CASE STUDY: MANAGING THE ACQUISITION OF A CLINICALLY INTEGRATED NETWORK

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Authors Note: *This case study is based on a real-world case that instructors of the Health Insights Hub were a part of. The name of the organization, location and other identifying details have been changed to protect the anonymity of the client.*

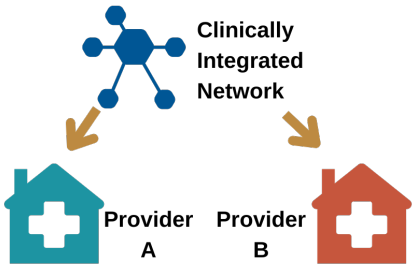
INTRODUCTION AND BACKGROUND

Members of the Health Insights Hub Team were contracted to manage the acquisition of a $40 million per year clinically integrated network (CIN). The CIN was designed as a care management entity for approximately 7,000 adults determined to have a serious mental illness (SMI), 2,000 of which were under court ordered treatment through the county mental health court. Following several years of contracting changes and system transformation, the CIN had become financially insolvent. No single entity had the capacity to assume their full operations so the board of directors of the CIN agreed to sell off half of the company's assets to Provider A and the other half to Provider B.

PROJECT PURPOSE

The purpose of the project was to successfully coordinate the acquisition of the CIN through asset purchases by two entities, Provider A and Provider B, shown in **Figure 1.0**; while successfully transitioning six clinic locations under new management, dividing 200 administrative and clinic-staff members, facilitate continuity of care for 7,000 individuals determined to have SMI and coordinate the transition of 2,000 individual's court ordered treatment with the county mental health court.

Figure 1.0 CIN Dissolution



METHOD AND APPROACH

Below we describe how we successfully managed this unique acquisition.

PROJECT INITIATION

Due to the financial insolvency of the CIN; Provider A, which was also a $40 million per year agency, assumed immediate management of the CIN's day-to-day operations through an administrative services contract. Provider A then contracted with one of the Health Insights Hub's instructors to manage the dissolution project. The Project Manager developed a high-level **project charter** within 48-hours of being assigned, which was approved by Project Sponsor within Provider A, as well as by the Project Sponsor within Provider B, and the Project Sponsor within the CIN. Additionally, the primary payer of specialty services for individuals with SMI was heavily involved throughout the process and needed to approve all key decisions to transition the CIN's contract to Provider A and Provider B; and additionally approved the project charter. **Identified stakeholders** included all four sponsoring entities and the executive leadership teams within those entities.

PROJECT PLANNING

Due to the multiple sponsoring entities, the Project Manager developed three separate and distinct project management plans. The first project management plan addressed how the CIN would manage the dissolution of its assets with Provider A and Provider B; collectively. The second project management

plan was only for Provider A, which documented how the Provider A project management team would then implement the requirements of their portion of the asset acquisition (excluding Provider B). The third project management plan then detailed how Provider B would manage their acquisition of the CIN's assets (excluding Provider A). Collectively, the CIN, Provider A, Provider B and the managed care organization agreed to use the same Project Manager for all three components to promote continuity and optimize knowledge management.

PROJECT EXECUTION

Project Scope Management. Project scope was ultimately defined by the CIN's clinic licensure type, and contract requirements. The Project Manager used these requirements as the baseline to **define the work breakdown structure** for the CIN's asset sale. Provider A and Provider B then added elements to the project scope based on their respective organizational policies, procedures and the terms of their asset purchase agreements, respectively. Consequently, the Project Manager then created separate work breakdown structures for Provider A and Provider B; resulting in three aligned documents.

Project Schedule Management. The project schedule was developed using an agile approach. Based on the defined scopes of the three concurrent projects, the Project Manager analyzed the three work breakdown structures, **defined activities**, **sequenced activities** and then **estimated activity durations**. The Chief Executive Officer of Provider A requested a critical path analysis and that the Project Manager pay heightened attention to the critical path given the project's dynamics. Based on these, a project schedule was developed.

Project Cost Management. Project cost management was not within the scope of the Project Manager for this project, due to the multiple entities involved and their respective budgets. All financial decisions and allocations were managed by the Project Sponsors at the respective organizations involved.

Project Quality Management. The managed care organization held ultimate authority to approve or deny the asset purchase and contract acquisition. The activities list defined the person responsible to develop deliverables as well as the internal party that would perform quality checks prior to the deliverable being submitted to the managed care organization for final approval. When revisions were required, the deliverable would return to the subject matter expert responsible for its development to be corrected or revised per feedback from business owners or the external managed care organization. The activities list was configured to track each step of the deliverable submission process to provide a single source of truth for Provider A and Provider B, respectively.

Project Resource Management. Project resources were managed at multiple levels of the transaction. Due to the financial insolvency of the CIN; Provider A assumed administrative management of the CIN. Provider A, Provider B and the managed care organization injected operating capital to keep the CIN solvent while the dissolution was taking place. Resource needs were negotiated by the executive leadership of the CIN, Provider A and Provider B. The CIN, Provider A and Provider B dedicated executive leadership and management staff to support the project goals. Both Provider A and Provider B used different electronic medical records than each other and as compared to the CIN, and so additionally technology resources were needed to successfully transition medical records. Because this project involved the dissolution the CIN, the staff that worked at the CIN were included in the scope of the acquisitions by Provider A and Provider B. To ensure continuity, the CIN provided all staffing information including staff names, credentials, years of experience, and total compensation information to Provider A and Provider B; who in turn, created job offers for every clinic staff member. The CIN's executive leadership team was then split between Provider A and Provider B based on negotiations and terms of the asset sale.

Project Communication Management. Project communication was configured to ensure appropriate transmission of relevant information across the involved parties, while also protecting the intellectual property of Provider A from Provider B. This included:

- **Provider A Project Status Meetings.** The project team from Provider A convened weekly for project status meetings to review progress towards completion of all deliverables on the work breakdown structure and activities list. Project status meetings were also used to identify emerging risks and coordinate across the project team members. Provider B was not invited to nor privy to discussions that took place in Provider A's project status meetings.
- **Provider B Project Status Meetings.** The project team from Provider B used a similar approach to facilitate weekly project status meetings. Provider A was not invited to nor privy to discussions that took place in Provider B's project status meetings.
- **CIN Project Status Meetings**. Weekly project status meetings were held with the CIN and senior project team members from Provider A and Provider B. CIN Project Status Meetings were intentionally scheduled to take place after Provider A and Provider B's respective project status meetings to enable priorities to be discussed internally first, then collectively, as needed. Agendas were carefully crafted to focus only on topics relevant for all parties in attendance, without inappropriate disclosure of proprietary information. The Project Manager was the only person that had access to the full universe of information throughout the project life cycle.
- **Working Sessions**. Project team members used working sessions to collaboratively develop project deliverables, to analyze and plan responses to project risks as they arose. Working sessions were schedule on an ad hoc basis based off the topic and parties that needed to be involved.
- **Ad Hoc Communication**. In addition to these formal structures, the project team members and Project Manager were in continually communication via email, phone call, text message and 'water cooler' conversations. The Project Manager had dedicated time on site at the CIN, Project A and Provider B which enabled spontaneous collaboration and solutioning to address project needs.

Project Risk Management. Project risks were tracked at the organizational level using a risk, assumptions, interdependencies, decisions and questions (RAIDQs) log. The RAIDQs log included description of requirements referenced, a description of the RAIDQ, who submitted the RAIDQ, the date, and who was responsible to provide a response. The project team then routed RAIDQs to the appropriate party. The responsible party conducted **qualitative and quantitative analysis of risks**, reviewed best practices and convened subject matter experts to **identify risk mitigation strategies**. When risk mitigation strategies were provided, they were documented on the RAIDQ log and submitted directly to the submitting party for implementation; and closing the loop. Through this process, over 50 risks were successfully managed during this project.

Project Procurement Management. This project was a procurement process. When the CIN became financially insolvent, they engaged the managed care organization to identify solutions. The managed care organization used a procurement process to identify Provider A and Provider B and then entered into tri-directional negotiations to facilitate the dissolution of the CIN through a split asset purchase by Provider A and Provider B. Additionally, Provider A and Provider B negotiated with CIN independently and collectively to identify the assets they would acquire and licensing of assets that would be provided to both entities. For example, the organization's policies and procedures and much of its intellectual property was dually licensed to both Provider A and Provider B. Whereas the physical plant, furniture, equipment and supplies were allocated based on which clinic Provider A acquired versus Provider B.

Uniquely, the Project Manager's time was tracked by which party the work was being performed for. Services performed on behalf of the CIN directly, were billed to the CIN; then project management hours were billed to Provider A and Provider B, based on the specific task being performed. Invoices were not shared across the three agencies as they contained proprietary details on Provider A versus Provider B's respective approach.

Project Stakeholder Management. Project stakeholders were tracked throughout the life cycle of the project for the CIN broadly, within Provider A and Provider B. Additionally, the Project Manager provided routine updates directly to the managed care organization that held ultimate authority over the transfer of the CIN's contract to Provider A and Provider B. Another unique element of this project was the transfer of court ordered treatment for 2,000 individuals.

Transferring Court Ordered Treatment for 2,000 Individuals

Court ordered treatment exists to protect the health and safety of the community and individuals who demonstrate danger to themselves or others. Through this process, individuals must be independently evaluated by two psychiatrists, separately, who both must affirm that the individual is unable voluntarily fulfill treatment that is necessary to ensure their health and safety or that of the community. The independent psychiatrists must then petition the court and testify before a judge who may then order an individual to receive treatment at a specific clinic location.

Because the court order to treatment is specific to a clinic location; all 2,000 individuals under courted ordered treatment by the CIN were required to have a judge re-order treatment to Provider A or Provider B, based on which clinic they were assigned to.

Given the volume of orders that needed to be executed within a matter of days the Project Manager assumed responsibility for this process. The Project Manager defined a roster of all individuals who were court ordered to treatment that identified which Provider they would be transitioning to. The Project Manager then worked with a team of Court Coordinators to produce petitions to the court and pre-populate the judge's forms that the judge would sign to update the individual's court ordered clinic assignment. The judge has explicit instructions on what forms could be stapled, versus paper-clipped, wanted color-coded signature tabs on each document and wanted them in a specific order. If there were any errors, the judge stated they would not sign and the process would be delayed.

The Project Manager applied LEAN principles and selected two individuals to support this project, to reduce opportunity for process variance. The Project Manager then personally verified all 2,000 sets of court documents and personally delivered them to the court clerk. The Project Manager also personally returned to the court daily to pick up completed court orders and filed them with the appropriate parties.

MONITORING AND CONTROLLING PROJECT SUCCESS

The Project Manager monitored and controlled success through a variety of tactics:

- **Project Activities List Dashboard**. The Project Manager configured a dashboard that was connected to the project activities list to track progress towards completion of all required deliverables. The dashboard tracked progress by functional area/department and by responsible party. The dashboard additionally tracked project risk status tied to each deliverable on the activities list, including the project schedule to identify deliverables that were behind schedule. As deliverables were submitted to the managed care organization, they received formal 'approval,' indicating they satisfied requirements.
- **Project Communication**. As described above, a series of project status meetings and working sessions were used to monitor and control project success.

- **RAID-Qs Log**. The risk, assumptions, interdependencies, decisions and questions log was used to track all concerns and needs that arose throughout the project. Each item was categorized and assigned a risk score so that it could be escalated to the appropriate party with the appropriate sense of urgency.

PROJECT CLOSURE

Upon completion of all project deliverables, they were submitted to the managed care organization for review and acceptance. After receiving approval from the managed care organization, Provider A and B successfully executed their asset purchase agreements and newly expanded contracts with the managed care organization. Upon approval from the managed care organization, all project resources were released to return to their day-to-day jobs. The Project Manager compiled all project materials which were provided to Provider A and Provider B, respectively. Upon submission, the Project Manager's contract was sunset.

Provider A and Provider B were responsible to submit evidence of tracking every individual that transitioned to their respective clinics until they attended their first appointment to ensure continuity of care. It took nine-months for the last client to attend an appointment at Provider A's clinic.