California HealthCare Foundation

Testing the Waters:
Five California Clinics Explore Strategic Restructuring

CASE STUDIES

February 2013

Introduction

California's community clinics are facing economic pressures that are threatening the way they do business. Although health reform holds promise for these institutions, it also poses challenges in the near term, as clinics continue to feel the effects of the still-foundering economy and the erosion of the safety net. The next two to three years will test the limits of what clinics' traditional business configurations can bear and may force consideration of new ways to respond.

To help clinics learn about and explore strategies for greater sustainability, the California HealthCare Foundation launched an initiative in 2010 that provided technical assistance to clinics interested in implementing a formal collaboration or restructuring initiative. The five participating clinics — from various parts of the state — included:

- North County Health Services in San Diego
- Mountain Valley Health Centers in Northern California
- St. Anthony Medical Clinic in San Francisco
- The Children's Clinic in Long Beach
- Santa Barbara Neighborhood Clinics

The formal two-year initiative concluded in 2012, although many of the efforts are ongoing. This report summarizes the project activity in each organization between October 2010 and October 2012 and offers insights on what was learned.

The participating clinics have generously agreed to enable the sharing of their experiences in order to benefit other clinics interested in strategic restructuring. The five case studies follow.

Collaborating to Compete in a Changing Environment

North County Health Services (NCHS) in San Diego County operates 10 fixed-site clinics and two mobile medical/dental clinics. Of the 60,000-plus unduplicated patients served annually, just over half are on Medi-Cal and approximately one-third are uninsured. NCHS is a federally qualified health center (FQHC).

PURPOSE

NCHS leadership saw the initiative as a way to better position the clinic for health reform by using strategic partnerships to leverage existing strengths and expand its market share. The goals would be to serve newly insured patients through expanded Medi-Cal coverage as well as those procuring coverage through the health benefit Exchange. NCHS set about seeking potential partners to acquire managed care capacity to help it attract, retain, and meet the needs of a larger and more diverse client base.

Initially, NCHS planned to explore clinical integration with two other community health centers. Although all three organizations were in favor of a partnership, competing priorities (including electronic health records (EHR) implementation and a patient centered medical home demonstration project) compelled the

two other partners to shift their attention toward other projects.

Based on its strength as a large regional system of clinics, NCHS changed tack and began to look for a private-sector partner for integrated care delivery. Irma Cota, NCHS president and CEO, characterized this strategy as an effort to meet the triple aim of better care for individuals, better health for populations, and reduced per capita costs: "I wanted a private partner that had the experience, reputation, and provider groups and systems in place that would help us attract and retain patients, share and compare quality outcomes, and coordinate care in such a way so as to yield significant savings."

PROCESS

NCHS was proactive in building its capacity to manage change initiatives. Cota hired a vice president of strategic initiatives because "I knew I didn't have the bandwidth on my own to think about getting into new ways of doing business and how to pay for that."

After working with consultants to clarify strategic goals and define a process for identifying and reaching out to potential partners, NCHS conducted a series of stakeholder interviews to gauge the interest of local health organizations and open up the conversation. Organizations that expressed interest during the initial interviews were sent a Request for Information (RFI), as a more formal step toward getting to know potential partners. The response was mixed, said Cota: "We got a number of RFIs returned, but most didn't seem like they understood what we were asking for. No community clinic had ever sent them an RFI before."

NCHS received a promising response from a large integrated health delivery system, and the two parties engaged in exploratory discussions that, although they have not yet resulted in a collaborative agreement, have yielded valuable lessons for NCHS. Both organizations were interested in some of the same strategies, such as forming a narrow network for the newly insured. However they had differing visions of partnering. The system would have considered NCHS as simply another physician member in its independent practice association (IPA). The takeaway for NCHS was that it would need to be more deliberate about conveying the unique value it brings to the table.

Subsequently, at least two other large health systems have responded to the RFI, and NCHS is meeting with each of them to explore options for partnership. Although it took longer than anticipated for these opportunities to develop, and it remains to be seen whether any will result in collaboration, Cota maintains that "the story is not over." NCHS remains committed to exploring collaborative strategies.

TAKEAWAYS

This is pioneering work. One of the top takeaways for NCHS is the fact that it is treading new ground. It is a bold move to approach large hospitals and health delivery systems and ask to be considered as a partner; this has not been done before. Sharing the NCHS rationale, Cota said, "We have the population expertise. The private sector, to date, has not wanted that population, but now that there will be low-cost insurance options, it may not be the physicians in the existing IPAs that take those patients on." This should make community health centers an attractive partner, but there is still a question of what more they can bring to the table to capture partners' attention.

Partners have competing demands. It also became clear that hospitals and other large health systems may be no better able to take on new strategic partnerships than are clinics. Kitty Bailey, NCHS vice president of strategic initiatives, said: "I went into this thinking the hospitals had access to tremendous bandwidth and that we as clinics were at a disadvantage because of our limited resources. Now I realize they're in the same boat that we are. At this time, they're just not in the position to be

able to take on something new. They've got a lot already going on."

Relationships come first. Although NCHS took care to reach out to potential partners initially through exploratory conversations, the more formal information gathering and sharing process of the RFI did not seem to result in specific and actionable ideas. This caused Cota and her team to reflect on the importance of cultivating a relationship before taking on the more technical aspects of different partnership options. "Ideally, we would have started with the relationships, then talked about what could make us successful," she said.

Tend to the internal part of the process. Cota said that she could have used more support to attend to communications within her organization. "The biggest challenge is internal. It opens up a lot of questions and anxiety," she said. Even when the vision is shared, employees are still concerned about the timing of rolling it out and financing. "People have questions like 'What will it mean for my job if it leads to merger?'" Cota stressed the importance of communicating with the team during these kinds of planning processes.

It takes time. NCHS began its planning phase in August 2011 and had its first substantive conversations with a potential partner a year later. Cota stressed that the process is lengthy because it is not simply about "matchmaking." It demanded that NCHS think about its organizational strategies and how collaboration would fit with achieving its overall goals. Cota said, "It's a much slower process than I thought, and surprising that the wheels move so slowly. Although each meeting brings a new insight…and along the way we continue to get clarity."

NEXT STEPS

NCHS is using what it has learned to inform its next steps. It will continue conversations with potential partners, and also consider conducting a feasibility study or developing a business case to demonstrate the clear and compelling value it can bring to a private-sector partner. Said Bailey, "We need to take the responsibility for coming up with options that they could consider. We could go to them and say 'the partnership opportunity that would benefit both of us looks like this…' and then outline specific recommendations on how a potential partnership could work."

> *"We have the population expertise. The private sector, to date, has not wanted that population."*
>
> — IRMA COTA, NCHS

Exploring How to Be Stronger Together

Mountain Valleys Health Centers (MVHC) operates six clinics in rural northeastern California, serving more than 13,000 unduplicated patients annually over a 6,000-square-mile area. Approximately 44% of its patients are on Medi-Cal, Medicare, or another public program, and 23% have no insurance. MVHC is an FQHC.

PURPOSE

MVHC and other providers in the region face the challenges of serving a rural population separated by great distances. They must provide a broad range of services despite the small patient base and limited earned revenue. Providing access to specialists is particularly difficult in these remote communities. In the midst of a national and state budget crisis threatening rural health programs, these providers are being severely stretched. As a leader in the local health care community that has successfully used strategic restructuring in the past, MVHC sought to reach out to its peers to explore collaborative solutions.

MVHC applied to the initiative for consulting assistance with exploratory discussions with a small family practice clinic to determine how their combined strengths might create a stronger foundation to sustain services to the community. The aim was to leverage resources while bringing together two very distinct organizational cultures. Ultimately the clinics did not identify a mutually desired partnership opportunity.

Still committed to examining collaborative strategies to strengthen the fragile local safety net, MVHC revised its approach. "We decided to look more broadly," said CEO Dave Jones. Instead of singling out one potential partner, MVHC sought to convene a group of providers sharing responsibility for providing services along a rural portion of the highway State Route 299. The "CA299 Health Collaborative" brought MVHC together with another FQHC, three critical access hospitals, and a rural health clinic (the same family practice clinic with which it had initiated conversations earlier) to weigh a wide range of potential collaborative options.

PROCESS

The CA299 Health Collaborative participants met with consultants to clarify their goals and determine what kinds of partnership opportunities would most interest them. Although the members of the group already had good relationships with one another, this was the first time they came together for a shared purpose. It took some time for them to get used to working in this new context before they could begin surfacing their needs and interests.

Eileen Tremaine, program director* for the CA299 Health Collaborative, noted that each organization likely came with different ideas of what should happen, and that the focus in fact shifted over time: "Initial goals were to see where the organizations could work together to support the partner organizations, especially the hospitals," she said. An early idea was to merge support services such as HR and IT. "But where we ended up was to look at the needs of the population and how we could collectively meet those needs, and in turn make the organizations more stable."

After examining several collaborative options, the group agreed to pursue a joint effort to bring specialists to the area to provide services at the local hospitals. The CA299 Health Collaborative determined that if combined efforts could attract more specialists, not only would patients be better served, but local providers could grow their revenue by maximizing existing capacity currently being underutilized for lack of specialists.

The Collaborative has a letter of intent formalizing its agreement. As currently conceived, a six-month planning process will be used to determine what specialties to recruit for, the willingness of specialists to participate, the number of procedures that can be provided within a given time frame, and the kind of structure the collaborative may need to put in place to successfully implement the program.

> *"The bottom line is that collaboration out here in the rural areas is vital to our survival. We have to be able to work together and be cooperative as opposed to working in competition."*
>
> — DAVE JONES, MVHC

*A new position funded by a 2012 grant from HRSA's Office of Rural Health Policy.

TAKEAWAYS

Relationships are built face to face. For this group, meeting in person was no small feat. For some, it meant driving up to 70 miles each way. But, as Tremaine noted, this is important investment in the process: "The in-person meeting is very helpful…to have that connection… even allowing for time before and after the meeting for informal networking." Jones agreed, "The networking opportunities are really just as important as the meeting content." Trust-building is an essential part of any collaborative effort, and for this group of executives who are geographically isolated from one another, having face time was especially valuable.

Maintaining momentum is critical. One of the challenges MVHC reported was that of keeping the momentum going in the face of external factors. The project hit a lull while waiting for more information about another planning effort in which some of the collaborative members were also participants. Tremaine recalled: "There was a six-month time frame where we didn't really know whether to move forward or not, and this hurt our momentum." Although the potential that one process might inform the other argued for some caution moving forward, it may have been just as risky to slow down. "The likelihood of anything developing out of these collaborative efforts is hard enough," Tremaine asserted. "Once you lose momentum, it feels even more difficult."

It is an experimental, learning process. In the beginning of an initiative, generating ideas and options for collaborative strategies is important. Then, there is a period of narrowing down the possibilities. "We almost had more 'ah ha's' about what we learned we couldn't do," noted Jones. "We were looking at things like pooled self-insurance, where it turned out we didn't have enough employees to do it…things like that." This learning process also entailed some "letting go," Tremaine explained. "Don't get attached to your ideas," she said. "Come in with an open mind, and be prepared for your ideas to not necessarily survive the meeting."

NEXT STEPS

The CA299 Health Collaborative is moving forward in exploring efforts to bring more specialty care to the community. It will be seeking funds to support research into the project's feasibility and ultimate design. "The need for information over this next phase of work is huge," Tremaine said. "It will definitely require the support of consultants who have knowledge and can help us move it forward in a way that makes it whole, sustainable, and doable."

Assessing Whether Collaboration Is the Right Strategy

St. Anthony Medical Clinic (SAMC) operates one clinic in San Francisco's Tenderloin neighborhood, serving approximately 3,000 unduplicated patients annually. Its patients are uninsured and most are ineligible for Medi-Cal or Medicare; one quarter are homeless. SAMC is pursuing FQHC status.

SAMC leadership is acutely aware of the range of unmet need, and is open to partnering with others to provide access to comprehensive and financially sustainable health services. The clinic initially requested technical assistance in exploring how it might work with a local FQHC to offer more integrated services through a network approach. When this potential partner declined the opportunity, SAMC readjusted its scope and asked that continued consulting support focus on developing a referral relationship with a women's health services clinic. SAMC saw the opportunity to provide primary care services to clients of the women's clinic, while also being able to expand the scope of services available to its patients through referrals to the women's clinic.

The potential partnership between SAMC and the women's health clinic faced a difficult hurdle. SAMC is governed by the St. Anthony Foundation, a faith-

based charity founded and led by Franciscan priests. The prospect of developing a referral partnership with a women's health clinic in a progressive community like San Francisco demanded that SAMC consider the potential tension with its parent organization's values regarding reproductive health services. SAMC leadership determined that this would require an internal conversation that was too important to rush into; it is taking the opportunity to step back and consider the possibility of more modest opportunities for small-scale collaboration.

Although SAMC is not pursuing a collaborative relationship as originally anticipated, the initiative gave it access to consultants who could help its leadership identify and think through critical questions about organizational readiness and partner alignment or fit. Strategic restructuring may not be the right strategy. SAMC will continue to seek out ways to better meet the needs of its clients in a way that maximizes limited resources and ensures that those services remain available for the community.

Determining the Mutual Benefit of Collaboration

The Children's Clinic, Serving Children and Their Families (TCC), located in the greater Long Beach area, operates eight health centers, including three school-based health centers. It serves more than 30,000 unduplicated patients annually; more than half are on Medi-Cal and approximately 41% are uninsured. TCC is an FQHC.

PURPOSE

TCC has a strong relationship with a well-respected regional hospital, on whose campus its main clinic has been located for more than 30 years. TCC approached the initiative eager to develop an emergency department diversion and hospital discharge program in partnership with the hospital. Cognizant of the changes in payment structures and other impacts of health care reform, TCC saw this as an opportunity for better population management, according to COO L. Jina Lee Lawler. Technical assistance was requested to research program design models and to develop projections of potential cost savings.

TCC had recently negotiated a contract to acquire two new clinic sites that it would finance with a forgiveness loan from the hospital, a loan that was provided in exchange for the development of an ED diversion program. Beyond implementing the program, a secondary goal of this effort was to assess the value of the program relative to the value of the loan.

PROCESS

Development of the ED diversion and hospital discharge program was delayed for several weeks while licensing was secured for the two new clinics, which slowed momentum. It was also a challenge for TCC and the hospital to carve out staff time to plan the program, given the many other demands on their schedules. However, the partners were ultimately successful in negotiating a plan for a patient referral program that continues to evolve.

Originally, the program was to have served two types of patients: non-emergency patients seeking care at the ED, and inpatients being discharged who have no primary care home. For both, TCC would provide a more appropriate source of health care that might help keep these patients from re-entering the hospital. Soon after the pilot was launched, however, TCC discovered a third source of referrals. Several specialty physicians at the hospital had begun referring patients who needed a primary care provider. "When specialty doctors found out we had the capacity, they wanted to give us some of their patients, too," explained Lawler. She noted that while this was an unexpected development, it also reinforced the need for (and value of) such a referral program.

The diversion and referral program was launched in July of 2012. It is currently a small scale initiative; TCC only has the capacity to receive two patient referrals a day

from the hospital, a small fraction of the ED's patient volume. However, Lawler pointed out that this modest scale had been helpful during the initial planning and pilot phase: "Because our numbers were small, we could control the variables and come up with a great program," she said. Lessons learned from the pilot phase have helped TCC and the hospital refine the protocols guiding the program's implementation moving forward.

The partners recently formalized how they will track and share data on patients served, and identified the metrics they will use to gauge the program's impact and value. TCC's work included researching similar referral programs to learn about cost savings, but results have been largely undocumented to date. Thus, the clinic is keen on the opportunity to track and share its own data to inform the field. Lawler said that hoped-for next steps include a six-to-12 month longitudinal study to capture the full scope of cost savings.

TAKEAWAYS

Know the goal. Although the primary motivation for creating this program was to "provide the right care, by the right provider, at the right time," it is also part of the terms of a sizable loan. This dual purpose makes sense logically, but also subjects the program to different sets of expectations. The primary purpose of the diversion and referral program is to reduce as many avoidable visits to the ED as possible and provide a medical home to patients who have none. On the other hand, it is also a means to discharge a debt, a much shorter term goal. TCC is nearing a level of service sufficient to fulfill its commitment to the hospital, but the long term goal remains to bring the new program to even greater scale.

Build in time for learning. Before fully launching the program, the partners ran a pilot test, which revealed a great deal about what it would take to implement and their readiness to "go live." Things did not go smoothly in the pilot, which could have discouraged both parties. But instead they accepted it as a learning opportunity to identify the additional preparations they would need to run the program effectively. Fortunately, they had allowed themselves that time to do so.

Scale matters. The impact of this program is still limited by its small scale. Although TCC is making a significant difference for individual referred patients, its current capacity is too small to substantially reduce the number of non-emergency patients seen in the ED. The program's benefit to the hospital, and thus its value relative to the loan, will be greater if it can be expanded to serve more patients. Achieving this greater scale will also help the program to attract more attention and buy-in from both partners, making it a collaboration that is truly sustainable over the long term.

> *"I'm not sure the hospitals and private providers really understand what we can do to save them money. We need to be able to show the value add."*
>
> — L. JINA LEE LAWLER, TCC

NEXT STEPS

Although the program is still in its infancy, the hospital is confident in its value in exchange for the loan, and TCC's Lawler noted that "we may even be working out the loan forgiveness a bit earlier than expected." More importantly, patients served by the program are getting not only currently needed care, but also preventive services.

TCC is beginning to explore the possibility of a partnership with mental health providers to be able to help the ED with patients with mental health issues. In the meantime, Lawler sees great potential in this model.

"Ultimately," she said, "it is about patients having a medical home and what a medical home can do."

Collaborating to Create Something New

Santa Barbara Neighborhood Clinics (SBNC) operates three medical clinics, a dental clinic, and a health promotion center. It serves 17,000 unduplicated patients annually, 60% of whom are beneficiaries of Medi-Cal or other public programs. SBNC is an FQHC.

PURPOSE

SBNC is not new to strategic restructuring; it was created in the late 1990s through the merger of three existing medical clinics. Its leadership is keenly attuned to potential partnership opportunities and new ways of doing business. It has relationships with numerous other health care providers and community-based organizations, and is eager to explore ways to engage in collaborative action.

SBNC approached the initiative with several ideas in mind. Initially, it requested support for two areas of work: to negotiate a partnership to establish a new clinic location, and to explore opportunities to strengthen its relationship with a large health system. The new clinic location would enable SBNC to increase access to services in an underserved area of the county, if a partner could be found to provide the space at low or no cost. Partnering with the hospital was seen as offering an opportunity to enhance and expand services while streamlining operating expenses.

After further assessment, SBNC submitted a follow-up request concentrated on developing a collaborative program with the hospital. Although establishing the new clinic was a goal to which SBNC was still strongly committed, it was not a match for the potential partners SBNC had in mind. SBNC will continue to pursue this possibility with other partners that may emerge. In the meantime, it has focused on developing a primary care referral project to provide services to non-emergency patients coming to the hospital's ED. SBNC has also initiated conversations with the regional health authority and third-party Medi-Cal provider to seek opportunities for savings or incentives.

PROCESS

Early in the second phase of the initiative, SBNC experienced a major staffing change that demanded the organization's attention and delayed its partnership discussions. The resignation of its medical director (CMO) was, in retrospect, a disruptive opportunity. The hiring process enabled SBNC to think deliberately about the role the new CMO might play in these kinds of strategic efforts. Then-CEO Cynder Sinclair said that, ultimately, "it ended up being a real benefit," after all.

At about the same time, two new members — both physicians — joined the SBNC board. Involving them in the conversations with potential partners lent additional credibility to its position. One of the new board members had been in charge of a hospital ED for many years, making him a particular asset to the discussions with the hospital. An added benefit of involving the physician board members is that they were able to report back to the board on progress being made, from their own first-hand perspective.

Even with such advantages, the process itself (and the trust that must be built for it to succeed) took time. However patience and perseverance paid off. Sinclair explained that committing to carving out space for these conversations to unfold was an important part of the process: "Our presence at those meetings, and inviting the creativity to take place, has gotten [our partners] to think in new ways…has given permission for that and encouraged that."

SBNC is now partnering with the hospital to develop and implement the primary care referral project, which helps shift non-emergency cases out of the ED and to the more appropriate clinic setting; it also gets patients

assigned to a primary care provider. For patients that are already assigned, the program seeks to learn why they are choosing the ED instead. Sinclair said that if the program is successful, it "will send us more of the patients that we want and that the hospital doesn't want."

Conversations with the Medi-Cal provider are continuing to evolve. Sinclair observed: "We know them well and work with them all the time, but the idea of involving us in some of their creative ideas is sort of a new thing for them." She is hopeful about this effort because this partner can offer real financial opportunities for SBNC that can help it to do even more for the community.

> *"Begin by understanding the other organization's frustrations and then responding with even a small idea.… You begin to lay a foundation of trust — trust in the fact that you're serious, you'll follow through, and that you'll really do something."*
>
> — CYNDER SINCLAIR, SBNC

TAKEAWAYS

Allow time for trust to develop. "A lot of it just takes time, especially in the health care field where people are used to doing things a certain way," said Sinclair. "But because we got the ball rolling and have continued to follow up with them, some of these talks have evolved into some real possibilities. If you keep meeting with people, you build credibility. They feel they can count on you to be there and follow through, and will likely be more open to new ideas."

Avoid getting too formal too fast. "At the very beginning of the project, [the consultant] gave us a detailed letter of intent we were going to have everybody sign, but when I showed it to our potential partners, they balked because all of a sudden 'things got real.' In this field of such regulation, people are very wary… they're saying 'this is going to have to go to our legal department.'" Sinclair advised being flexible about using a simpler LOI and to be casual with potential partners before the LOI stage. "Meet over a cup of coffee," she advised. "Then you can ease into an LOI when you know there's a need and to help you get on the same page. To move forward, back into it."

Manage the urgency. "There's a lot of complexity and turmoil in the health care industry today," Sinclair said. "And the tendency, when in turmoil, is to focus on things that are both urgent and important." This can make it difficult to generate and maintain momentum for the kind of planning that collaboration requires. She added, "I had to intentionally take one step at a time toward the grant parameters. This has also meant reminding myself that I don't have to do the whole thing in one day."

Work with the right people. For Sinclair, sharing the responsibility for moving collaborative conversations along was a key to success. By working with a small team of trusted staff and board members, and providing them with clear expectations but plenty of flexibility, she was able to encourage their creativity and they were able to make things happen. She recognized that "as a CEO, sometimes you have to be there [at meetings], but other times you don't." Connecting with the right people on the other side of the table is also important, she added.

NEXT STEPS

Sinclair said the initiative "opened up possibilities that weren't there before, and we're pursuing them to see where they might lead." SBNC is meeting with the hospital to add detail to and implement the patient referral program, and with the Medi-Cal administrator

to identify opportunities and next steps. She noted that as a result of the meetings with the hospital, it found a grant that will be applied to their collaborative work. "It never would have happened before," she said. SBNC is also optimistic about finding a partner to facilitate its new location, which could involve a private/philanthropic collaboration.

Lessons Learned

Ultimately, four main themes emerged regarding the challenges and opportunities facing California's community health centers and how they can become more strategic and sustainable.

The Urgency Dilemma

For organizations to consider a major change like strategic restructuring, they first need to feel a sense of urgency. This may mean reaching a tipping point where the pain of the current situation is greater than the anxiety of the unknown future. For California's primary care clinics, things have been growing increasingly uncomfortable, but conditions are not yet perceived by many as critical enough to warrant making a structural change. The five clinics taking part in the strategic restructuring initiative, by their participation, signaled their openness to change. But even among this cohort, the lack of a strong sense of urgency contributed to delays getting underway and

Leading Change: Seven Questions for Executives on Readiness

Clinic leaders will want to consider the following questions before embarking on strategic restructuring efforts.

1. *Do you have a solid relationship with your board?*
   The board's participation and buy-in are critical to any strategic restructuring effort. Having a relationship of mutual trust and good communication will sustain your efforts throughout the process.
2. *What is your level of risk tolerance?*
   Relatively few community health clinics have engaged in strategic restructuring, and none that are exactly like your organization. You may be trying something that doesn't have an existing model, making you the trailblazer.
3. *Are you ready to make difficult choices?*
   Leadership is all about being able to make the tough call, but rarely more so than in a strategic restructuring process. Your intentions may be called into question by your partner organization or by your own staff and board, and you will need to be able to manage conflict.
4. *Can you put your own ego aside and not take things personally?*
   The success of a strategic restructuring effort does not rest on one person's shoulders alone. However, you play a pivotal role as a leader and may have strong feelings and reactions to the decisions being made. It is important that you be able to recognize your own emotions and keep them out of the way of the process.
5. *Are you a good communicator?*
   The key to successful partnerships is communication. You will be looked to not only for your technical expertise and decisionmaking, but for the soft skills you bring, such as the ability to communicate well with staff and other stakeholders.
6. *Are you supported by a strong operations team who can assist in planning and execution?*
   The degree to which management or other key staff are involved in developing the partnership will vary, but when it comes to implementation these are the individuals you need on your team. Paying attention to this technical capacity is important for success.
7. *Do you already feel overextended?*
   Strategic restructuring demands that you bring your "A game," as a leader and as an organization. If you cannot devote the time, attention, and resources to providing the direction and hard work to support it, you may want to postpone until you can reprioritize your other work to make room.

ongoing challenges to momentum. Part of the problem is that the sector is in such a state of flux that clinic leaders are under numerous, often competing, demands.

One Strategy Among Many

Strategic restructuring is not always the right solution. In order to determine its best strategy, an organization first needs to clearly define the problem it is trying to solve. When the initiative was launched, several of the applications focused more on strategic planning than restructuring. This indicated an appetite for assistance thinking through strategic options, where the initiative had assumed that clinics had already gone through that process to identify partnership as a desired course of action. Working with the five groups selected to participate in the cohort demanded significant time defining the problem and "trying on" various options.

> *"We had some doubts that we'd find something that everyone could benefit from, but what we learned is that we can find those things. There's always some common ground."*
>
> — EILEEN TREMAINE, MVHC

Money Matters

Organizations that are best able to leverage strategic restructuring are those that approach it from a position of strength. On one hand, strategic restructuring can help clinics become more sustainable over time by consolidating administrative functions, expanding successful programs and services, and otherwise leveraging a larger pool of resources. On the other hand, clinics that are already in poor financial shape are not well positioned to participate in a planning process and may not be seen as a viable partner.

Before inviting clinics to engage in strategic restructuring conversations, it is important to assess and understand their financial status. As with any partnership, it is important to consult with key funders about any potential impacts; for community clinics, this can mean checking with an array of funding sources and regulators to identify implications with respect to reimbursement rates, licensing, and corporate structures.

If the future means that clinics will have to grow their capacity to participate in the expanded health care market, those clinics need to have a certain level of financial robustness. Clinic leaders and funding organizations might consider the role of financial assessment and business model awareness, in addition to strategic restructuring, as part of preparing for this future.

Testing New Ground

Collaborations among community health centers pose just one option. Increasingly, clinics are looking for ways to partner with hospitals or integrated health systems. However, getting the attention of these larger organizations can prove a challenge. In trying to position themselves as partners capable of helping health systems absorb the influx of newly insured patients, clinics have to "sell" themselves, and be ready to demonstrate the value they can bring to the table.

Clinics often face a "David and Goliath" mismatch in terms of their negotiating power; yet many hospitals are no better prepared to engage in strategic conversations about collaboration than clinics are. Both are pressed to the limits of their capacity, trying to determine what the future will bring, and struggling to survive the present. Working under these circumstances, it can be difficult to tap into people's creativity. This, and the time it takes to build trust among potential partners, means that strategic restructuring conversations require patience and

perseverance. The greatest success of this initiative is the ongoing conversations that are now beginning to bear fruit.

What's Next?

Strategic restructuring is not just about collaboration or the opportunity to be more efficient with limited resources. It can also help health clinics to achieve a more competitive position and assert their community leadership.

To tap into this transformative potential for their organizations, leaders must articulate a vision and inspire their organization. For clinics seeking strategic restructuring or collaboration, executives must be upfront about the challenges the organization faces and how a successful partnership can ultimately serve the mission. Maintaining a laser-like focus on the mission is essential to ensure that the inspiration behind the strategy is compelling enough to see the organization through the hard work ahead.

The impetus behind this strategic restructuring initiative was the knowledge that the health care market is changing significantly, perhaps even radically. As health reform is implemented, many more consumers will be seeking care and will have their choice of providers. If community health centers are their provider of choice, clinics will need to ramp up their capacity quickly enough to take on this expanded patient base. If they cannot do that, it is unclear how clinics will remain viable in an increasingly competitive environment. Whether or not clinic organizations are ready to consider strategic restructuring, they need to embrace a sense of urgency about their future, take a critical look at their business model, and consider a range of potential strategies to meet the coming challenges and opportunities.

About the Initiative

The California HealthCare Foundation launched the Strategic Restructuring Assistance for California Primary Care Clinics initiative in 2010, engaging a multidisciplinary team of professionals from La Piana Consulting, Garcia Consulting Group, Inc., and HFS Consultants to plan and deliver technical assistance in strategic restructuring for clinics.

The first phase focused on assessing organizational readiness and identifying partnership options. Thirteen clinics applied and five were provided with consulting hours to explore strategic restructuring opportunities. A follow-up phase in 2012 concentrated on guiding each of the applicant organizations in planning and implementing a collaborative alliance.

The lessons from this initiative have been shared with and carried forward into the design of the California Catalyst Fund, which was launched in March 2012 by CHCF in partnership with Nonprofit Finance Fund. The Catalyst Fund is a funder collaborative designed to support clinics in exploring, creating, and/or implementing different forms of partnership. In April 2012, Blue Shield of California Foundation joined as a partner funder. As of January 2013, the fund has accepted 21 applications, underwriting $347,500 worth of direct consulting services in support of 15 projects.

For more information, go to www.nonprofitfinancefund.org.

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.