

# **The Impact of Today's Challenges on the Organizational Structure of California Community Health Centers**

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## I. Introduction and Purpose

This study documents the processes followed by East County Community Health Services and Escondido Community Health Center, both in San Diego County, California, over the course of three years. During this period, these two health centers moved through a multi-phased restructuring plan to become a single organization, now named Neighborhood Healthcare. The study also highlights seven other community health centers, describing how they worked to overcome or alleviate similar challenges. The key method many of the health centers used is a process known as restructuring.

The health centers in this study (as well as many other community health centers and non-profit organizations) confronted a common set of challenges:

- Threats to achieving and maintaining financial stability:
  - Pressures to reduce administrative costs
  - Lack of capital and operating reserves
  - Inadequate financial controls and systems to monitor financial trends, maximize revenue and provide timely and reliable analysis needed to support decision-making and strategic planning
- Lack of organizational leadership resulting from the resignation or retirement of the executive director and/or other executive management staff
- Declining patient caseloads or changing patient and payor mix
- Staff retention and turnover
- Need for more sophisticated management systems
- Lack of board leadership or involvement in appropriate board functions.

Many health centers face similar situations at different times. Others are financially healthy and looking for new opportunities to meet the needs of their communities. Pressures from both internal and external forces vary in intensity. Often health centers are encouraged by funders to explore relief from external pressures by collaborating with other similar organizations.

As community health centers and other nonprofit organizations consider models of strategic restructuring, they often examine how the changes will affect a number of different systems within their organization(s). These include:

- governance
- corporate entity
- organizational structure
- administrative systems and related costs
- staffing and personnel systems
- clinical systems and staffing
- financial management systems and staffing
- building ownership and leases.

Other essential considerations of the decision-making process often include:

- Are the missions complementary?
- Is there a previous history of successful collaboration between the organizations?

- What is the status of the role of the executive director of each participating organization?
- Is there geographic compatibility?
- Are the organizational cultures of the participating agencies complementary?

It is important to recognize private and public funding sources have driven as well as fostered corporate restructuring efforts in response to major challenges in the external environment. Some of these trends include the following:

- Mergers are occurring everywhere in the health care community—nationally, regionally and in both urban and rural communities. These mergers aim to achieve economies of scale, administrative and programmatic efficiencies, and greater strength in the environment.
- Smaller organizations find information technology increasingly difficult to purchase or access on their own. Yet such technologies are now essential to any business, especially in health care. However, clinics are sometimes unable to access funding sources because their management information systems and technical skills are outdated or not sufficiently sophisticated.
- Health care reimbursement and funding systems require very sophisticated management, data reporting and outcome measurement systems. These systems are often not available in smaller health centers. Moreover, individual health centers are similarly often unable to implement the systems necessary to measure outcomes of clinical practice or management strategies.

## **II. History of Neighborhood Healthcare and its Predecessor Clinics**

East County Community Health Services (East County) was located in the eastern sector of San Diego County. It operated three clinic sites in the area—El Cajon, La Mesa and Lakeside—starting with one site in El Cajon in 1974. Escondido Community Health Center (Escondido) operated in the north inland area of San Diego County and southwest Riverside County and had been in existence since 1969.

In 2000 the two agencies with nine sites presented a strong service profile, as shown in Table 1. East County served 15,907 patients in 38,649 visits. Most of its patients were low income: 61% had incomes below the federal poverty level (FPL) and 37% had incomes between 100-200% FPL. Escondido served 28,000 patients in 81,566 visits. Most of its patients lived in poverty: 77% had incomes below the FPL and 22% had incomes between 100 and 200% FPL. Most patients (62%) were Latino, while 26% were white. Escondido's total revenues of \$7,950,000 were more than twice East County's revenues of \$3,400,000, for combined total revenues of \$11,350,000.

**Table 1. Neighborhood Healthcare Clinic Data, 2000**

	Neighborhood Healthcare	
	East County Community Health Center	Escondido Community Health Center
Year of Restructuring	2000	
Total Patients	15,907	28,000
Total Visits	38,649	81,566
Income Status		
<100% FPL	61%	77%
100 – 200% FPL	37%	22%
>200% FPL	2%	1%
Total Health Center Revenues	\$3.4m	\$8.0m

*Source: California Office of Statewide Health Planning & Development. Annual Report of Clinics, 2000.*

## A. Challenges

In 1990, East County’s Board of Directors, in unison with local medical institutions, determined that the agency should expand its capacity and services by opening multiple sites to the residents of its service area. The result was three out of seven years with operating losses between 1990 and 1996. This was the first time in its history that the organization found itself in the negative column.

In an attempt to regain financial stability, East County entered into a Management Services Agreement (MSA) with the University of California San Diego (UCSD) in the mid-1990s. This move, which provided some important services for the agency, proved in the end to be more harmful than useful. UCSD provided funding to cover losses, which allowed East County to avoid implementing essential systems to build its internal capacity, efficiency and cost-effectiveness. Simultaneously, the organization experienced the resignation of its executive director and had no management team.

In 1998, the agency’s Board of Directors hired a consultant group to conduct an organizational assessment to determine more effective options for building East County’s capacity and administrative strength. The two key findings of this study were:

- Management systems were insufficient to assure accountability and efficiency.
- The agency needed skilled internal management and fiscal expertise as soon as possible.

The assessment identified other challenges: an over-reliance on physicians without use of midlevel providers, lack of systems for many aspects of the agency’s operations, lack of financial safeguards and inadequate cash flow.

The challenge of expanding from one to multiple sites cannot be overstated. The expansion compounded organizational complexity exponentially and was a significant contributor to East County's problems. This common issue has a number of traps: usually a health center is responding to a perceived or real community need and/or perceived or real funding opportunities. The center moves ahead only to find that it lacks adequate funding for infrastructure. To compensate, the agency stretches existing resources too thin. In addition, the communication channels and abilities to manage and interact can change in ways that lead to systems disintegration even under the most watchful eyes. Key management staff leaving during the transition—especially the executive director or chief financial officer—can undermine the expansion. Expansion under the most favorable conditions is hard to manage and many organizations underestimate the impact until it's too late.

## **B. Transition**

East County's consultants presented options to procure high quality management services in a turnaround plan that included these restructuring options:

- Bring talent and expertise in-house. Recruit and hire an effective management team.
- Obtain management services from another organization by:
  - Merging with another corporation
  - Establishing a joint governance agreement to share management services with another organization
  - Establishing a shared services agreement, affiliating with another health center to share management services while maintaining separate boards
  - Creating a management services agreement, procuring management services from another organization in exchange for a management fee.

In 1998, East County wanted to maintain its autonomy, so a merger was not considered. The UCSD MSA contract was scheduled to continue until February 28, 2001. Therefore, the board worked collaboratively with UCSD to identify and purchase management services from an organization more similar to East County: an existing community health center.

The five primary criteria for selection of the management services agreement option were:

1. Commitment to East County's mission
2. A proven track record with organizational management
3. Ability to improve efficiency and quality
4. Ability to enhance marketplace and community relationships
5. Ability to improve financial results.

Based on these criteria, the East County board contracted with Escondido Community Health Center to bring their management expertise to East County on a part-time basis.

They established a new MSA and terminated the MSA with UCSD. Escondido shared a similar mission; had a proven track record; their executive director, Tracy Ream, had provided excellent leadership for a number of years; and their financial officer, Lisa Daigle, brought financial expertise.

The agencies next had to overcome a statute in the Health and Welfare Code barring one agency from managing another while they each had separate boards of directors. The clinics obtained legal advice to address this issue and obtained waivers from the relevant state and federal agencies.

The new MSA began in May 1999 and specified that Ms. Ream would act as the executive director of East County, with responsibilities for strategic and business planning; development of an annual budget; all contracts negotiations and compliance; program development; personnel and financial management; and representation of East County at all internal and external meetings that would further its objectives.

Under the terms of the MSA, Escondido also provided the following:

- Policy level human resources services
- Management information systems services, outside the scope of their billing services, but interfacing with it
- Financial management services, including bookkeeping and accounting, records management, financial reporting, accounts payable processing, accounts receivable processing, employee records and payroll processing (through an outside payroll service), and employee benefits administration
- Medical director mentoring services, in order to provide assistance to one of East County's long-time pediatricians who agreed to serve as East County's medical director. This pediatrician possessed strong leadership skills but had no experience as a medical director.

The executive director, human resources director, financial officer and medical director remained employees of Escondido. Escondido's Board of Directors reviewed the contract periodically and made recommendations for changes.

Escondido required East County's board to complete the following at the time of signing the MSA:

- Terminate the accounting agreement with current outside accounting agency
- Delegate authority to sign contracts to the executive director.

At the same time, UCSD removed its financial support by terminating its MSA agreement with East County.

Shortly after the MSA was implemented, Escondido identified another serious challenge related to East County's billing service. Because of internal difficulties in managing an effective billing department and because East County relied on San Diego County's antiquated computer system, the billing services had been outsourced a few years prior

to the MSA. Escondido's initial assessment had been that, while the outside service was not ideal, at least it assured billing was done. Very quickly, however, it became obvious that the outside (and well-respected) billing service was unable to meet the unique demands of a health center and its various funding sources. The billing service also did not do Medi-Cal billing for its other clients and was not re-billing, working denials, or otherwise aggressively maximizing Medi-Cal income.

East County's accounting services were also outsourced, with the intent of saving money internally while assuring management of financial statements and accounts payable. Unfortunately, the outside accounting agency had to rely on revenue information from the outside billing service, resulting in unreliable accounts receivable and income information.

Escondido, faced with an inability to achieve financial stability without the critical billing function operating properly, was forced to bring the three East County sites onto its own HealthPro system and add billing staff within a very short time.

After the MSA with Escondido had been implemented for a year, East County conducted a strategic planning process with an external consultant. This process resulted in a strategic plan covering the period from 2000 to 2003. The strategic plan listed nine major goals and identified the agency's priorities. None of these goals or priorities included merger discussions as an option. Later in 2000, East County obtained a grant from The California Wellness Foundation for core operating support as they implemented the strategic plan.

Around that same time, in September 2000, Escondido conducted an internal analysis of the MSA. The analysis found that the relationship had been beneficial so far to Escondido but might not remain so given East County's financial position. Some services in the agreement were modified. The Escondido board oversight committee also reviewed Ms. Ream's ability to handle both health center corporations and concluded that her workplan was achievable and that demands on her time and effort away from Escondido would diminish over the coming two years.

In 2001, representatives of both East County and Escondido boards met and recommended and approved minor revisions and another two-year term for the MSA.

Over the three years of the MSA, the agreement allowed East County to move forward in implementing the turnaround plan from its 1998 assessment and its 2000 strategic plan. East County improved its cash position through staff changes, facilities financing and use, re-mortgaging and obtaining new loans, fundraising and grantwriting, and improving its billing services. The agency also made functional changes, closing the adult primary care program at the La Mesa site and instead focusing that site's services on women's health and pediatrics.

One of the reasons Escondido chose to affiliate with East County was because this expansion allowed for growth and additional depth, especially in the accounting department. Escondido was a mid-size organization that wanted and required more

depth to manage the complexity of the business, but couldn't afford it. By sharing management staff and resources, both organizations benefited.

Although the affiliation through a management services agreement met with success, East County struggled to meet the monthly management fee to Escondido during the turnaround transition. East County became delinquent in its monthly payments and Escondido was forced to balance its fiscal responsibility for Escondido with its commitment to support the turnaround of East County. Financial analysis revealed that a merger would result in a lower overhead cost for the combined organization than for either organization separately and would further result in a surplus for the combined organization even if East County continued to experience losses for another two years. It also revealed that without the management fee, Escondido would be hurt financially. As a result of the analysis and after considerable discussion with each board and between the two boards, the two agencies decided to merge and completed the merger on August 1, 2002 after three years of the management services agreement.

### **C. Current Status**

Neighborhood Healthcare has nine sites throughout the county. As part of the merger, the Escondido board remained and added two more slots with a new requirement that five of the 17 seats be filled by East County representatives. Three of the existing East County board members assumed roles on the Neighborhood Healthcare board.

The financial turnaround took much longer than anticipated and is still in process because it has involved changing organizational culture. East County's predominantly physician culture was not ready to support a nurse practitioner model. Several key changes that would have sped the turnaround were delayed because of long-term leases and contracts that would have been costly to break.

Change in East County's patient and payor mix added to the delay in achieving financial stability. At the time of initial discussions with Escondido, East County had a significantly higher percentage of Medi-Cal managed care enrollees than Escondido and significantly fewer sliding scale, low-paying patients. Escondido believed that if the organization could be stabilized and billing and collections maximized, East County would be very successful financially. Escondido also recognized that the window of opportunity was relatively short. Competition for Medi-Cal managed care enrollees was increasing both from other community clinics, which were opening sites in the area due to East County's ongoing relative weakness, and from an increased number of local private physicians beginning to participate in Medi-Cal managed care. In addition, changes occurring in the county and statewide were flattening growth in new Medi-Cal managed care beneficiaries. This led to an overall decline in enrollees countywide, which affected East County.

Like many California health centers, East County has experienced a significant decrease in Medi-Cal patients and a concomitant increase in uninsured patients. Staffing turnover and access issues at its largest site during the turnaround may have

contributed to a shift of their managed care patients to other primary care providers. This change in patient mix dramatically impeded financial turnaround.

In September, 2002, Neighborhood Healthcare received HRSA Bureau of Primary Care 330 funding that will further strengthen its organizational capacities. Neighborhood Healthcare’s budget is currently \$16 million, providing 149,000 visits annually. As shown in Table 2 below, Neighborhood Healthcare has more than doubled the number of visits provided, while increasing total revenues 53%. They have been able to spread administrative costs over a much larger caseload.

**Table 2. Neighborhood Healthcare Clinic Data, 2000 and 2002**

	Neighborhood Healthcare	
	2000	2002
Total Visits	120,215	149,000
Total Health Center Revenues	\$11.35m	\$16.0m

*Source: California Office of Statewide Health Planning & Development. Annual Report of Clinics, 2000.*

### **III. Other California Community Health Centers: Organizational Challenges and Their Responses**

Neighborhood Healthcare’s response to its challenges and opportunities shares many similarities with other community health centers throughout the state. Yet each situation is unique. This section describes how 14 other California community health centers, now seven clinic corporations, responded to similar challenges to their operations and potential survival and the steps they took to meet those challenges. Each has its own story to tell.

The information provided here was gathered from a review of restructuring reports and from interviews with executive directors of the study participants. The agencies and the representatives who participated in interviews are listed in Attachment A, along with contact information.

Table 3, on the next page, summarizes clinic data for each of the sixteen study participants, including East County and Escondido, during the year of their restructuring discussions. It shows the number of patients and their ethnicity and income, the number of patient visits and the organization’s total revenues. Each of the organizations is grouped together with its partner(s) or potential partner. The data used is from the Annual Report of Clinics required of each community health center to be submitted to California’s Office of Statewide Health Planning and Development (OSHPD).

**Table 3. Demographics During Restructuring Year**

	Neighborhood Healthcare		Alliance Medical Center	Southwest Community Health Center	Gardner Family Health Network, Inc.		Lifelong Medical Care			Mountain Valleys Health Centers, Inc.		Santa Barbara Neighborhood Clinics, Inc.			West County Health Centers, Inc.	
	East County Community Health Center	Escondido Community Health Center			Gardner Health Center	Family Health Foundation of Alviso	Berkeley Primary Care Access Clinic	Over 60's Health Clinic	West Berkeley Family Practice	Big Valley Health Center	Butte Valley Medical Center	Carrillo Medical Center	Isla Vista Health Center	Westside Health Center	Occidental Area Health Center	Russian River Health Center
Year of Restructuring	2000		1999		1997		1997			1999		1996			1998	
Total Patients	15,907	28,000	5,781	5,292	7,545	16,305	3,847	3,223	2,389	3,186	3,520	5,121	6,103	3,716	3,161	2,875
Total Visits	38,649	81,566	27,962	17,547	28,718	71,699	12,982	16,315	7,329	9,896	13,604	8,261	11,054	14,985	10,854	13,735
Ethnicity																
White	12%	26%	23%	27%	3%	12%	30%	24%	23%	80%	40%	40%	51%	63%	82%	89%
Latino	9%	62%	71%	69%	77%	74%	13%	8%	28%	16%	59%	45%	38%	32%	12%	6%
African American	1%	2%	2%	1%	0%	2%	39%	55%	31%	0%	<1%	8%	4%	2%	2%	1%
Asian/Pacific Islander	>1%	1%	1%	1%	3%	4%	7%	11%	6%	0%	<1%	4%	5%	2%	2%	1%
Other/Unknown	78%	9%	3%	2%	17%	8%	13%	3%	12%	4%	0%	2%	2%	1%	2%	3%
Income Status																
<100% FPL	61%	77%	78%	88%	25%	69%	75%	52%	78%	31%	29%	28%	72%	64%	39%	41%
100 – 200% FPL	37%	22%	19%	9%	49%	12%	16%	33%	15%	41%	55%	34%	23%	18%	13%	19%
>200% FPL	2%	1%	3%	3%	26%	19%	9%	16%	7%	28%	16%	38%	5%	18%	48%	40%
Total Health Center Revenues	\$3.4m	\$8.0m	\$2.5m	\$1.5m	\$5.2m	\$16.0m	\$2.0m	\$2.0m	\$0.9m	\$1.3m	\$0.9m	\$1.1m	\$0.5m	\$0.7m	\$0.9m	\$1.5m

Source: California Office of Statewide Health Planning & Development. Annual Report of Clinics, 1996, 1997, 1998, 1999, and 2000.

## **A. Alliance Medical Center and Southwest Community Health Center**

### **1. Challenges**

In 2000, Southwest Community Health Center in Santa Rosa was fighting to regain financial stability after a change in key management staff and a decline in the effectiveness of its computer system. This was coupled with tremendous growth for a relatively new (five-year-old) organization that hadn't yet settled down. Southwest had no history to rely on and no experience with major challenges. With no long-term staff, there was a leadership vacuum. With no long-term structures, the agency lacked the procedures and policies to operate in such a vacuum.

While the medical services were high quality and working well, substantial turnover at the front desk and in medical records added to the chaos. The clinical coordinator did not speak Spanish, a serious challenge given the clinic's target population.

Memorial Hospital, the local hospital that had been Southwest's founder, provided staff to evaluate Southwest's situation, increasing collaboration between the hospital and the clinic. Hospital staff wrote a report with recommendations for improvements. The clinic turned to the hospital to ask for continuing financial support. When the hospital turned down the clinic, telling the board to instead implement the report recommendations, the clinic examined its options.

While doing so, the Southwest board of directors decided to contract for management services with Alliance Medical Center. They invited the Alliance executive director to act as Southwest's interim executive director on a part-time basis to assist in sorting out its financial situation and to transition to the next stage of development. Both clinics are located in the same county, in different service areas, and both serve a predominantly Latino population.

Options explored included the following: a merger study with Alliance; maintaining a long-term MSA with Alliance; closing; using county staff or staff from Memorial Hospital to fill gaps; or identifying a network that Southwest could become a part of. The director called on his peers in the Redwood Community Health Coalition and throughout the county for help. The clinic worked with Sonoma State University's Organizational Development Department, which provided a more formal management group but proved to be detrimental to the clinic's financial stability. At the time of the MSA, both agencies had strong service profiles. Alliance provided 15,907 patients with 30,473 visits. Most clients were Latino (71%) and nearly a quarter of the remainder were white. Most lived in poverty (78%), while 19% had incomes between 100-200% FPL. Alliance's total revenues were \$2.5 million. Southwest provided its 5,292 patients with 17,547 visits. It served a similar ethnic population as Alliance: 69% were Latino and 27% were white. A larger proportion of its patients lived in poverty (88%), while 9% had incomes between 100-200% FPL. Southwest's total revenues were smaller than Alliance's, at \$1.5 million.

## 2. Restructuring Discussions

In recent years, Alliance's executive director had become a recognized leader in issues related to rural health and small community health centers. He was admired by the Alliance board and staff for his work in rescuing Alliance Medical Center and strengthening it over the previous eight years. During his tenure as interim director at Southwest, he proposed to both boards that they conduct a merger study to see if their strengths and needs could mesh in a way that would bring financial stability to Southwest, lower Alliance's administrative costs and better serve the low-income and Latino populations of Sonoma County.

The medical staffs of the two health centers were also assets, both individually and in the possibility of a merger. The two medical staffs were very close. The medical directors of Southwest of Alliance knew each other well during their residency program and were involved together with other physician colleagues in stimulating the development of Southwest. Southwest's medical director had worked at Alliance; Alliance's medical director had worked at Southwest. Other key physicians had also worked at both health centers. They all expressed excitement about the potential to work together more closely.

Practice management at Southwest needed support. The director arranged a loan to buy HealthPro, a practice management system used in many health centers, including Alliance. This was a major step in addressing the billing and collections problems.

Southwest's staff turnover was a serious issue at many levels of the organization. The billing supervisor left and the temporary fill-in didn't know what to do. As the interim director arrived, several key people left, including all the finance staff.

There were also a number of forces that acted as brakes on the process. The union started to organize at Southwest at the time of the merger discussions. The Alliance board was beginning to turn its dream of a new building into a reality. Timing became a major factor in whether or not this was an appropriate time for restructuring discussions.

Progress on a merger study stalled for some time during the summer of 2000 while financial and program data were being collected and verified. Activity on the study began again in the fall. Staff and individual board members raised a number of important questions and concerns throughout the process. Key issues included:

- Financial stability of Southwest and potential financial drain on Alliance
- Compatibility of the organizational cultures at Alliance and Southwest
- How boards would be integrated given different board styles
- How staff administrative and financial functions could be integrated given some duplication of effort at the two health centers and distances between health center sites
- How hospital relations at each health center could be maintained and even strengthened given different hospital referral patterns

- How community relations could be maintained and strengthened in each separate community
- How the health centers could learn from each other
- How the medical staffs would work together effectively
- What effects there would be on the clinics from public discussions about the future viability of the Southwest Community Health Center
- Whether staff would be expected to travel from one site to another.

Following the merger study, the following recommendations were made:

- Although the merger of these two organizations made theoretical sense financially and administratively and ultimately could benefit the community served, the timing and need for strong local leadership led to a recommendation of a shared services arrangement. The clinics chose to postpone merger discussions for two years while both pursued their own priorities.
- Some shared services, like grantwriting and billing services, could be further explored.
- Alliance should complete its new building project and Southwest find a new executive director and solidify its financial stability.

### **3. Current Status**

As of 2003, both organizations were moving forward successfully. Both have received federal 330 funding and improved their financial positions. The new executive director hired by Southwest has strengthened the organization in every aspect. No sharing of services has occurred.

Southwest's retrospective evaluation shows that the decision that resulted from the merger study was correct, that the interim executive director process was successful in allowing time for stabilization at Southwest, and that both health centers needed to build on their own—Alliance its new facility, Southwest a new infrastructure. Southwest was fortunate to have an experienced manager on its board of directors who was willing to take on the job of executive director, assuring the board's confidence. They can now look at merging from a place of strength and opportunity. The use of an MSA and interim director was effective because it started the process of making necessary changes.

## **B. Gardner Family Health Network, Inc.**

### **1. Challenges**

By 1996, Family Health Foundation of Alviso (Alviso), with five sites located throughout Santa Clara County, had struggled with financial and organizational stability issues for a number of years. The Bureau of Primary Health Care, which provided federal funding, was notified that the board was managing operations and that the health center was experiencing difficulty meeting mortgage payments and payroll. The Bureau determined that the agency had no internal controls, clinic administration was incapable of addressing the reduction in demand and administrative capability was limited.

The Bureau acted with emergency powers as primary funder, hiring a new executive director and management team and requiring a new interim board with a majority of users. The Bureau also notified the state according to Cal Mortgage requirements. This, in turn, triggered not only involvement of the state, but also Santa Clara County and the City of San Jose, because of the Medicare waiver program.

Meanwhile, Gardner Health Center, a smaller but very stable health center in San Jose, was advanced in its strategic planning processes and had a strong board, money in the bank and a new computer system. However, its behavioral health component was larger than its primary medical care component. It was considering clinical expansion important to its long-term survival and was already thinking of expanding into southern Santa Clara County. Gardner's chief executive officer had previously been executive director of Family Health Foundation of Alviso.

Managed care was just beginning in Santa Clara County and Gardner recognized that having a larger agency would provide more influence as the process continued. Gardner had a \$5 million operation and a \$500,000 bank reserve, while Alviso had \$16 million in operations and was \$2 – 3 million in debt. Gardner served 7,545 patients with 28,718 visits. Most of its patients were Latino (77%). Only a quarter of its patients lived in poverty, while 49% had incomes between 100-200% FPL. Its total revenues were \$5.2 million. Alviso, with its three sites, provided its 16,305 patients with 71,699 visits. Most of its patients were Latino (74%) and 69% lived in poverty, while 12% had incomes between 100-200% FPL and 15% had incomes above 200% FPL.

### **2. Transition**

The government agencies involved jointly issued an RFP for another organization to operate Alviso. Gardner was approached by both the County of Santa Clara and the federal government to submit a proposal to take over Alviso in January 1997. The County and the City of San Jose encouraged the two clinics to come together. Together, the County and City formed a joint merger committee.

As part of the investigation to merge, Gardner Health Center management discovered that a merger would be more financially successful if the two corporations remained, but shifted services and programs so that one corporation would provide the primary care services and the other, the behavioral health services. The clinics established Gardner Family Health Network for medical services and Gardner Family Care Corporation for behavioral health services. Both corporations are governed by two boards, made up of the same individuals. They meet on all issues concurrently.

After being awarded the contract to operate Alviso, Gardner's administration remained in place and Alviso's administrative staff was terminated. However, Alviso's patient caseload remained the same. This generated a cost savings of \$800,000. Through establishing the two corporations, the federal money was maximized in the Gardner Family Health Network corporation.

The process toward affiliation included the following broad steps:

- Development of joint merger study committee
- Adoption of joint Letters of Intent from each board of directors
- Identification of key staff contacts to answer questions
- Participation by Region IX of the US Public Health Service, County of Santa Clara Health and Hospital System, City of San Jose and other relevant stakeholders of process
- Notification of staff and unions of both organizations about merger process
- Identification and selection of legal counsel to process the merger
- Analysis of financial and organizational implications
- Exploration of restructuring options including joint ventures, clinic IPA, medical foundation
- Decision about merger
- Conduct of due diligence
- Beginning of Transition Period, which resulted in the termination of Alviso's administrative staff. Gardner was not obligated to include any previous Alviso board members because the federal government had already removed the Alviso board from office.

### **3. Current Status**

While the combined net worth of the two agencies was negative in 1997 at the time of the merger, by 2000, the new clinic organization had a surplus of \$1.8 million. Prior to affiliation, Alviso had \$31,846 in cash on hand. Now the organization has \$3.2 million cash on hand. Accounts receivable shrank from \$2.8 million to \$1.8 million, while liabilities decreased from \$3.2 million to \$1.5 million. The fund balance grew from \$872,000 (or 10%) to \$5,940,000 (50%). Pre-affiliation cash at Gardner was \$1.1 million; now it is \$1.2 million. Accounts receivable have grown, because of the growth of the agency, from \$1.1 million to \$2.3 million. Gardner Family Care Corporation grew from \$5.8 million to \$10.8 million, with a doubling of liabilities (from \$900,00 to \$1.8

million) due to 88% growth in the budget. Its fund balance grew from \$2.4 million to \$2.6 million.

The combined volume of services at both corporations is now about 40% higher than it was pre-affiliation. The Gardner administrative staff has remained stable in people and in numbers, from pre-merger to now, even with the addition of five new sites and two corporate structures.

## **C. Lifelong Medical Care**

### **1. Challenges**

For many years, West Berkeley Family Practice (West Berkeley) had been under scrutiny for its management practices by its federal funding source, the Bureau of Primary Health Care. Berkeley Primary Care Access Clinic (Berkeley Primary Care) was a relatively new clinic created in 1990 to serve the primary care needs of high-risk pregnant women and their children in the Berkeley area. Over 60's Health Center (Over 60's), started in 1976 by the Gray Panthers, was nationally known as a model of care for low-income older adults.

Some of the challenges facing West Berkeley Family Practice, Berkeley Primary Care Access Clinic and Over 60's Health Center included:

- Pressure from funders to cut administrative costs in each of the health centers
- Seeking access to FQHC status for clinics with limited target populations
- Complicated relationships with local hospitals
- Lack of administrative expertise to contract with managed care companies due to small size and limited administrative budgets.

In 1997, Berkeley Primary Care Access Clinic and Over 60's Health Clinic both had operating revenues of \$2.0 million, about twice that of West Berkeley. Berkeley Primary Care served 3,847 patients with 12,982 visits. African Americans were the best represented ethnic group (39%), followed by whites (30%), Latinos (13%) and Asian/Pacific Islanders (7%). Most patients lived in poverty (75%) and 16% had incomes between 100-200% FPL. Over 60's served about 16% fewer patients (3,223) for about 25% more visits (16,315). Most of its patients were African American (55%), followed by whites (24%), Asian/Pacific Islanders (11%) and Latinos (8%). While most patients lived in poverty (52%), a third had incomes between 100-200% FPL. West Berkeley saw significantly fewer patients (2,389) for fewer visits (7,329). The ethnic representation of clients was more evenly diverse: 31% were African American, 28% were Latino, 23% were white and 6% were Asian/Pacific Islanders. Most of its patients lived in poverty (78%), while 15% had incomes between 100-200% FPL.

## **2. Transition**

For several years prior to merging, Over 60's and Berkeley Primary Care carried out discussions and negotiations regarding the benefits of merging. During that period, West Berkeley went into bankruptcy. The City of Berkeley and Alameda County asked Over 60's and Berkeley Primary Care to jointly take over the site. This new management began operating under the legal auspices of Over 60's in 1995. In July 1996, the merger of Over 60's and Berkeley Primary Care was completed legally.

The merger took seven years to institute more fully; creating a common culture and overcoming practice differences took much longer than anticipated. The two health center leaders initially assumed the positions of chief executive officer and chief operating officer. The merged agency was renamed Lifelong Medical Care, while each site retained its own name and community identity. This model made the merger possible initially; still, the different sites had to learn to work together, each with a very different corporate culture.

This merger was initially a business merger; that is, a merger of the two agency's boards, human resources, business offices, accounting and facilities management systems. Lifelong chose not to merge clinical practices because it was not determined to be an organizational priority at the time. Only now, in 2003, as the business merger is being completed, is Lifelong making serious attempts to merge the three agencies' medical practices and clinical staffs.

In retrospect, it might have been helpful organizationally to speed up the clinical merger by bringing staff clinicians together earlier to determine what would work for them. Because the process was not initially a clinical one, the organization didn't consider the need for a new vision in health care services, only the need to meet the legal requirements and maximize available services and resources to the community.

The organizations dedicated considerable resources to improving administrative systems and to working on cultural issues. This was difficult given that the agencies were operating close to the edge financially during the merger process.

By and large, because of the strained financial issues, Over 60's administrative staff assumed responsibility for all three organizations, adding only a chief operating officer to its management team. Only now are structures being put in place to resolve the need for additional middle management level services.

## **3. Current Situation**

The merged organization continues to be run by the same executive director, now called chief executive officer. It is now a stronger one and is perceived as a force in the community. It has been able to address issues of homeless health care, geriatric care and substance abuse among pregnant women. As of 2003, Lifelong has installed a new common practice management system and continuing efforts are underway to

strengthen internal systems. The five clinic sites, once left to run on their own, are now part of a common management system and are working to improve consistency across clinics and sites while maintaining site identity and patient and target population focus.

## **D. Mountain Valleys Health Centers, Inc.**

### **1. Challenges**

Big Valley Medical Center (Big Valley) and Butte Valley Health Center (Butte Valley) are located in remote areas of northeastern California. Together, they have served the small rural communities surrounding Bieber, Dorris and Tulelake for over 20 years. The organizations shared similar missions, scopes of services, history and administrative organization. The executive director of Big Valley relied heavily on the experience of Butte Valley founder and executive director. Together, over a number of years, they discussed key issues related to rural health centers, compared notes on a variety of administrative functions and procedures, and talked about the future of the health centers. This in-depth knowledge and history provided a relatively receptive atmosphere for merger discussions. Over the course of time, the executive director of Big Valley, like Alliance's executive director in Sonoma County, had become recognized throughout the state as a leader in issues related to rural health policy.

Butte Valley operated clinics in Dorris and Tulelake. In the mid-90s, the agency had declined in its financial stability and found itself substantially in debt. As a result, it had closed its Tulelake clinic in 1995. When farmworkers from Tulelake began to use the Klamath Falls Emergency Department, the hospital contacted Butte Valley's board to encourage them to re-open the clinic. With loans from the hospital to pay off their debts, Butte Valley was able to re-open the Tulelake site until 1998, when the clinic manager left.

Concurrently, a possible government purchase of lands in the Tulelake area highlighted concerns about the future sustainability of a clinic site there.

In 1999, Butte Valley served 3,520 patients with 13,604 visits. Most of its patients were Latino (59%), followed by whites (40%). Most had incomes between 100-200% FPL (55%), while 29% lived in poverty and 16% had incomes above 200% FPL. Its total operating revenues totaled \$.9 million. Big Valley with its two sites served about 10% fewer patients (3,186) with 9,896 visits. The vast majority of its patients were white (80%) and 16% were Latino. The income of its patients was more evenly spread: 31% lived in poverty, 41% had incomes between 100-200% FPL and 28% had incomes above 200% FPL. The agency's total operating revenues were \$1.3 million.

## 2. Transition

In 1995, Butte Valley's long-term, well-respected executive director retired, creating a leadership vacuum both in operations and on the board. Facing financial struggles and a lack of leadership, Butte Valley's board first rehired an office manager to allow the Tulelake clinic to continue to function. Its next step was to fill the leadership void. First Merle West assigned a director, who himself resigned in 1999. At that time, based on the long-term relationship of the two clinic organizations, the Butte Valley board decided to enter into an MSA with Big Valley, for the services of its executive director and management team.

The executive director gained mutual respect and support of both health centers' board members, staff and community members. In addition, Big Valley's medical director had a long history with the Tulelake community and had similarly earned respect for his work. In part, challenges were more easily overcome because of the hard work, integrity and leadership that both executive director and medical director provided to the centers and their communities over the years. In addition, the boards of both health centers wholeheartedly endorsed the need for a study of the merger's potential and were cooperative throughout the process.

As the first step in the MSA, the executive director worked to decipher Butte Valley's financial problems and to develop board leadership. Acting closely under the leadership of its board president and medical and dental directors, he laid the groundwork for a merger study.

A consultant group was engaged to do a thorough assessment of the systems at Butte Valley Health Center and to recommend how integration of the corporations might occur. This addressed issues related to corporate compliance, financial viability, staffing structures, board composition and patient care management. Both boards were presented with the funding and recommendations.

While Big Valley was financially secure and well-run, its board acknowledged that three strong and stable clinic sites in the geographic area would help each other and would allow the merged corporation to access new funds. A long-standing loan agreement with Klamath Falls Hospital, which had also been providing medical and office supplies, was forgiven so that the merger process between the two clinic corporations could begin.

It was clear that the economies of scale that would result from a merger of Big Valley and Butte Valley would strengthen the ability of Tulelake's clinic to continue even with a potentially large reduction in the labor force there, should the government land purchase occur.

A number of environmental factors specific to these two clinics contributed to the decision to move forward:

- The appointment in early 2000 of Big Valley Medical Center's respected executive director as the interim executive director of Butte Valley Health Center.
- The two health centers had similar missions, funding sources, complementary services and long-serving staff, but different communities, different organizational cultures and different services.
- The geographic proximity of the two health centers and the three sites, even in rural geography terms, made travel to each health center site relatively easy.
- The region was in need of a strong, visible spokesperson and unified voice for health services, particularly given the three counties that the sites serve.

### **3. Current Status**

The agencies merged successfully in July, 2001 and now have expanded services, including the acquisition of a private practice.

## **E. Santa Barbara Neighborhood Clinics, Inc.**

### **1. Challenges**

For the five years up to 1997, Isla Vista Health Projects (Isla Vista), Carrillo Medical Clinic (Carrillo) and Westside Neighborhood Medical Clinic (Westside) were independent community clinics dedicated to providing health services to low income patients. Each had ongoing cash flow problems, no cash reserves and no funds for capital improvements. To some degree, each showed the regular and recurring symptom of having a hard time making payroll.

All three clinics suffered from weak management systems, in large part due to the lack of capital funding and the low priority of this issue for both staff and board. Perhaps all three clinics existed in an atmosphere of historical nostalgia; they had all been established 20-25 years earlier and, in many ways, had changed little in the ensuing years in terms of management sophistication and management systems. The threats to survival were imminent in the minds of the boards and the management staff of all three clinics throughout the pre-merger study period and during the merger process, as well.

In early 1996, the Santa Barbara County Public Health Department asked the Santa Barbara Community Clinics Association (SBCCA) and its members to explore the transfer of County primary care services to other providers. This offer presented opportunities as well as tremendous challenges to member clinics, individually as well as collectively.

New funding sources were becoming available that required of clinics, as a condition to access them, more sophisticated management information systems and greater staff technical skills. Some of these included funding opportunities from Family PACT and the Healthy Families Children's Health Initiative. A merger would be one way to increase sophistication and access those funds.

Mergers were occurring everywhere in Santa Barbara County. Two community clinics in the northern part of the county had recently merged with Marian Hospital as a result of difficult financial situations. At the same time, Marian Hospital affiliated with Catholic Healthcare West and St. Francis Hospital in southern Santa Barbara County. The two major medical groups in Santa Barbara—Santa Barbara Medical Foundation and the Sansum Medical Clinic—were in the process of merging in order to achieve economies of scale and other administrative efficiencies. In addition, Cottage Hospital in Santa Barbara and Goleta Valley Hospital merged in 1996.

In the immediate months preceding the initiation of the merger feasibility study, Westside Neighborhood Medical Clinic was under intense pressure to improve its internal operating systems due to the clinic's negative financial situation. A report prepared by consultants identified a number of operating deficiencies during this process and Westside was exploring a variety of approaches to stability.

Westside's financial situation, in the meantime, had gotten more desperate and the agency chose to take its situation to the public. The clinic was extremely successful in its public appeal for funds, receiving approximately \$150,000 in donations and loans within a few short months. As a result of this financial situation, Westside assessed the possibility of merging with American Indian Health Services (AIHS), which would allow them to obtain Medicaid cost-based reimbursement through AIHS' Federally Qualified Health Center (FQHC) designation. However, the merger talks stopped abruptly because AIHS had been told by the federal government that it could not pursue the merger, due to Westside's operating deficiencies.

Carrillo also experienced concern about its financial situation, appealing to funding sources for assistance. Later in November, Carrillo received funds from the Santa Barbara Health Initiative which eased its financial situation considerably.

As a result of these varied challenges, the three agencies sought to conduct a merger study, with the approval of the Santa Barbara Health Care Services Agency, Santa Barbara Foundation and Santa Barbara Health Initiative. All three key stakeholders expressed commitment to the merger concept and to the potential of another strong and unified clinic system in Santa Barbara County.

In 1996, Carrillo served 5,121 patients with 8,261 visits. The largest ethnic group served was Latino (45%), followed by whites (40%), African Americans (8%) and Asian/Pacific Islanders (4%). Patient income was somewhat evenly distributed: 28% lived in poverty, 34% had incomes between 100-200% FPL and 38% had incomes above 200% FPL. Isla Vista served the largest number of clients of the three clinics (6,103) with 11,054

visits. Most of its patients were white (51%), 38% were Latino, 4% were African American and 5% were Asian/Pacific Islanders. Most of its patients lived in poverty (72%), while 23% had incomes between 100-200% FPL. Westside served the fewest patients (3,160) with the largest number of visits (14,985). Most of its patients were white (63%), followed by Latinos (32%). Carrillo had the largest operating revenues of the three clinics: \$1.1 million, compared to half a million dollars at Isla Vista and \$.7 million at Westside.

## **2. Transition**

The missions of all three organizations were extremely compatible, with the distinct geographic emphasis of Isla Vista on the Isla Vista community and Westside on the Westside neighborhood. Carrillo did not have such a particular geographic target area.

The histories of all three organizations were also extremely similar. All three opened within five years of one another and were at least 25 years old.

All three organizations had fairly parallel corporate cultures, with somewhat participatory decision-making structures, staff with stability and strong commitments to the organizations, similar funding sources and similar reputations among community members and other healthcare providers.

## **3. Current Status**

Some seven years later, the new corporation is thriving. Patient volume has increased. A new executive director, hired in 2001, has facilitated the integration of administrative systems. The medical director oversees the clinical operations at all sites.

All administrative personnel, once scattered in whatever rooms could be found at the various clinics, are now centralized at the Isla Vista facility. All clinics operate an integrated patient management and billing system. All program functions are shared among the three clinics. These functions are now located, along with clinical services, in the Health Program Center at the Eastside Neighborhood Clinic, newly constructed to replace the Carrillo Clinic site. This new facility opened in May 2003. In addition, more than \$200,000 has been invested to renovate and improve the Westside facility.

Net assets of Santa Barbara Neighborhood Clinics (SBNC), the merged entity, at the end of its first year of operation ending 6/30/2000, stood at \$629,000. Three years later, net assets exceed \$5 million. In the same period of time, gross receipts have increased by approximately 50% (more than 100% over the 1996 levels described above to over \$3 million). It is anticipated that the Carrillo Family Dental Clinic, in which SBNC was a collaborating partner, will merge into SBNC as another of its wholly owned clinics before the end of summer 2003.

## **F. West County Health Centers, Inc.**

### **1. Challenges**

Occidental Area Health Center (OAHC) and Russian River Health Center (RRHC) were both located in western Sonoma County and had served the small rural communities of the area for more than 20 years. The organizations shared similar missions and similar scopes of services. Both organizations were members of the Redwood Community Health Coalition of Sonoma County. Through the Coalition, the executive directors of both health centers began to talk about the similarities of the organizations as well as the potential benefits of a closer corporate relationship. Both directors had become significant forces within their own organizations in a relatively short period of time, gaining the mutual respect and support of board members, staff and community members.

When the executive director of RRHC resigned her position, she recommended to the board that they consider a potential business alliance with OAHC and that they employ its executive director as their interim executive director. The leadership vacuum was a serious challenge to RRHC at this time. While the clinic was in very good shape financially, it was geographically isolated and had difficulty retaining clinicians and executive leadership.

Meanwhile, neighboring OAHC was finding it increasingly difficult to sustain itself financially from year to year. Its small size made it difficult to retain sufficient administrative staff with the skills to support its growing level of services.

Palm Drive Hospital, located in western Sonoma County, was facing threatened closure and the area was in need of a strong, visible spokesperson and a unified voice for its then fragmented health services system.

RRHC had experienced a decline in encounters over the previous three years, primarily due to shortages of providers. OAHC had experienced 10% annual increases in patient encounters in the previous three years and had reached capacity in its current facility. It had just completed a major facility remodel and expansion, doubling the number of exam rooms. Without concentrated efforts and discussions, the twin challenges of staffing and finances would likely continue and jeopardize the stability of both clinics.

In 1998, OAHC served 3,161 patients, about 10% more than RRHC (2,875). RRHC provided more patient visits (13,785) than OAHC (10,854). Both served a predominantly white population (82% at OAHC and 89% at RRHC). OAHC served Latinos at twice the rate of RRHC (12% and 6% respectively). Patient income was also similar at the two agencies: 39% at OAHC and 41% at RRHC lived in poverty; 13% at OAHC and 19% at RRHC had incomes between 100-200% FPL; and 48% at OAHC and 40% at RRHC had incomes above 200% FPL. RRHC had \$1.5 million in total operating revenues, compared to \$.9 million at OAHC.

## 2. Transition

In March, 1999, the executive director of OAHC was engaged by the Russian River Health Center board as RRHC's interim executive director. At the same time, she was directed by both organizations' boards to move forward with a consultant on a merger study.

This merger study was undertaken to specifically analyze whether a merger could address the specific challenges and strengths of the two clinics. While the study analyzed systems, services, management, clinical services and financial projections, communication with staff and board was critical. At joint key managers meetings, staff from both health centers expressed concerns about the potential merger:

- Both agencies' staffs wanted to continue to be involved in the process and in the development of the final merger process recommendations.
- Several staff expressed concern about the role of the executive director in guiding and shaping the merger process; some RRHC staff felt that RRHC was without a "dedicated" advocate since their executive director had resigned.
- Some OAHC staff expressed concern about losing the "strong identity" of their health center and its community-based culture.
- Both staffs wanted to preserve the best of each agency, including community commitment, HIV focus, compensation and benefits, autonomy of decision-making and organizational cultures.
- Many staff from both organizations expressed support for the merger as well as for the process. Other staff questioned why a merger was necessary.

In addition, important concerns among board members and staff of both organizations were raised relative to differences between the two communities served and how well they would blend in a merger.

While the communities were indeed somewhat different, these differences turned out to be a benefit to enhance the process as the two organizations moved more closely together. The relatively close geographic proximity of the two health centers, even in rural terms, together with overlapping service areas, enhanced their ability to work together. Almost 50% of patients came from the central core of each health centers' service area, while the remaining 50% came from overlapping and contiguous towns in western Sonoma County.

Some of the key recommended steps to merging follow:

- Create a single, new corporate 501(c)(3), West County Health Centers, Inc. (WCHC), to manage two health RRHC and OAHC, merging both health center corporation's and assets into it.
- WCHC should maintain service sites at the current locations. In addition, the sites for services should continue to be called by their current names for brand recognition among patients, community organizations and funders. It was considered extremely important not to lose the identity of the current sites in this process.
- The new WCHC should include a board of directors composed of 15–24 members including board members from the two agency boards, residents from the target areas and an at-large member.
- The boards of directors of RRHC and OAHC should spend the period between August and November, 1999 as a Merger Study Period to study the merger report, its recommendations and the proposed timeline. A Merger Study Committee made up of three board members and three staff members from each organization should participate on the committee, reviewing the merger report, its recommendations and implications in detail, and reporting monthly to the staffs and boards of each health center during the Merger Study Period.

### **3. Current Status**

Since the merger, WCHC has developed a strong leadership team including the original executive director, the new chief financial officer, the WCHC medical director originally from RRHC and the operations director and the community programs director, both originally from OAHC. Staff move from one site to another as needed, a key area of resistance before the merger. Major remodeling and expansion of the RRHC site has been completed and agency-wide billable encounters have increased by 20% since 1998.

The combined agency budget has grown from \$2.5 million in 1998 to \$4.5 million in 2003 and services have expanded to include case management, health education and outreach for specific target populations including under-fives, teens, Latinos, women and chronic disease patients. In 2002, the corporation received federal Section 330 funds to support the low-income uninsured residents of the area. The clinics have increased visibility with local elected officials and the WCHC executive director sits on the Board of Directors of Palm Drive Hospital which is now a publicly-owned district hospital.

## **IV. Common Challenges Facing Community Health Centers**

Non-profit, community-based health centers face a number of challenges and opportunities. These challenges may vary in specific details, in intensity and in their effect on a given health center. All require some action on the part of leadership, and one option they may consider is merger with one or more other health centers. Below follows a list and then a table of the type of challenges facing agencies described in this study. Table 4 is organized from the most common to the more individual ones faced by the study participants. They illustrate the range and similarity of challenges faced by agencies that sought restructuring.

### **East County Community Health Center & Escondido Community Health Center**

- Need to expand its capacity and services to the residents of East County, resulting in three of seven unprofitable years between 1990 and 1996
- Management services agreements not always helpful
- Unclear accounting trail and lack of financial safeguards
- Lack of solid management
- Over-reliance on physicians without use of mid-level providers
- Lack of policies and procedures for many aspects of the agency's operations
- Inadequate cash flow
- Expansion to multiple sites without adequate infrastructure

### **Alliance Medical Center & Southwest Community Health Center**

- Financial difficulties
- Billing system/practice management system inadequacies
- Staff turnover and lack of long-term staff
- Union organizing impacts on budget and personnel management
- Clinic manager did not speak Spanish

### **Gardner Community Health Center & Alviso Health Foundation**

- Financial difficulties
- Board vs. management staff managing operations
- Need for staff reduction in force
- Deteriorating services

### **Over 60's Health Center, Berkeley Primary Care Access Clinic & West Berkeley Family Practice**

- Pressure from funders to cut administrative costs
- Access to FQHC status for clinics with limited target populations
- Complicated relationships with local hospital

### **Butte Valley Health Center & Big Valley Medical Center**

- Loss of long-term leadership and resulting leadership vacuum
- Financial difficulties/debts
- Need to expand to meet patient needs
- Management contract

- Lack of financial controls
- Lack of board leadership
- Possible government purchase of lands threatening sustainability of clinic site
- Multiple sites without adequate volume

**Carrillo Medical Center, Isla Vista Health Center & Westside Health Center**

- Weak management systems
- Lack of capital funding
- Opportunities for more funding dependent on economies of scale and larger numbers, as well as more sophisticated management systems
- Negative financial situation

**Occidental Area Health Center & Russian River Health Center**

- Financial difficulties
- Administrative costs were high
- Declining patient caseload with resulting decline in provider productivity
- Loss of long-term leadership (through retirement) and therefore leadership vacuum
- Geographic isolation and lack of visibility

**Table 4. Common Challenges Facing Health Centers**

Challenge	Clinic		Neighborhood Healthcare	Alliance Medical Center	Southwest Community Health Center	Gardner Family Health Network, Inc.		Lifelong Medical Center	Mountain Valleys Health Centers, Inc.		Santa Barbara Neighborhood Clinics, Inc.			West County Health Centers, Inc.	
	East County Community Health Center	Escondido Community Health Center				Gardner Health Center	Family Health Foundation of Alviso		Butte Valley Medical Center	Big Valley Health Center	Carrillo Medical Center	Isla Vista Health Center	Westside Health Center	Occidental Area Health Center	Russian River Health Center
Lack of financial stability	X				X		X		X		X		X		
Pressure from funders to cut administrative costs	X						X	X			X	X	X		
Considering expansion/ expansion to multiple sites	X	X	X			X		X							
Weak management systems	X										X	X	X		
Lack of capital funding											X	X	X		
Declining patient caseload							X							X	X
Loss of long-term leadership					X			X							X
Lack of board leadership							X	X							
Opportunities for more funding with economies of scale								X	X						
Management Services Agreements not always helpful	X							X							
Complicated relationships with local hospital							X	X							
Board managing operations							X								
Need for staff reduction in force							X								
Access to FQHC status for clinics							X								
Geographic isolation															X
Billing/practice management	X														
Staff turnover	X														
Possible government purchase of lands threatening sustainability								X							
Language capabilities					X										

## V. Conclusions

At this time, all but two of the agencies in this study successfully have used the organizational restructuring method of a corporate merger to reorganize their agencies. All are moving forward to positions of greater strength. The two agencies which chose not to merge are also each in a position of strength, in terms of financial stability, leadership and credibility within their communities.

Restructuring can help community health centers with common missions to achieve overall stability and also can increase their possibilities for expansion. They may use different routes of restructuring, including management services agreements, shared services, shared management, separate corporations, takeovers, or mergers. Factors that enhance the possibilities of a successful merger include similar missions, location (not competing for the same patients while being close enough to travel easily) and compatible corporate cultures. For example, the similar corporate cultures of Big Valley and Butte Valley allowed them to move ahead rapidly, while the clinics involved with the Lifelong merger have taken a long time to complete their merger as they have worked on finding the right mesh of their very different cultures.

The role of the executive director is critical. In most of the cases in which the restructuring began with an MSA, the merger proceeded in a way that allowed trust to build rapidly between the two agencies' staffs and boards.

However, the timing must be right for all concerned: if one agency is in substantial financial difficulty, it can require a specific set of circumstances to turn the situation around by another agency. Gardner was able to do it, with substantial support from government funders and the ability to take over Alviso's management and board. Big Valley had to work with the local hospital to convince them to forgive their loan to Butte Valley first. Escondido worked through its MSA to turn East County around before agreeing to a merger. Alliance decided it was not in a position to overcome Southwest's financial difficulties, given that Alliance was embarking on a capital campaign of its own.

While there are commonalities of challenges and responses across all of these health centers, each set of agencies had to work from their own specific needs and strengths. Using a road map to restructuring is useful and requires diligence from leadership at each agency to determine what works best for them.

## VI. Attachment A

### List of Study Participants

<u>Agency</u>	<u>Staff Interviewed &amp; Contact Information</u>
Neighborhood Healthcare San Diego, California	Tracy Ream, MPH, Executive Director (760) 737-2030 <a href="mailto:TracyR@nhcare.org">TracyR@nhcare.org</a>
Alliance Medical Center Healdsburg, California	Max Dunn, Executive Director (707) 431-8234 <a href="mailto:amc@alliancemed.org">amc@alliancemed.org</a>
Gardner Family Health Network, Inc. San Jose, California	Reymundo Espinoza, Chief Executive Officer (408) 278-7794 <a href="mailto:respinoza@gfhn.org">respinoza@gfhn.org</a>
Lifelong Medical Care Berkeley, California	Marty Lynch, Ph.D., Chief Executive Officer (510) 704-6010, ext. 261 <a href="mailto:martyl@lifelongmedical.org">martyl@lifelongmedical.org</a>
Mountain Valleys Health Centers, Inc. Bieber, California	Dave Jones, Executive Director (530) 294-5241 <a href="mailto:djones@mtnvalleyhc.org">djones@mtnvalleyhc.org</a>
Santa Barbara Neighborhood Clinics Santa Barbara, California	David Landecker, Executive Director (805) 968-1511, ext. 105 <a href="mailto:david@sbclinics.com">david@sbclinics.com</a>
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West County Health Centers, Inc. Occidental, California	Mary Szecsey, Executive Director (707) 874-2444, ext. 11 <a href="mailto:mszecsey@wchealth.org">mszecsey@wchealth.org</a>