities to consolidate business functions to reduce overall costs and enhance service delivery. It has been speculated that California's high merger rate may be due in part to its relative size, with respect to the sheer number of clinics—particularly small, grassroots clinics—that exist. By the same token, the state may be too large and diverse to make some forms of back-office consolidation feasible at the state level.

Partnerships Short of Merger: Shared Administrative Functions

Clinics can collaborate on many levels short of merger, including sharing or integrating:

- Administrative functions, including human resources, purchasing, corporate compliance, and communication;
- Clinical services and programs, such as health education, disease management, pharmacy, electronic medical records, and quality improvement;
- Managed care functions including credentialing and contracting;
- Finance, such as grants management, claims processing, accounting, and billing; and
- Information services/information technology, such as chief information officer services, project management, training, help desk, Web design, and infrastructure.

The Health Resources and Services Administration (HRSA) has been supporting and encouraging this type of cooperation among clinics for several years though its Health Center Controlled Networks initiative. While many of the networks funded by HRSA focus largely on technology issues (health information technology and electronic health records, for example), others—such as Miami's Health Choice Network and Central Oklahoma Integrated Network System Inc.—supply a wide range of services to their members.[7]

Examples of Collaboration Through California's Regional Clinic Associations

- The **Council of Community Clinics** in San Diego serves as the parent corporation for Council Connections and the Community Clinics Health Network (CCHN). Council Connections is a for-profit group purchasing organization serving members in 40 states; CCHN provides its 30-plus members (clinics as well as other consortia) with disease and quality management and managed care contracting services as well as information technology support.
- In 1996 the **Alameda Health Consortium** and seven of its member clinics created the Community Health Center Network (CHCN). Its original purpose was to facilitate member clinics' participation in the managed care system and to support improvements in their operational infrastructures. CHCN has since expanded and now serves as both a practice management support network and a full-service managed care service organization.
- The **Redwood Community Health Coalition,** serving Sonoma, Marin, Napa and Yolo counties, offers a wide range of support services to its member clinics, including a technical services organization that provides access to expertise in infrastructure, project management, and hosted software systems (such as an electronic health record), as well as a help desk.
- The **Central Valley Health Network** recently hired a director of human resources to serve both the network and its member clinics.
- The six clinic members of Mendocino County's **Alliance for Rural Community Health** are currently exploring the feasibility of sharing senior staff for human resources, information technology, and finance.

In California, collaborations of this type have for the most part been initiated at the consortia level. Some are well established, while in other cases consortia are just beginning to explore what it would mean to share some level of staffing or functionality involving human resources, administration, finance, or quality improvement.

Clinic Mergers: Mini Case Study Examples

Completed mergers and merger discussions have been motivated by a variety of pressing events at individual clinics. At least 18 California clinics have undergone one or more mergers in the past 15 years, many of them starting with a less permanent form of partnership (such as the consolidation of administrative functions as governed by a management services agreement, or MSA) that eventually led to a merger. A few of these are profiled below.[8] Although many share common characteristics, each offers unique lessons.

SOUTHWEST COMMUNITY HEALTH CENTER: MERGER AS A STRATEGIC CHOICE

Southwest Community Health Center (SCHC) was founded in 1996 as a family clinic serving southwest Santa Rosa and has since opened several additional sites to become the largest CHC in Sonoma County. Roseland Children's Health Center had operated as a program of a local multiservice agency since 1996, providing pediatric services through its school-based program. Santa Rosa Free Clinic started in 1999 as a program of another charitable agency to serve the homeless.

As small neighborhood programs, Roseland and the Free Clinic had been operating on thin margins for some time. In 2007, conversations began about bringing both under the auspices of SCHC, which had already engaged in several successful mergers and other partnerships. SCHC's Federally Qualified Health Center status had the potential to bring improved rates, and thus greater sustainability, to the two smaller clinics. Roseland and the Free Clinic also welcomed the opportunity to have a medically oriented home. Because neither was yet in severe financial crisis, merger discussions were able to progress in an orderly and unhurried manner; the fact that the clinics already had established relationships with SCHC (Roseland's medical director was part of SCHC's team) eased the transition. The mergers were announced in 2008.

SCHC has a track record of using mergers to diversify its scope and deepen its impact in the Santa Rosa community. Although SCHC has engaged in such partnerships as opportunities emerged, CEO Naomi Fuchs made the case for a strategic approach that emphasizes going in "with eyes wide open" and taking care to ensure that the benefits to all parties are worth the potential costs.

MOUNTAIN VALLEYS HEALTH CENTERS: MERGER IN RESPONSE TO A LEADERSHIP TRANSITION AND MERGER WITH A PRIVATE PRACTICE

Mountain Valleys Health Centers (MVHC) was formed in 2001 by the merger of Butte Valley Medical Center and Big Valley Health Center. Both centers shared similar missions and complementary services, though each served different rural communities in this tri-county area of northeastern California. The merger arose in response to financial hardship at Butte Valley and the retirement of its longtime CEO. The leadership of both clinics had already developed a strong working relationship prior to the merger, which smoothed the way for an MSA by which the CEO of Big Valley took over management responsibilities at Butte Valley after its CEO retired in 1999. This, in turn, allowed for a period of trust-building before entering into a full merger. MVHC CEO Dave Jones reported that although the anticipated economies of scale were not fully realized, the merger did enhance the sustainability of community health care services in the region through the consolidation of resources and efforts.

At the time this clinic merger was under way, a private practice group approached Big Valley and asked to be brought under its aegis. Mergers or affiliations between

CHCs and private practices are becoming increasingly common as physicians either retire or seek out a more satisfying experience than they might receive from a provider group. However, private practices may not share the same mission as community clinics, nor are their patient populations necessarily the same. Both of these factors were cited as challenges in the cultural integration following MVHC's acquisition of the practice. The physicians had to adjust to the more charitably minded clinic culture, and they brought with them a different clientele than typical clinic patients: Many of their patients didn't qualify for federal reimbursements, so the clinic in effect doubled its size without increasing its federal grant dollars. Jones reports that MVHC is still completing the transition from both the clinic and private practice mergers and probably will not engage in another merger until these have fully settled.

CLINICA SIERRA VISTA: MERGER AS A RESPONSE TO FINANCIAL CRISIS

Clinica Sierra Vista (CSV) began in 1971 as a small, storefront clinic to meet the needs of migrant farmworkers in the southern San Joaquin Valley. It has since expanded its services to diverse communities in Kern and Inyo counties and grown to become one of the largest private, nonprofit health center systems in the state. Sequoia Community Health Centers was established in 1978 as a small health and social outreach program in downtown Fresno and began providing clinic services two years later. Over the next 27 years, it added six sites, enabling it to serve a diverse client population of over 37,000 by 2007.

In early 2008, Sequoia's leadership contacted CSV's CEO, Stephen Schilling, for his counsel on financial and administrative issues. CSV provided the requested advice and even extended a loan to Sequoia in an effort to help it fill gaps and effect a turnaround. However, Sequoia ultimately filed for bankruptcy. CSV then proposed to the courts that it acquire Sequoia's assets in order to maintain the provision of services to the Fresno community.

The severity of the financial trouble at Sequoia, and CSV's assumption of its debts along with its assets, resulted in a complex merger process. In addition to the legal costs involved in navigating through bankruptcy court to obtain the asset transfer agreement, the process took a great deal of time. While legal counsel represented CSV in the courts, Schilling and his staff delved into sorting out and renegotiating the numerous grants, loans, leases, and contracts Sequoia had left behind. In particular, obtaining updated licenses and permits through HRSA and state agencies was no small task.

Far from a planned partnership, CSV's acquisition of Sequoia might best be described as a "merger by necessity." As Schilling characterized it: "Our choice was to either watch them shut down, or to rescue them."

ALTAMED: MERGER AS A COMPETITIVE STRATEGY

AltaMed Health Services Corp., serving Southern California for nearly 40 years, is one of the five largest Federally Qualified Health Centers nationwide. Founded as the East Los Angeles Barrio Free Clinic in 1969 by volunteer community leaders, AltaMed now serves over 66,000 families per year, offering a wide array of services and programs. It has grown in large part through the strategic and proactive use of mergers to expand capacity and build market share, and ultimately to deliver services to a broader swath of the regional community.

One of AltaMed's most recent mergers was with Community Care Health Centers (CCHC) in Orange County in 2008. According to AltaMed CEO Cástulo de la Rocha, AltaMed had already identified a strategic interest in expanding into that geographic area, which coincided with CCHC's needs when the latter found itself in financial difficulties and failed to receive Section 330 funding. What had started as conversations about less formal collaborative opportunities soon turned into successful merger discussions. Shortly after that merger, AltaMed acquired three additional practices in Orange County, effecting fast growth in that area. This is

illustrative of AltaMed's use of partnership to enhance its competitive position, and reflects de la Rocha's conviction that CHCs are best positioned—more so than private physicians or other types of providers—to provide a true medical home to the populations in greatest need.

THE EFFORT: MERGER TO STRENGTHEN BUSINESS MODEL

Family Service Agency (FSA) in Sacramento was established in 1953 to provide mental health and social services in support of children and families. The Effort was founded in the 1970s as a substance abuse clinic following the Haight Ashbury Free Clinics model.

In 2005, a significant leadership crisis prompted The Effort to seek out the advice of FSA's CEO, Robert Caulk, who was well known for his knowledge of the local health care system. FSA was a more established organization that had reached a point in its development where it needed to expand in order to remain sustainable. Caulk proposed a merger of the two organizations, preceded by a six-month management services contract during which he and his leadership team worked to improve The Effort's financial and management systems while the two boards conducted due diligence to explore the viability of a merger. The merger was approved and the combined organization adopted The Effort's name.

FSA was motivated in large part by recognition of external trends and the limitations of its own business model. At the time, many of the family mental health services it had been providing were migrating to the primary care sector, leaving less room for standalone agencies like FSA. To remain relevant, it needed to broaden its scope of services. FSA was still small enough that it was relying on fundraising to meet its budget, and it saw the opportunity to achieve a scale with the potential to become more self-sustaining. Since the merger, the organization's budget has doubled in size, in part through the development of innovative programming such as an emergency room diversion project it conducts in partnership with the hospital.

The Effort later merged with the Birth and Family Health Center in 2008, adding prenatal and perinatal care to its portfolio of services, and it continues to consider merger in cases where it will strengthen its ability to serve the community.

LIFELONG MEDICAL CARE: INITIAL USE OF EXTERNAL EXPERTS BUILDS FUTURE CAPACITY

LifeLong Medical Care operates nine health centers tracing deep community roots back to 1976. It was formed when the Over 60 Health Center merged with Berkeley Primary Clinic in 1996. Since then, LifeLong has maintained a steady pattern of growth allowing it to expand its services in an urban area with an ethnically and socially diverse population.

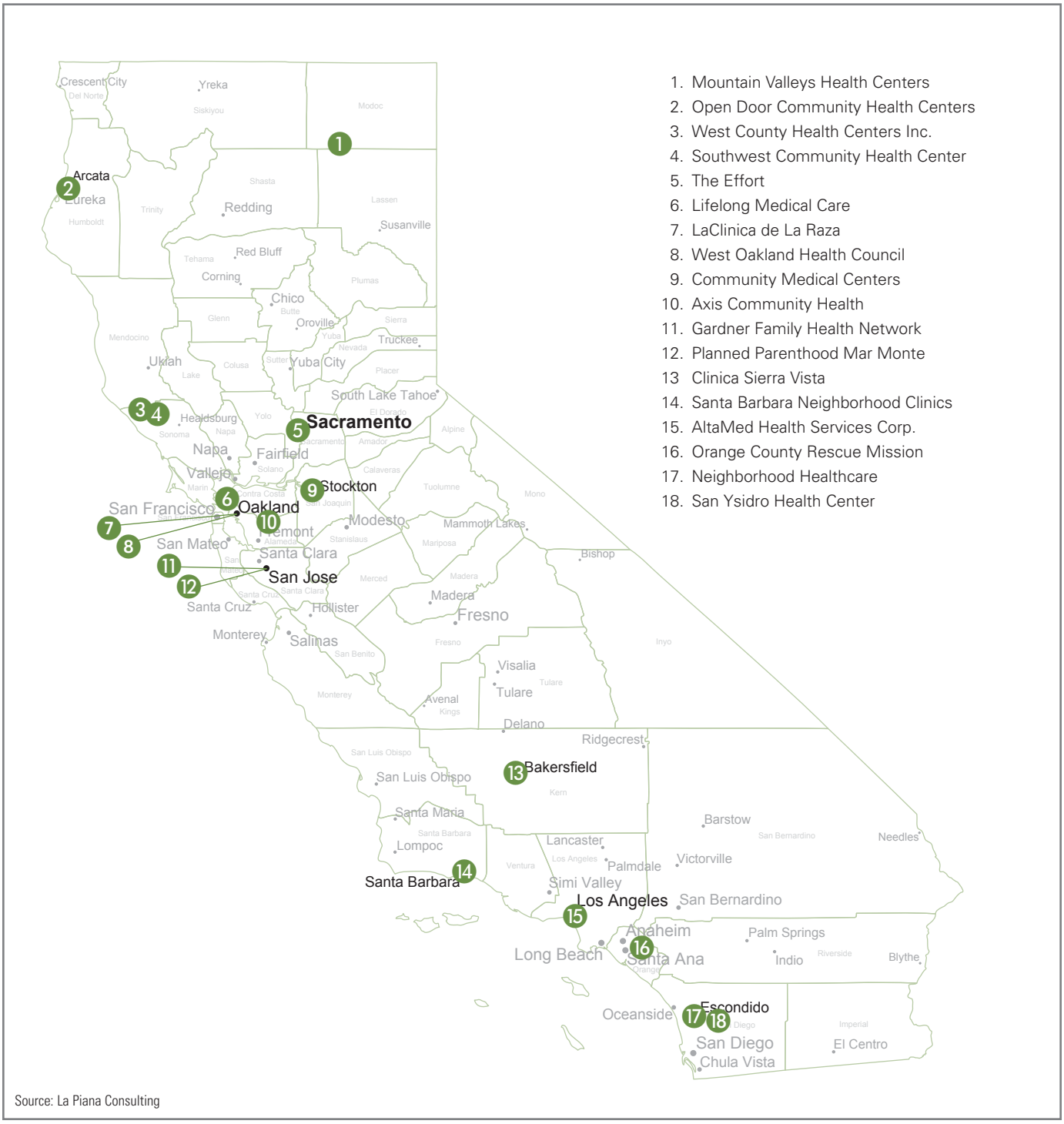
The merger of Over 60 Health Center and Berkeley Primary Clinic was motivated by efforts to reduce overhead costs and consolidate administrative expertise. The two clinics had discussed the potential of merging for several years before formalizing their partnership. Because this was a first-time merger for both clinics, consultant expertise was used to carefully evaluate the feasibility of a merger before committing to a final decision, and was particularly important in assessing financial and business model implications. Outside assistance was also used to quickly identify needs pertaining to human resources, internal cultural integration, and relations with external stakeholders. LifeLong CEO Marty Lynch reported that knowing the requirements and challenges ahead of time helped both organizations prepare for a more successful merger. This experience left LifeLong with a tested process and real-life model to follow in subsequent merger/partnership activities, and it no longer relies on outside assistance to evaluate and implement partnerships.

The LifeLong merger did not entail a comprehensive cultural integration of the two partner clinics, at least

at the outset. Instead, the new entity operated with the same administrative functions while the clinics and staff retained their own identities in the community. Even so, the merged organization was stronger than the two clinics had been independently, and thus became a more influential force in the community.

Figure 2 identifies several other clinics that have gone through one or more mergers in the past 15 years.

Figure 2. Merger Experience among California CHCs



Source: La Piana Consulting

Merger Discussions That Do Not Result in a Merger

Some clinics have considered or discussed merging with another CHC but chose not to. Their reasons for deciding against merger are typically rooted in some form of self-interest on the part of the board, the administration, or both. In one example, the two boards were unable to agree on which CEO would serve as the leader of the new organization. Additionally, both clinics so strongly believed that their business model was the "right" model that they were unwilling to consider alternatives. In another case, two struggling clinics conferred for a year until each board decided that their own clinic was the only one uniquely positioned to adequately serve the community. Both are now focused on how to survive independently, though it is unclear whether they will be able to do so.

Challenges and Lessons Learned

Among nonprofit organizations, clinics face unique challenges when merging or pursuing other types of strategic restructuring. While merger is seen as an increasingly common strategic option in many subsectors, clinics are often reluctant to consider a merger until they must—which by nature adds pressure to the process. Differences in core values between clinics and private practices can also present challenges, as can dealing with complex licensing and billing issues. Some of these challenges and lessons are further outlined below.

TOO MANY MERGERS ARE BY NECESSITY RATHER THAN BY STRATEGIC CHOICE

Despite their involvement in a clinic merger, several of the CEOs interviewed for this issue brief felt that clinics probably would only consider a merger as an option of last resort. A few of the case studies involved this type of merger, in which the destabilization of one clinic spurred its acquisition by another. The already challenging task of implementing a successful merger is made even more difficult when it starts in the midst of a crisis.

These mergers can be particularly complex if a clinic became endangered through financial or administrative mismanagement. If the acquiring partner is not careful to start with a clean slate, the cleanup of bad books, old contracts, and the like can be both expensive and time-consuming.

PARTNERSHIPS ARE COMPLICATED BY DIFFERENCES IN CORE VALUES OR MISSION

Mergers are more difficult between partners with differences in fundamental beliefs or values, however slight. Because most CHCs have similar missions—to provide medical care to the most vulnerable—this may be less of a challenge in mergers between clinics than in those in which a clinic takes on a private practice or specialty service that is not already part of its portfolio.

Such challenges are not insurmountable but can be deal-breakers if other complications already make the partnership problematic. Technical issues such as finances or staffing arrangements often can be resolved through conscientious effort and communication, but a fundamental difference in core mission typically signals a bad match and is likely to remain a sticking point. Conversely, when partners share a commitment to the same values and ideals, they can more easily build on that commonality to arrive at mutually satisfactory agreements.

NAVIGATING LICENSING AND BILLING ISSUES TAKES PREPARATION AND PERSEVERANCE

Even in the case of a merger that has gone fairly smoothly, securing updated licensing is typically an intensive undertaking requiring tenaciousness in working with HRSA and other oversight agencies. Dealing with gaps in the payment of reimbursements while licenses and permits are transferred requires cash reserves, and the process can take months.

ESTABLISHING (OR REPAIRING) REPUTATION IN THE COMMUNITY IS IMPORTANT

Mergers can serve to enhance or jeopardize an organization's community reputation. In the case of a merger where mismanagement or malfeasance was involved, the surviving entity may have to do some damage control, reestablishing the trust of key stakeholders and the community. On the other hand, an organization entering a new community also has obstacles to overcome as a perceived outsider.

ECONOMIES OF SCALE ARE NOT ALWAYS REALIZED TO THE DEGREE ANTICIPATED

It is commonly assumed that mergers save money through the consolidation of services, administrative functions, etc. The reality is that mergers rarely result in hard cost savings, and even when savings are achieved they can take a few years to materialize. Yet several interview subjects indicated that expansion allowed them to leverage, or spread out, operating (administrative, financial, information technology, human resources, and other infrastructural) costs. While economies of scale can be an attractive motivation, it is critical that such potential be considered alongside other, more mission-related benefits.

Factors Contributing to Success

Although some of the challenges clinics encounter in merger situations are different from those faced by other nonprofits, the success factors, for the most part, are not. Most of the top six success factors cited in a 2000 study of integrations and alliances among social service and cultural organizations in the United States are also among the top success factors cited by the clinic CEOs featured in the examples above.[9] These include:

- Having a staff or board member to champion the alliance and lead the effort;
- Positive past experiences with collaboration;
- An orientation toward risk-taking and/or growth; and
- Positive past relations with potential partners.

Other factors cited by both clinic CEOs and the 2000 study include careful planning, flexibility in the face of unforeseen challenges, and attention to communication.

STRONG LEADERSHIP IS ESSENTIAL DURING TIMES OF TRANSITION

One of the most significant contributors to a successful merger effort is skilled leadership. This includes having a strong CEO to lead the process, as well as a strong management and operations team to assist with implementation. Some found that having key leaders already embedded in the partner organization was helpful in effecting a smooth transition. Others spoke about the sheer amount of time and attention needed to devote to the process and the importance of having dedicated staff to maintain these efforts.

SUCCESS BREEDS SUCCESS: PREEXISTING RELATIONSHIPS OR REPUTATION SMOOTH THE WAY

Clinic CEOs who have demonstrated skilled leadership in turning their own clinics around and/or have been through a merger before are more likely to be approached and trusted as potential partners.

Some of the merger examples detailed earlier started out as MSAs, which offered the advantage of allowing a period of enhanced discovery and trust-building before the actual commitment to merge.

FINANCIAL AND LEGAL EXPERTISE IS CRITICAL TO THE PROCESS

Several interview subjects cited the importance of conducting a financial assessment when considering a merger. In a few cases, funding had been made available to hire outside expertise to conduct this research, though this seems to be more the exception than the rule. Having highly skilled financial staff in-house can be a critical asset, not only for planning in advance of a merger but in its implementation.

Legal counsel is also important. Every merger should be conducted with a careful eye toward the proper execution of agreements. For some mergers, such as those involving bankruptcy or significant liabilities, legal expertise may be necessary to untangle even greater complexities during the negotiation and transition process.

COMMUNICATION IS KEY TO SUCCESSFUL CULTURAL INTEGRATION

While the technical aspects of a merger can be challenging, care must be taken not to overlook the "softer" aspects of organizational integration. Whether it is a merger, an MSA situation, or simply the sharing of administrative staff, in *all* situations communication is key. "Communicate early and often" is common—and very sound—advice.

Recognizing and addressing cultural and organizational personality differences is also important. An organization taking on administrative functions for another needs to be conscious of the change that implies for those affected, and that doing things differently is not always easy. Such concerns are even more acute after a full merger. However, while some deliberate effort toward cultural integration is highly recommended, full integration is not always necessary, or required—the parent organization can provide the common vision and identity while individual clinics maintain their unique culture reflecting their community.

Barriers to Merger

On the whole, there is little evidence of a national trend suggesting that clinics are merging with any great frequency. There does seem to be greater openness to sharing some level of administrative functions, but even this is approached with caution. Given the fragility of the many small clinics struggling to survive, what are the barriers to considering more formal and highly integrative models of strategic restructuring, such as merger?

PERSONAL INVESTMENT OF FOUNDING CEOS AND/OR BOARDS

Among consortia directors interviewed for this issue brief, the most frequently cited barrier was the sense of ownership and emotional attachment that goes with leading a CHC. This is thought to be an issue particularly with CEOs; many have been in this field (or even in their current positions) for as long as 30-plus years, and in some areas there has been little turnover in leadership since the 1970s. These founding leaders have great personal investment in their organizations. This level of dedication is seen not only among CEOs, but among their boards as well. There is a tendency in nonprofits of all types to build an organization around specific personalities when leadership has been stable for a long time; this can be a limiting factor when decisions about the ultimate good of the organization are influenced by the personalities involved. Change becomes harder—especially major change, such as the prospect of merging with another entity.

COMMUNITY IDENTITY AND ORGANIZATIONAL CULTURE

Many CHCs were born out of community-driven efforts, and their organizational identities are tightly linked with the local community—cultural and ethnic as well as geographic. There are very real concerns about the prospect of ceding control to an outside entity, and it is human nature to want to protect one's turf. The history of merger and partnership efforts between clinics and hospitals[10] has done little to assuage such concerns, as clinics often did not fare well in dealing with these larger partner entities.

Like most nonprofits, clinics tend to see themselves as unique, and each has its own organizational culture. This defining culture may or may not be tied to the culture of the primary population served. In either case, cultural differences among clinics are often seen as barriers to a merger, as ideally the merger would result in a combined identity and common way of operating. No one is eager to risk giving up their identity and autonomy.

JOB SECURITY

In a merger, it is possible that some staff positions will be consolidated and some existing personnel will be terminated. Often, one or both of the merging CEOs will have a new job description or be let go. Fear of job losses can keep leaders from pursuing merger opportunities. Additionally, clinics are also community employers and may be reluctant to merge due to the risk of job losses, however minimal, in the local community.

STIGMA OF MERGER

For the smaller or more vulnerable clinic, a merger may be perceived as a takeover, which can feel threatening and unpleasant. It is very important that both parties feel respected in a merger process and that the partners establish a basic level of trust so that neither feels like a victim. Although many mergers may feel (and in fact may be) unequal, both parties should be credited for bringing something to the table, just as both are receiving a potential benefit.

Some consortia directors indicated that although a consortium may be in an ideal position to recognize and point out opportunities for collaboration, it can be awkward to raise the issue with member clinics because of the consortium's role as a support to all of its members. Consortia executive directors are supervised by their boards, which are composed of member clinic CEOs, thus making it challenging for consortia staff to endorse potentially controversial concepts or actions involving those clinics.

INABILITY TO RECOGNIZE CRISIS OR IDENTIFY OPPORTUNITY

Few clinic CEOs have come to this work with formal training in health care administration, and thus many have not been equipped with advanced financial, business modeling, or negotiation skills. Likewise, few CHC boards either possess these skills or demand that they be applied in the clinic context. Not only has the clinic sector been dominated by a values-driven ethos that suggests that "doing good" is "good enough," but many CHCs have survived for the bulk of their existence on thin margins. These two dynamics together may have desensitized some clinic leaders to the level of financial or managerial crisis under which their organizations are operating. Failure to recognize the severity of these threats until it is too late contributes to the "emergency merger" phenomenon illustrated in a few of the case study examples above.

The flip side of this barrier to merger is that without a business-oriented perspective, or filter, through which to view the clinic's financial model, organizational capacity, and evolving market position, CEOs and boards may fail to recognize strategic partnership opportunities. Knowing when and how to seize such opportunities is an important competitive advantage.

Potential for Strategic Restructuring Among CHCs

Given what has—and has not—been under way in California with regard to strategic restructuring among CHCs, it appears that there may be some untapped potential. Clinics seeking to strengthen their position now and remain viable and vital in the years to come might be wise to consider strategic restructuring as one of many tools they can apply. The benefits of doing so will vary by situation, but can include:

- Increased administrative capacity and quality;
- Economies of scale in purchasing, staffing, and/or service provision;
- Ability to serve a greater number of patients and/or broader geographic area;
- Ability to offer higher-quality and/or greater range of services;
- Increased access to more sources of funding;
- Access to Federally Qualified Health Center status (if not previously held);

- Expanded options for succession planning and leadership development;
- Enhanced visibility and a more prominent role in the community; and
- Stronger competitive position for contract negotiations or other advocacy efforts.

Each CHC must carefully consider its situation when evaluating potential partnership opportunities. While each type of strategic restructuring offers benefits, one might be a better fit than another under specific conditions or at a given point in time. Table 1 is an analysis of just some of the potential pros and cons of each.

Table 1. Pros and Cons of CHC Partnership Opportunities

TYPE OF PARTNERSHIP	PROS / BENEFITS	CONS / CAUTIONS
Administrative Consolidation One or more CHCs contracts with another to provide human resources and financial management services. or **Joint Programming** Two or more CHCs work together to evaluate, select and implement a centralized disease management system.	• Allows each partner to maintain a relatively high degree of autonomy while still increasing administrative capacity and quality and realizing some economies of scale. • Can make it easier to attract and afford higher quality management and administrative staff. • Can provide an opportunity to strengthen relationships and build trust among partners, opening up opportunities for additional collaboration down the road.	• Economies of scale are often difficult to come by, slower to materialize, or not as large as hoped.
Management Services Organization or Joint Venture Corporation Create or utilize the services of an independent organization to provide administrative, clinical, managed care and/or information technology services to a group of clinics. Note: While multiple clinics could band together to establish an independent organization to serve one or more of these functions, an alternative would be to build the capacity of existing organizations to do more of this work throughout the state. Several regional consortia play this role within their existing corporate structures, and several others are considering doing so (see page 4).	[same as above, plus:] • Allows for shared governance of the entity providing the services. • Allows each organization to focus on its core mission and strengths. • An independent organization is often better suited to offer its services to an expanding number of clinics, thus building strength, expertise, and scale that ultimately benefits all participating clinics.	• Consortia have different resources, targeted work areas, and capacity; not all are designed or funded to support this type of effort at this time. • Each member clinic can contract for as few or as many services as they wish; clinics that haven't fully embraced the concept of shared services may underutilize available resources and miss out on some of the benefits.
Merger Two or more CHCs merge into one legal entity, or a CHC incorporates a previously independent private practice into its organizational structure.	• Can allow smaller clinics—or any that are struggling with developing, funding, and supporting increasingly complex systems and structures—to maintain or increase the level of service they provide to their community. • Can better position clinics to compete for patients, contracts, funding, and staff. • Can facilitate a more coordinated system of care within a given region. • Can be an effective means to secure stable and experienced leadership in the face of pending executive transition. • Potential to gain new sources of revenue.	• Must be done carefully to ensure that close community ties are not compromised. • Both the term and concept of "merger" come with negative connotations for many; there is usually much resistance to address and overcome.

Implications and Recommendations

The use of merger and administrative consolidation by California's CHCs and consortia suggests a nominal level of interest in strategic restructuring and presents opportunities to learn from existing examples. It also points to numerous options for educational opportunities and other actions that could serve to advance and elevate this issue among clinics, highlighting strategic restructuring as a more accessible and viable set of options.

Change the Conversation

Perceptions shape our reality. Many mergers are not entered into as a strategic choice, but rather as a last resort, further supporting the notion that mergers are somehow evidence of failure. It is important to shift this paradigm to acknowledge that merger can be an opportunity. Even for clinics that are not in a position to use a merger to expand their service area or scope of programming, partnership may still be a viable strategy for best serving the needs of the community, as a way to "do more with less." Even if this means the organization would no longer exist in its current form, its services and employees could endure—it is not losing if the community wins.

The effort to open this dialogue could be supported by information that helps clinic CEOs and board leaders begin to assess their position and to learn about mergers that were proactively planned and successfully approached. For example, it may be helpful to feature more in-depth cases in which mergers were approached strategically, sought out from an assumption of opportunity rather than necessity, and were given time to unfold at an intentional and reasonable pace. Tools could be developed to enable CEOs and boards to assess the strategic opportunities posed by various partnership options. One tool in which some interview subjects expressed an interest is a study revealing the potential return on investment as a result of merger or partnership—not only cost savings, but other, more qualitative benefits—to help inform strategic choices.

Educate Clinic Leadership

In some cases, the CEO is open to strategic restructuring options and the board is not. In other cases, it may be the CEO who keeps the board sheltered from the organization's reality or from needs or opportunities that might be viably addressed through merger or partnership. Both CEOs and boards need access to quality, accurate information to make the best decisions for their organizations. This could be supported by augmenting existing executive training opportunities with board development training and educational opportunities that include discussion of strategic restructuring options. Ensuring that CEO and board training opportunities build awareness of organizational capacity and business model issues may help move longtime leaders away from personal attachments and interests and engage them more objectively in addressing the question of how best to serve the community.

Explore a Range of Educational Opportunities

Other resources and tools that may be useful in positioning partnership as a strategic option for clinics include:

- Develop shared terminology. Identify and share language (including neutral terms that better reflect the benefits of collaboration) that can be used to discuss a broad range of partnership possibilities in a less threatening way;
- Support research, presentations, trainings, and targeted technical assistance to help clinic leaders plan. Presentations may be held in familiar forums and venues, such as association events, and include panels featuring clinic leaders who have been through strategic restructuring themselves;
- Develop tools tailored to CHCs that can walk CEOs and boards through the various partnership

configurations, pre-merger assessment, planning, implementation, and post-merger activities; and

- Maintain a pool of consultants available to help guide the merger process, partnering with clinics in this work so that the organizations develop full ownership and buy-in.

Support Assessment

Several interview subjects cited the importance of pre-merger financial, human resources, legal, and public relations assessments, or other viability studies to help them make informed decisions. Such assessments often are best performed by an external expert or a third party, suggesting a potential role for funders, consortia, or consultants. However, tools could also be provided to help CHCs conduct such assessments, in whole or in part, on their own.

To further encourage the consideration of strategic partnership as a proactive response rather than a reaction to crisis, tools should be developed to help clinics assess strategic partnerships from an opportunistic approach, identifying the potential benefits. Tools that include the whole scope of potential partnerships would allow clinics to test lower-risk partnerships along the way, perhaps starting with smaller, quick achievements to build trust, and working toward more significant partnerships. Such tools should help clinics select the right level of partnership for their goals at the time.

Support Implementation

In addition to assessment resources and tools, support is needed during the merger negotiation, implementation, and post-merger integration phases. Clinics might benefit from dedicated funds to engage external facilitation for exploratory conversations between CEOs and board chairs, as well as for ongoing patient/stakeholder communications and marketing throughout the merger process and transition. For particularly complex mergers, extra support may be needed for implementation, sorting out finances, contracts, licensing, etc. Finally, to encourage organizations to consider a wide array of partnership options, grant funds might be set aside for testing and/or exploring partnership ideas short of merger.

Support Consortia

Consortia play an important role in modeling collaborative and partnership opportunities and providing various types of technical support to member CHCs. Another way to enhance the conversation around strategic restructuring could be to provide financial support to consortia to ensure that they survive the economic downturn so they can, in turn, continue to help strengthen clinics. Educating consortia leaders about strategic restructuring may help enable them to think through strategic issues with their clinic membership, and may highlight more opportunities for consortia to provide centralized administrative support to member clinics. Training may be needed to help consortia directors have these kinds of conversations with clinic CEOs and/or boards.

Be an Objective Third Party and Help Facilitate Connections

Funders and consortia are in a unique position to be able to offer trusted advice to CHCs, encouraging consideration of new solutions and approaches. They can also suggest potential partners and facilitate connections, not only with other clinics but with others with merger experience, expert consultants, etc.

Explore Incremental Approaches to Partnership

Although mergers are a significant focus of this issue brief, research suggests that other forms of strategic restructuring, short of merger, are probably more accessible and acceptable to many clinics, at least for the time being. There may be potential for high-performing clinics to provide MSA services to smaller clinics to help address pressing financial or other capacity issues, either

to allow them to continue independently or as a precursor to merger.

Facilitate Longer-Term Conversations

While incremental partnerships may be appealing to many in the short term, long-term viability may depend on a more aggressive approach to consolidation. If universal health care becomes a reality, CHCs will find themselves competing more aggressively with a wider range of health care providers. CHCs have many strengths and advantages, including their community ties, ethos of frugality, culture of teamwork, and bipartisan political support.[11] This positions CHCs as central players in any emerging managed care and universal health care system, making it increasingly important for clinics to become advocates for themselves and their communities. To do so, they may need a stronger and more coordinated voice and approach to care. What exactly this might look like in 10 to 20 years is uncertain, but ongoing conversations about the future of the sector should be both nurtured and supported and the widest possible range of options considered.

Conclusion

Given the current economic climate and other pressures—both those that are unique to CHCs and those common to nonprofits of all kinds—creative solutions are needed to ensure the continued provision of critical services to those in greatest need. Strategic restructuring offers a set of options for California's clinics to consider as they look at how to strengthen their organizations and build their capacity to deliver quality health care services. By learning more about these partnership options, CHCs can add tools to their strategic toolbox, enhancing their ability to proactively respond to emerging challenges and opportunities. Although the experiences of clinics and consortia that have already experimented with various forms of partnership offer excellent learning opportunities, more resources are needed to advance and elevate the conversation about merger and administrative consolidation in the clinic context.

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About the Foundation

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

Endnotes

1. Wasley, Paula. 2008. "100,000 Nonprofit Groups Could Collapse in Next Two Years, Expert Predicts." *Chronicle of Philanthropy* 21(4):19.

2. Cortez, A., W. Foster, and K. Milway. February 2009. *Nonprofit M&A: More Than a Tool for Tough Times*. The Bridgespan Group.

3. National Association of Community Health Centers. February 2009. *The American Recovery and Reinvestment Act of 2009: Frequently Asked Questions.*

4. Adapted from Kohm, A., and D. La Piana. 2003. *Strategic Restructuring for Nonprofit Organizations: Mergers, Integrations, and Alliances*. Westport, CT: Chapin Hall Center for Children.

5. Ibid.

6. See, for example, National Association of Community Health Centers. 2008. *A Sketch of Community Health Centers. Chart Book 2008*; Schacht, J. April 2007. *The Future of Community Clinics and Health Centers in California's Safety Net: A Blueprint for Action — 2007 Update*; and Capital Link and the California HealthCare Foundation. March 2009. *California Community Clinics: A Financial Profile*.

7. U.S. Health Resources and Services Administration. *Fact Sheet: Health Center Controlled Networks* (**www.hrsa.gov/healthit/factsheet.htm**). The HRSA Web site has an excellent overview of the types of collaboration possible within integrated service networks. See also *Health Center Controlled Networks Matrix for Collaboration/Integration* (**www.hrsa.gov/healthit/matrix.htm**).

8. Case studies were informed by interviews with clinic CEOs, news articles, and clinic Web sites. Historical information was also drawn from: Wunsch, Bobbie, and Tracy Ream. July 2003. *The Impact of Today's Challenges on the Organizational Structure of California Community Health Centers*. The California Wellness Foundation.

9. Kohm and La Piana, *Strategic Restructuring for Nonprofit Organizations*.

10. See, for example, Sparer, Michael S., and Lawrence D. Brown. July/August 2000. "Uneasy Alliances: Managed Care Plans Formed by Safety-Net Providers." *Health Affairs* 19(4):23 – 35.

11. Smith, Mark. February 19, 2009. "How Should CPCA Prepare for the Future?" Presentation at CPCA Strategy Meeting.