SANTA BARBARA COMMUNITY CLINICS ASSOCIATION

MERGER FEASIBILITY STUDY

CARRILLO MEDICAL CLINIC
ISLA VISTA HEALTH PROJECTS
WESTSIDE NEIGHBORHOOD MEDICAL CLINIC

Final Report Completed - December 5, 1997

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I. INTRODUCTION

In July, 1997, three members of the Santa Barbara Community Clinics Association (SBCCA) - Isla Vista Health Projects (Isla Vista), Carrillo Medical Clinic (Carrillo) and Westside Neighborhood Medical Clinic (Westside) - jointly agreed and SBCCA concurred - to undertake a merger feasibility study. The agreement to move forward on the study was a result of a recommendation for the three clinics to merge included in a James Irvine Foundation-supported consultation to strengthen the association and its members. The decision to move forward was concurred by the three Boards of Directors, Executive Directors and Medical Directors at several joint and separate meetings of the SBCCA as well as two joint meetings of the Boards of Directors of the three clinics. SBCCA members that were not included in the feasibility study recommendation also agreed that the feasibility study was an important and effective use of Blue Cross Community Clinics Grants funds that remained and were in the custody of the Santa Barbara Community Foundation. SBCCA voted to use a portion of the remaining funds in this manner.

A merger feasibility study was commissioned and funded in August, 1997. Three consultants were chosen to prepare a merger feasibility study (See Attachment A - Merger Feasibility Proposal) that included a survey of the three clinics identified earlier. The study identified that the following systems would be investigated in each clinic and recommendations would be developed as to the feasibility of merging these functional areas:

- governance
- corporate entity
- organizational structure
- administration
- staffing and personnel systems
- clinical systems and staffing
- financial management systems and staffing
- building ownership and leases
- merger costs and liabilities
- merger benefits
- transition plan.

The consultants (see Attachment B - Consultant Resumes) were Bobbie Wunsch, MBA, Lead Consultant (governance, organizational structure, administration, staffing and personnel systems), Barbara Rosa, MS, NP (medical management systems) and Regina Nowotny, MS (financial management systems, building ownership and leases, merger costs and liabilities).

The products that would result from the merger feasibility study were identified in advance to be:

- feasibility study of the potential merger of Westside Neighborhood Clinic, Carrillo Clinic, and Isla Vista Medical Clinic, including issues related to finances, revenue recovery, personnel, administration, governance, legal and medical staffing, medical systems and information management, including anticipated cost-savings and additional merger-related expenses.

- implementation workplan and timeline to initiate the merger process if clinics agreed to move forward.

The intent of the study was not a complete review of all aspects of clinic services or management; the intent was to identify the key elements that needed to be evaluated in order to prepare additional recommendations regarding the feasibility of the merger of the three clinics. A timeline and cost estimate were also developed and based on three clinics participating in the study. Originally it was anticipated that the study results would be presented in mid- to late- September, 1997. In fact, the initial study results were presented in early October with the final recommendations in late November and the final report in early December, 1997.

II. PURPOSE OF THE STUDY

A. Study Process

The feasibility study began with a request for advance materials from each clinic (see Attachment C - Advance Materials Requested). An initial on-site visit was made in early August and approximately 1.5 days was spent by each of the consultants on-site. Time was spent before and after the site visits studying and critiquing materials, speaking to staff and board members from each clinic involved and in discussions among the consultants as to the best approach.

B. Unanticipated Events

In the 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 separate report prepared by The Bernal Group - Barbara Rosa and Jack Brandenberg - and funded by the California Endowment and requested by Westside's Executive Director identified a number of operating deficiencies during this process and Westside was exploring a variety of approaches to stability.

At the SBCCA meeting during which the merger feasibility study was approved, Westside announced that American Indian Health Services (AIHS), a community-based non-profit organization that did not directly provide primary care services except through a contract 4-hours per week with Westside, had proposed a merger of AIHS and Westside to obtain Medicaid cost-based reimbursement through the Federally Qualified Health Center (FQHC) designation. As an American Indian clinic, AIHS would be eligible "automatically" to receive this designation if it had a community clinic license and met basic FQHC requirements. Westside announced that its Board of Directors would explore the possibility of this option at its next meeting.

In early September, the consultants were notified by SBCCA that Westside had indeed entered into negotiations with AIHS to merge its operations and access cost-based reimbursement for its Medi-Cal patients. SBCCA asked the consultants to continue the study, to include data related to Westside and its operations, but to develop the final recommendations for Carrillo and Isla Vista as they continued to be extremely interested in a potential merger. The consultants agreed to re-work their recommendations and asked for a several week delay in presenting their findings. SBCCA agreed and a meeting date for early October was confirmed.

Subsequently, in late September, the merger talks between Westside and AIHS were stopped abruptly because of a federal report commissioned by AIHS that would not allow AIHS to continue its merger plans with Westside, due to operating deficiencies previously identified in the Bernal Group report. Westside's financial situation, in the meantime, had gotten more desperate and Westside chose to take its situation to the public to request assistance in a variety of newspaper articles and pleas for financial support. The consultants regularly requested updates on the situation in order to ascertain whether or not the composition of the potential merger partners would change, due to the ever-changing circumstances in the environment.

At a meeting of SBCCA on September 29, it was confirmed that Isla Vista and Carrillo would move forward as the main merger study partners and that information that had been collected about Westside would be included as appropriate. The consultants were informed that no recommendations related to Westside were to be included in the report.

On October 7, the consultants met with members of the Boards of Directors and staff of the three clinics to present the initial feasibility study draft report and recommendations for a two-clinic merger between Carrillo and Isla Vista. Westside Board members and staff expressed concern that Westside had not been included in the draft recommendations and, after lengthy discussions, requested that the report and recommendations be re-designed to include Westside. The consultants suggested that the follow-up report and revised recommendations could include two options: a two-clinic merger (Carrillo and Isla Vista) and a three-clinic merger option. All participating clinics agreed. Westside also agreed to provide a letter of commitment to SBCCA expressing its intent to participate in the merger discussions (see Attachment D).

In the intervening weeks, there was much discussion among the clinics and the consultants in an effort to verify data, collect additional information from each of the clinics and other stakeholders and to re-design the report and recommendations based on the two merger options. In addition, Westside was extremely successful in its public appeal for funds, receiving approximately $150,000 in donations and loans by early November. For a time during this period, Carrillo also experienced concern about its financial situation, appealing to funding sources for assistance. Later in November, Carrillo received notification and funds from the Santa Barbara Health Initiative which eased its financial situation considerably.

Nerves and tensions ebbed and flowed within and among the clinics during the extended study period. The constantly changing micro-environment created difficulties for the consultants in preparing and finalizing the report and recommendations. Information was flowing in many directions and objective analysis was often hard to make.

In early November, Bobbie Wunsch, MBA, Lead Consultant for the merger study, visited Santa Barbara to meet with the senior executives at the Santa Barbara Health Care Services Agency, Santa Barbara Foundation and Santa Barbara Health Initiative. The purpose of the meetings was to bring these key stakeholders up-to-date on the merger study process, its final recommendations and to explore several unsettled issues. 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. All three parties expressed a keen interest in supporting the clinics and in providing whatever assistance was feasible in the coming months. Each requested an opportunity to read the report when it was completed and to engage in further discussions afterwards with the consultant and the leadership of the clinics.

Needless to say the continually changing landscape throughout this merger study process, while somewhat disruptive to the original process, was also extremely illustrative of the reasons that the original merger recommendation was made. The situation emphasized the need for strong and stable clinic organizations as essential to the future provision of care to low-income and indigent individuals in Santa Barbara County.

C. Why Restructure

A number of factors contributed to the decision to move forward into merger discussions:

- an early 1996 request to SBCCA and its members to consider the Santa Barbara County Health Services Agency's proposal to explore the transfer of primary care services to other providers presented opportunities as well as tremendous challenges to member clinics individually as well as collectively.

- for at least the past five years, all three clinics had continually had cash flow problems, had no cash reserves and had no funds for capital improvements; each presented the regular and recurring situation of having a hard time “making payroll,” to one degree or another.

- all three clinics relied heavily on the year-end Santa Barbara Health Initiative’s (SBHI) (14 year old county-wide Medi-Cal managed care, county organized health system) savings distribution to primary care providers in order to leverage debts each year. The clinics came to rely on these savings distributions, budgeting them in their annual budgets, even though these funds are not intended as “secure” funding from year to year. SBHI is currently restructuring its methodology for calculating savings pool redistributions further complicating the clinics’ reliance on these funds.

- mergers were occurring everywhere in the health care community, nationally, regionally and in Santa Barbara County. The two community clinics in the northern part of the county had recently merged with the local hospital in their area as a result of difficult financial situations just as that hospital (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.

- new funding sources were becoming available that, in order to access successfully, required more sophisticated management information systems (i.e. Family PACT and Healthy Families - Children’s Health Initiative) and more technical skills on the staffs of community clinics, both here in Santa Barbara as well as everywhere else.

- all three clinics suffered from weak management systems due in great part to the lack of capital funding and the low priority of this issue for both staff and board members. Perhaps all three clinics existed in an atmosphere of historical nostalgia - they had all been established 20-25 years ago 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 process as well.

- finally, the recommendation from the James Irvine Foundation report to explore a merger as one means to achieve stability was embraced enthusiastically as an important step forward. In fact, many commented that it was a step that many had thought of, but didn’t feel comfortable speaking aloud in the past. It seemed that the “time was right” to move forward.

D. Planning a Restructuring Strategy

Healthcare organizations form strategic alliances for several reasons:

- to achieve economies of scale
- to provide specialized clinical or expensive services
- to pursue common outcomes or projects.

Creative alliances (joint ventures, shared management and service agreements, etc.) allow healthcare organizations to work together without entering into binding legal agreements that may be irreversible and allow organizations to consider "courtship" as a preliminary step to further integration. Such alliances can be effective strategies for organizations that differ in size and financial strength and are most appealing to organizations that want to join forces without making a long-term commitment.

Two attributes characterize creative alliances:

(1) absence of structural and financial integration found in statutory mergers, consolidations, acquisitions, etc.
(2) the formal right of the participants to terminate a relationship upon the occurrence of specified events or after a stipulated period of time.

SBCCA is an example of a successful creative alliance - a joint venture intended to:

- raise the visibility of community clinics in Santa Barbara County;
- develop new avenues for funding that generally are unavailable to clinics independently; and
- share information, network and develop shared strategies together.

Generally these types of alliances, though, (SBCCA is a good example) do not involve the same degree of economic integration as mergers or acquisitions and may not provide the participating organizations with the same level of stability or confidence that a merger or consolidated organizational structure would offer.

The impetus to merge can arise in many ways. In an ideal scenario, a merger is the formalization of a long-nurtured, collaborative, mission-driven relationship between equally healthy organizations with a strong bond of trust. In such cases, restructuring discussions may seem to arise naturally perhaps driven by staff who are already working together closely and brought to the boards by enthusiastic executive directors. Or a merger may be initiated by one board that sees a need for creative solutions before diminished funding or weak management undermines the organization's effectiveness. In either case (and in other situations), economics may spur organizations into action, but improving the effectiveness in fulfilling mission is the primary benefit the organizations seek.

Even though restructuring rarely yields cuts in program or administrative costs, the most common impetus to join with another organization is the desire to shore up an economically faltering but programmatically viable organization.

Whatever the reason for considering any collaboration, boards and staff must recognize that the process before and after signing the final merger agreement is difficult and both resource- and time-intensive. Restructuring is not a quick fix. Success is most likely if the organizations engage in honest, open, and strategic self-examination and an extensive, thoughtful planning process before deciding to merge - and continue to invest in the success of the blended organization for years after the restructuring is complete.[1]

The restructuring process can take from 9 to 18 months. The members of SBCCA are already into the process which includes the following steps:

- decide to consider merging - SBCCA commissioned the merger feasibility study.

- choose the right partner - SBCCA members have similar missions, similar histories and generally speak with the "same voice" on behalf of patients and clients.

- make contact - the boards of the member clinics have met jointly on several occasions recently to discuss merger and the implications of the current environment.

- make a commitment - the clinics made a commitment to move forward together and asked SBCCA to vote to enable the clinics to do so through the funds from the California Endowment. Each clinic was asked to have its Board pass a resolution supporting the effort.

- communicate - SBCCA members involved have communicated regularly throughout the process. It is impossible to over-communicate during this process. By keeping staffs, boards and other stakeholders informed about the process, some of the anxiety and misinformation that is natural in a process such as this can be minimized. Once a decision to move forward is made, efforts should be made to give staff and board members more opportunities to meet together.

- decide to merge - a recommendation to merge should identify who will lead the new organization, what its identity will be, what will the name of the new organization be, how will governance be structured, what shape will the operations take, etc.

- fund the process - invest in organizational, staff and board development by obtaining funds to assist a smooth, orderly and enabling process including a merger committee to oversee the process. Don't expect cost savings - the process of creating a new organization out of existing organizations requires not only human commitment, but an infusion of funds for transitional expenses - legal fees, consultants' fees, new space, new logos, new identity, marketing materials, etc. It is

[1] *The Power of Mergers*, National Center for Non-Profit Boards, Volume 6, Number 8, September, 1997.'

rare for a merger to result in reduced operational costs. Generally there is a pent-up demand for more administrative services in non-profit organizations and certainly there is almost always a need for more sophisticated management systems.

- plan for the future - both a transition plan as well as a business plan for the new organization will help set clear goals and expectations for performance.

A number of barriers to restructuring do exist and should be explored by the member organizations. These barriers can be apparent in talking to individual board or staff members:

- loss of independence
- fear of the unknown
- turf problems
- costs and time
- loss of identity
- loss of personal security.[2]

Many organizations can overcome these barriers by choosing the right partners, building on previous history and successful experience in collaboration. Informal collaborations can be the foundation of building institutional trust.

Following is a list of factors that enable a successful merger:

- previous history of successful collaboration. Many years of working together in a variety of ways as well as the most recent efforts of SBCCA have laid important groundwork for its members in this way.

- role of the executive director - often it is easier to accomplish a merger if one of the organizations is in between executive directors. Since this is not the situation within the SBCCA merger collaborators, it will be recommended that one of the executive directors be chosen to be the new executive director. The main reason not to go outside of the clinic members for an executive director at this time is that two of the member executive directors are extremely interested in continuing as executive director with the new organization. An ad-hoc transition committee made up of board members of all participating merger partners should develop a job description (See Attachment E) and interview both candidates. In other merger situations, this recommendation might not always be made. Each situation is different and requires somewhat different strategies.

- non-overlapping markets - it is helpful if partners do not routinely compete with each other. With the three clinic configuration, issues of competition or over-lapping markets are serious, with two clinic locations in downtown Santa Barbara. If the partner configuration is two clinics (Carrillo and Isla Vista), this situation does not occur; both clinics have distinct and separate market areas. If this is a three clinic

[2] *Nonprofit Mergers: The Board's Responsibility to Consider the Unthinkable*, David LaPiana, NCNB, 1994.

merger, location of clinics in downtown Santa Barbara will have to be examined to achieve efficiencies.

- geographic compatibility - as was mentioned above, Carrillo or Westside and Isla Vista have excellent geographic compatibility. With three clinics as part of the merger mix, the issues are more complicated because of the proximity of Carrillo and Westside in central Santa Barbara.

- complementary culture - mission and values underlie behavior and all three merger partners have complementary missions, values and histories. These ingredients make a merger much easier.

- special assets - sometimes an attractiveness of a partner is not easy to quantify but includes such things as building ownership, strong entrepreneurial culture, different and complementary services or programs, good political connections, etc.[3]

Each merger partner has attractive qualities. Some of these include:

Carrillo	Isla Vista	Westside
Dental clinic	Facility	Fund raising success
Patient mix	Drug & alcohol programs	Building ownership
Provider stability	Building ownership	Provider credibility
Computer system	Location	Neighborhood focus
Medical Director longevity	Community visibility	Computer system

The Boards of Directors of the merger partners may consider a merger strategy for a number of reasons or a combination of the following situations under which the merger may be the means to achieving an individual organization's purposes:

- **Survival through merger:** a merger should be considered when, like it or not, a nonprofit group (or groups) cannot continue to function effectively in pursuit of its mission because inadequate cash flow is crippling its operations

- **Efficiency over duplication**: duplication of services (whether in actual service to consumers, or the strain caused on resources by limited resources - financial, technical and human, a limited donor pool or experienced community members who are willing to serve as board members), is harmful when services that could be coordinated are not. Duplication is also a problem when groups that provide similar services or serve the same population compete rather than cooperate for community attention, visibility, funds, staff and other resources and support.

- **Strategy for growth**: mergers can help organizations become more effective and to grow in size, scope of services and in sophistication of skills available. It is a relatively rare occurrence when groups agree to trade their autonomy for increased

[3] *Nonprofit Mergers and Alliances*, Thomas McLaughlin, NCNB, 1996.

strength and heightened potential for combined action. The confusion related to corporate takeovers add to the difficulty of a successful merger. The successful nonprofit merger that preserved the services of smaller, weaker groups with similar missions, actually does the community a remarkable service.[4]

A potential merger should be evaluated based on the following achievements[5]:

1. Is the new entity more visible in the community or communities it serves?
2. Does the new organization have the same market share as before? How does its present share compare with the originally desired level?
3. Is the new organization recognized more widely as having expertise in its field?
4. Do individual staff and board members of the new entity have more contact with public and private health care leaders and consumer representatives?
5. Has the new organization consolidated each major administrative system and taken advantage of economies of scale, where appropriate?
6. Can all employees concisely describe the new entity's mission and why the merger occurred?
7. Does the new entity have a program for continuously improving the quality of services and the satisfaction of both consumers and staff members?
8. Do the scope and intensity of services match the needs of the communities served?
9. Is the new organization more economically stable?
10. Are there more opportunities for resource development (financial, human, technical, etc.)? is the new organization able to respond quickly to new opportunities?

This merger feasibility study will explore these questions and provide an assessment as to whether or not a merger between two or three of the merger partners can be successful in achieving these ends.

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4 *Nonprofit Mergers: The Board's Responsibility to Consider the Unthinkable*, David LaPiana, NCNB, 1994.

5 *Nonprofit Mergers and Alliances*, Thomas McLaughlin, NCNB, 1996.

III. FINDINGS AND RECOMMENDATIONS

In this section, the findings and recommendations of this merger study are presented in detail. These findings and recommendations are intended to test the feasibility of two options - a two clinic and a three clinic model of merger. The recommendations also suggest other opportunities for systems improvement.

The findings and recommendations are organized in this order:

- A. Management
  - A.1. Organizational Structure
  - A.2. Governance
  - A.3. Administration

- B. Clinical Systems
  - B.1. Scope of Clinical Services
  - B.2. Capacity and Productivity
  - B.3. Role of Medical Director
  - B.4. Hospital Privileges and After Hours Care
  - B.5. Quality Improvement and Clinical Guidelines
  - B.6. Patient Satisfaction
  - B.7. Malpractice Claims History
  - B.8. License Status

- C. Financial Management
  - C.1. Merger Costs
  - C.2. Costs of Operational Changes
    - C.2.a. Cash Management
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    - C.2.c. Personnel Costs
    - C.2.d. Building and Occupancy
    - C.2.e. Debt Management
    - C.2.f. Budgeting and Financial Planning
    - C.2.g. Fiscal Reporting
    - C.2.h. Annual Audit
    - C.2.i. Risk Management
    - C.2.j. Estimated Financial Impact of Merger
  - C.3. Financial Projections

A. Management

A.1. Organizational Structure

Findings:

F.1. The missions of all three organizations are extremely compatible, with the distinct geographic emphasis of Isla Vista on the Isla Vista community and Westside on the Westside neighborhood. Carrillo does not have such a distinct geographic target area.

F.2. The histories of all three organizations are also extremely similar with the one exception that Westside and Isla Vista began initially as private practices and later became licensed non-profit community clinics. All three organizations are between 20 - 25 years old, having opened within five years of one another.

F.3. All three organizations have 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.

F.4. All three organizations are licensed community clinics. The Carrillo Family Dental Clinic, which uses the Carrillo Medical Clinic as its fiscal agent, is licensed under the Carrillo Medical Clinic's community clinic license.

F.5. All three organizations are incorporated in the State of California as 50l(c)(3) organizations with community-based boards of directors. Only Westside allows staff members to sit as voting board members.

F.6. All organizations have Articles of Incorporation and By-Laws, although Carrillo cannot find their By-Laws. They have been requested from the Secretary of State and have not arrived yet. There are differences in all of these documents which are identified in Table I. The differences are not significant but must be addressed as the new organization restructures.

F.7. The Executive Director in each organization is selected, evaluated and reports to its respective Board of Directors. In each clinic, the Medical Director reports to the Board of Directors, although the Medical Director has been hired and evaluated in different ways. At Westside, historically, the Medical Director has been chosen by the Personnel Committee and one member of the physician staff. At Isla Vista, the Board has hired the Medical Director, who has been evaluated by the Board's Medical Practices Committee made up of the physicians on the Board of Directors. At Carrillo, the Medical Director has been on board with the clinics for eighteen years and has not been evaluated.

TABLE I
Comparison of By-Laws

	Carrillo[6]	Isla Vista	Westside
Members	None	Board of Directors	Board of Directors
Officers	President, Vice President, Secretary and Treasurer	President, Vice President, Secretary and Treasurer	Chair, Vice-Chair, Secretary and Treasurer
Terms	2 years	2 years	2 years
Removal	N/A	2/3 vote	majority vote
By-Law Changes	2/3 vote	2/3 vote	2/3 vote
Power to hire/fire Executive Director	N/A	60% vote	None stated
Term limits	N/A	None	None
Elections	N/A	Biannually	Annually
Number of Board Members	5	9 to 15	9 to 15
Board Composition	Community members, no staff	Community members, no staff	No more than 49% may be interested persons (paid in some way by WNMC)
Executive Committee	N/A	Identified in By-Laws	Any three officers
Committees	N/A	Medical Practices, Finance, Personnel, Executive	Executive

Recommendations:

R.1. A new 50l(c)(3) corporation should be created, rather than merging the current corporations into one of the existing others. This approach will allow each organization to feel that it is becoming part of a new one, rather than being "absorbed" or "taken-over" by another. This should be accomplished and effective by July 1, 1998 to avoid split fiscal years and additional reporting costs. While this target date forces the clinics to move quickly, this merger should be done expeditiously to take advantage of the current momentum, interest and "relative" financial calm for the merger partners at this time.

R.2. All contracts, grants and assets of the merging organizations, including accounts receivable, should be assigned and transferred to the new corporation at the time of restructuring with the exception of the building owned by Isla Vista Health Projects and the building owned by Westside Neighborhood Medical Clinic.

R.3. The merger partners should develop a "Letter of Intent to Merge" no later than February 1, 1998 describing the merger partners' commitment to merge, merger goals, assets' transfers and the status of both buildings. For a limited time period (no less than six months and no more than two years) Isla Vista and Westside should retain their

[6] Have not been provided.

corporate structures in order to manage the ownership of their buildings. These decisions should be based on legal advice as to the timing of the transfer of the municipal bond that provides funding for the Isla Vista building and the circumstances surrounding the financing of the Westside building and its related indebtedness. It is further recommended that no rent be charged for the space occupied by the Isla Vista Medical Clinic by the Isla Vista Health Projects corporation, as is the current practice as long as the Isla Vista building debt service can be paid by rental income. It is also recommended that all rents collected from the other tenants of the building be contributed to the new corporation for operating costs as is the current practice with the Isla Vista Clinic. Rent will have to be charged by Westside to the new organization in order to pay its mortgage and related insurance costs. Fiscal staff of the new corporation can be assigned any duties related to financial management or reporting of the property on behalf of the Isla Vista Health Projects and Westside Neighborhood Medical Clinic (see Financial Systems Section of this report for more detail on the status of the buildings).

R.4. A mission statement and core values should be crafted incorporating the best statements of the merging organizations by March 1, 1998 for the new entity.

R.5. A statement about the histories of the merging organizations should be written no later than March 1, 1998, identifying similarities and differences, founding principles, and reasons for the merger. This historical statement should be attached to the mission statement and core values and should be incorporated into the new personnel policies of the new organization.

R.6. Legal counsel for the merger should be engaged and new Articles of Incorporation and new By-Laws should be created utilizing the current documents of both organizations no later than March 1, 1998.

R.7. A new corporate name for the new organization should be created through a participatory process involving all staff and board members of the merging corporations. The new corporate name should not use any of the identifying words (i.e. Carrillo, Isla Vista or Westside) in the new name. A new logo and letterhead materials should also be developed.

R.8. The new organization should maintain clinical site locations at the current sites for the time being. In addition, the sites for clinical services should continue to be called their current names for continued name recognition among patients, community organizations and funders. And these site locations should be listed on the letterhead either as “sites” or as “formerly Carrillo Medical Clinic, Isla Vista Health Projects and Westside Neighborhood Medical Clinic.” It is extremely important not to lose the identity of the current sites in this process. The Carrillo Family Dental Clinic should retain its name also.

During the initial two years after the merger, serious consideration should be given to identifying and obtaining a new clinic site in central downtown Santa Barbara. This

discussion should include the Santa Barbara County Health Care Services Agency, Cottage Hospital, Santa Barbara Foundation, Hutton Foundation, Santa Barbara Health Initiative, and other community stakeholders in order to decide on the most appropriate location for a new site (see Clinical Systems Section). The Santa Barbara Foundation has offered to convene these discussions and to encourage other foundations and health care stakeholders to participate.

R.9. The new organization should have an Executive Director, a Medical Director and a Financial Manager. The Executive Director should be chosen from one of the existing clinic executive directors who are interested in the position by the new Board of Directors. The Medical Director should be chosen in a process organized by the new Board of Directors or a group designated by them. The Medical Director of Carrillo has expressed interest in the position. A Financial Manager should be recruited by the new Executive Director. (See Attachment E for sample job descriptions.)

R.10. New community clinic licenses should be obtained given the new corporate structure. Each clinic site will have to be evaluated by the Department of Health Services, Clinic Licensing Division due to the corporate structure change. This will have to be completed by the official date of the merger.

A.2. Governance

Findings:

F.8. All of the clinic organizations currently have Boards of Directors. Carrillo has unspecified numbers of Board members (five currently sit on their board) and Isla Vista and Westside's By-Laws both require 9-15 members.

F.9. Westside has a cooperative Board of Directors model which allows staff members to sit as voting members. Westside's By-Laws allows that no more than 49% of voting members may be "interested" persons (persons in some way paid for their services by Westside). Westside's board membership has been in flux for at least the past twelve months.

F.10. Carrillo has no designated operating committees. Westside identifies an Executive Committee in its By-Laws made up of any three officers of the corporation. Isla Vista's By-Laws describe Medical Practices, Finance, Personnel and Executive Committees.

F.11. None of the three clinic organizations has term limits for board members although they all have 2 year terms of service.

F.12. Isla Vista and Carrillo have the following officers: President, Vice-President, Secretary and Treasurer, with similar duties. Westside has a Chair, Vice-Chair, Secretary and Treasurer, also with similar duties.

F.13. It takes a 2/3 vote of the Isla Vista Board to remove a director from office and a majority vote on the Westside Board. Carrillo has no such stipulation as far as is known.

F.14. All three clinics require a 2/3 vote of the Board members to change the By-Laws.

Table I on page 13 illustrates the comparison of By-Laws currently in place.

Recommendations:

R.11. A new Board of Directors should be created and composed of 11-15 members (no less than 11; no more than 15) and seated by July 1, 1998. The new Board of Directors should include individuals committed to the mission of community clinics who possess critical thinking skills, have former experience as Board members of community-based organizations, and have other professional or community-based skills that will assist the new organization during the early years of transition. It is important that several physicians who are prominent members of the medical community are included on the Board and actively participate in its work.

R.12. The initial seating of the new Board of Directors should occur in the following manner:

In the two clinic option:

a. Each merging organization should appoint approximately one-third of the new Board from their current members (4 from each current board)

b. 3-5 community members with demonstrated experience and commitment to community health improvement should be elected by the new Board members after nominations provided by a Community Nominating Committee (made up of the Director of the Santa Barbara Health Care Services Agency, the CEO of the Santa Barbara Foundation, and one other prominent member of the community with knowledge of community resources and no previous ties to the merging organizations) or nominated directly by either of the former Boards, by SBCCA or by any other community health leader.

c. One member should be chosen from the Carrillo Family Dental Clinic Steering Committee.

In the three clinic option:

a. Each merging organization should appoint three members of the new Board from their current members

b. 3-5 community members with demonstrated experience and commitment to community health improvement should be elected by the new Board

members after nominations provided by a Community Nominating Committee (made up of the Director of the Santa Barbara Health Care Services Agency, the CEO of the Santa Barbara Foundation, and one other prominent member of the community with knowledge of community resources and no previous ties to the merging organizations) or nominated directly by either of the former Boards, by SBCCA or by any other community health leader.

c. one member should be chosen from the Carrillo Family Dental Clinic Steering Committee.

Terms of office should be staggered, identified and begin as soon as the new Board is seated. Once the new Board of Directors is in place, future succession will be determined by the new By-Laws.

R.13. The new Board should choose its own officers as soon as it is seated and no later than July 1, 1998.

R.14. No staff members or other "interested" persons should be voting members of the Board of Directors of the new corporation.

R.15. The new By-Laws should include provisions for an Executive Committee and other standing committees to include but not be limited to Nominating, Personnel, Finance, Quality Assurance, Dental, Medical Practices, and Program.

R.16. A merger agreement should be created incorporating the merger recommendations and Board resolutions to dissolve current operations and should be adopted by all existing Board of Directors no later than April 1, 1998.

R.17. An Ad-Hoc Transition Team made up of the Board Presidents of each merging clinic, one additional board member from each merging clinic and the Executive Director of each merging clinic should be established no later than January 8, 1998 to guide the merger process. Non-personnel expenditures over $500 should be mutually discussed and agreed upon before expended, since the decisions will directly impact both the financial position and the programs of the new corporation. In addition, the Medical Directors should participate, as necessary, in discussions with the Ad-Hoc Transition Committee on a regular basis. Once the Ad-Hoc Transition Committee begins the process of recruitment, hiring and selection of a new Executive Director and Medical Director for the new organization, the individual clinics' Executive Directors and Medical Directors should not participate at all in the process due to obvious conflicts of interest, whether or not they are potential or interested candidates.

R.18. No later than the February board meeting, the merging organizational Boards should adopt a Letter of Intent to Merge (See Recommendation R.3.) and recommendations included in this report.

R.19. Notification should be developed and approved by the Ad-Hoc Transition Committee to all funding sources, community leaders and other interested parties regarding the intent of the merger process by May 1, 1998.

R.20. A regular and ongoing communications plan to discuss merger-related issues with staff members of the merging clinics should be developed no later than March 1, 1998, approved by the Ad-Hoc Transition Committee and implemented no later than March 1, 1998.

R.21. The new Board of Directors should purchase Directors and Officers Liability Insurance effective July 1, 1998.

A.3. Administration

Findings:

F.15. The merging organizations, as with many non-profit organizations, lack significant administrative staffing given the requirements of today's health care environment, emerging regulations and funding sources.

F.16. The administrative offices of the current organizations are located at each of the clinic sites.

F.17. Personnel policies do exist in all organizations. There are significant differences between the Personnel Policies, employee compensation and benefits structure among the merging organizations. The differences include the definition of full-time employment and benefits initiation, pay periods, paid holidays and clinic closures, vacation and sick leave allocations, etc. These differences are identified in Tables II and III which follow later in this report.

F.18. Job descriptions do exist in the merging organizations to varying degrees. They will need to be revised based on the new administrative structure. (See Attachment E - Sample Job Descriptions.)

F.19. Most of the grants and contracts held by the merging organizations are from similar sources. This will make the transition easier, given the staff's familiarity with the different funding sources.

Recommendations:

R.21. The following positions should be included as part of the management team of the new organization. Sample job descriptions are provided for these positions in Attachment E.

Executive Director:	responsible for all operations; chief spokesperson; in charge of external affairs and fund raising; reports directly to the Board of Directors (1.0 FTE)
Medical Director:	responsible for setting medical policies, supervising physicians and mid-level providers, responsible for developing and supervising a quality assurance and quality improvement program; works collaboratively with the Executive Director; reports to the Board of Directors monthly (1.0 FTE, including clinical time)
Community Services Director:	responsible for supervision of all community and support services, including dental, drug and alcohol, outreach, etc. (1.0 FTE)
Financial Manager:	responsible for implementing and supervising all financial management systems, management information system (computer system), accounts payable, payroll, etc. (1.0 FTE)
Site Managers:	responsible for day-to-day operations of clinic sites; may be working managers, providing direct service (2.0 - 3.0 FTE depending on merger partners, including time spent working on other day-to-day responsibilities)

R.22. One location for all administrative services needs to be secured. It is suggested that one of the vacant office suites in the building owned by Isla Vista Health Projects would be suitable and the least expensive given the financial arrangements with the building owner (Isla Vista) and the new corporation. All administrative staff, including billing clerk, would be located in the administrative offices, except for the designated clinic site managers who would be located at the clinic site they are responsible for and the Medical Director during clinical service times.

R.23. New job descriptions should be developed for all management positions no later than June 1, 1998 (see Attachment E - Sample Job Descriptions).

R.24. Priority should be given to filling staff positions that are available due to this merger with current staff that meet the qualifications and experience as identified in the sample job descriptions that are included as Attachment E. The Ad-Hoc Transition

Committee should set the policies for these employment opportunities.

R.25. New personnel policies should be developed no later than July 1, 1998, utilizing the analysis of the costs inherent in the differences between the current merging organization's policies. An outside personnel expert (a volunteer personnel or human resources manager from another large organization in the community or a personnel/labor attorney) should be engaged to review all policies, so that they are in compliance with current laws and regulations (see Table VIII, One Time Merger Costs).

R.26. A salary comparability study of local health care organizations and surrounding community clinics and county clinics should be completed and salaries for the positions in the new corporation set according to a combination of prevailing community and clinic standards, current salaries and available revenues. Salary parity will have to be developed for staff members in similar positions. This process should be undertaken with a personnel/human resources consultant and completed no later than the first quarter of the new organization. (See Financial Management Section for impact on merger of differential salary costs.)

R.27. Develop an on-going communication plan to notify the patients of the changes in the corporate structure and to keep them informed on an on-going basis, focusing on the expectation that this corporate change will do two things: (1) impact patients in a non-visible way and (2) increase the stability of the merging organizations.

R.28. Develop an administrative implementation plan no later than June 1, 1998, approved by the Ad-Hoc Transition Committee and each of the Boards of Directors of the merging clinics. This plan should delineate all changes planned and anticipated, timelines, staff orientation, training and responsibilities, service and location assessments, financial impact review, etc. Proposed Implementation Plans are included as Section IV of this report.

R.29. Create a merger evaluation process, developing benchmarks for measuring the success of the transition plan incrementally and the overall outcomes of the process.

R.30. Notify all funding sources of the impending corporate changes and inquire about any special requirements related to transfer of the grants or contracts to the new organization.

R.31. At the initiation of the merger in July, 1998 and six months thereafter, convene a group of Board members and staff in a planning retreat format to evaluate progress in meeting the merger's objectives and build a new sense of community and corporate culture.

R.32. Develop clear performance targets for Year One in terms of patient utilization, financial stability, staff retention, patient satisfaction, community relations, etc.

TABLE II
Comparison of Personnel Policies and Procedures

	Carrillo	Isla Vista	Westside
At Will Employment Status	Not stated	Yes	Not stated
Harassment Policy	No	Yes	Yes
Orientation Period	3 months	3 months	90 days
Full Time Employees	32 hours/week: all benefits	30 hours/week: all benefits	30 hours/week: all benefits
Part Time Employees	<32 hours/week	<30 hours: partial benefits	<30 hours: partial benefits; <20 hours: no benefits
Pay Periods	Not stated	Every other Thursday	Not stated
Pay Advances	Not stated	Yes	Not stated
Holidays	7: New Year's Day Memorial Day July 4th Labor Day Thanksgiving (2) Christmas Day Part timers eligible after 4 years	11: New Year's Day Martin Luther King President's Day Earth Day Memorial Day July 4th Labor Day Thanksgiving (2) Christmas Employee birthday	7: New Year's Eve (.5) New Years Day Memorial Day July 4th Labor Day Thanksgiving Day Christmas Eve (.5) Christmas Day
Vacation	0 - 3 years: 10 days 4 - 10 years: 15 days >10 years: 20 days	1st year: 10 days 2nd year: 15 days 3rd year: 20 days	0 - 2 years: 10 days 3 - 5 years: 15 days >5 years: 20 days
Medical Insurance	Full time: medical, dental, vision Part time: may purchase medical	Full time: comprehensive medical, dental, vision	Full time and reg. part time: comprehensive life, hospital, medical, and dental
Dependent Coverage	No	No	50%
Retirement Plan	403(B) plan. No matching contribution	403(B) plan. No matching contribution	403(B) plan. No matching contribution
Sick Leave	.5 days/month May accrue up to 12 days	1 day per month. May accrue up to 20 days	1 day per month. May accrue up to 30 days
Continuing Education	Approved on an individual basis	No limit, but must be pre-approved. Time counts as time worked for exempt employees. All employees may be reimbursed, if approved.	5 days per year, does not accrue; up to $600 for expenses

TABLE III
Comparison of Personnel Benefits

	Carrillo	Isla Vista	Westside*

Health Plan			
HMO			*
Insurer	Blue Cross	HPIC	
Cost PE/PM	$89 - 135	$80.03 - $374.56	
Employee Contribution Range	100% of dependents	100% of dependents	
PPO			*
Insurer	Blue Cross	HPIC	
Cost PE/PM	$89 - 135	$156 - $560	
Employee Contribution Range	100% of dependents	100% of dependents	
Indemnity			*
Insurer		HPIC	
Cost PE/PM		$98 - $376	
Employee Contribution Range		100% of dependents	
Dental Plan			*
Insurer	CICA	CICA	
Cost PE/PM	$31.80	$31.80	
Employee Contribution Range	100% of dependents	100% of dependents	
Vision Plan			
Insurer	Medical Eye Services	Medical Eye Svc	
Cost PE/PM	$8	$8	
Employee Contribution Range	100% of dependents	100% of dependents	
Retirement	403(B)	403(B)	403(B)
Insurer			
Cost PE/PM	No matching contribution	No matching contribution	No matching contribution
Employee Contribution Range	$100 - $790	$20 - $200	$50 - $500 per month
Disability Plan			
Insurer	STATE	STATE	STATE
Cost PE/PM			
Employee Contribution Range			
Life Insurance			*
Insurer		Paul Revere	
Cost PE/PM		.274/$1,000	
Employee Contribution Range		0	
Other		Long Term Disability (LTD)	
Insurer		Northwest Mutual	
Cost PE/PM			
Employee Contribution Range		100%	

* **Flexible spending plan administered jointly with Accrued Benefits Services, effective January 1, 1998. Includes medical, retirement, dependent care and life insurance. Cost is estimated at $700 per year per employee.**

R.33. At the end of year one in the Summer, 1999, develop a strategic planning process, including a board and staff retreat, to create a two year business plan for the new organization.

R.34. Celebrate the merger with a community event intended to promote the stability of community clinics in Santa Barbara County.

Management Conclusions

From a governance and administrative perspective, a merger between the clinics is not

only feasible, but it can be accomplished in a rather aggressive timeframe. Given the similarities and histories of the clinics, it should be relatively easy to move forward in choosing a new Board of Directors, developing a new mission statement and creating a coherent, highly integrated system of care throughout southern Santa Barbara County. This system of care will have the potential of offering a broader range of services, including dental care and alcohol and drug services, with certain economies of scale and the ability to recruit able management personnel.

Key to the success of the merger will be both the commitment of the merger partners to work through their differences, to compromise when necessary and to learn from one another as well as the commitment of community stakeholders to support the merger process in a visible manner. Financial and programmatic stability will be enhanced by the local stakeholders' support and recognition that the first several years of the transition will take patience, loyalty to the concept and changes in previous patterns of practice and business.

B. Clinical Systems

Introduction

To determine the feasibility of merging Isla Vista, Carrillo, and Westside clinics from a clinical or service perspective, the similarities and differences among the practices is examined. The strengths of each program as well as where there may be gaps in service are determined. The hours of operations, the staffing mix, the capacity and productivity, the medical leadership and the relationship the providers have with others in the Santa Barbara medical community are reviewed. The compatibility of the systems that support the practices, including medical records, information flow, and quality management are assessed. Industry benchmarks are used where available and where comparison clarifies the issue or supports the recommendation. The impact of a two-clinic merger and a three-clinic merger are considered in each area being assessed.

In planning a merger of two or three organizations, one hopes to find that the gaps in one organization are compensated for by strengths that will enhance the others and vice versa. Rather than complete similarity, complementary capabilities are sought. Observation of services, skills and talents among the clinics that can be combined and shared in order to make the new organization stronger and more complex than any of the individual clinics is made.

B.1. Scope Of Services, Hours Of Operation, Staffing Mix

Part of the decision to perform this merger feasibility study was predicated on the similarities between Isla Vista, Carrillo and Westside. The outcome of a merger is very dependent upon the structure of the newly merged entity. The comparison of the scope of services, hours of operation and staffing mix is the nucleus of the assessment of the structure of the clinical program. (See Attachment F - Clinical Elements Comparison

and Attachment H - FTE and Salary Comparison.) That structure is defined by the service capability, the availability of those services and the skills and talents of the individuals providing those services and supporting those providing the services. It is in this area one hopes to find the most complementary capabilities in order to build the new organization.

Findings:

F.20. Isla Vista's primary care practice seems to reflect the transient nature of the population in that area, with an emphasis on urgent care and episodic visits. Historically, there was a stable full-time or almost full-time provider staff. The fiscal constraints that have prompted this merger study also resulted in a reduction in provider hours, leading to resignations as providers looked for positions with more hours. Currently, there are several very part-time providers who provide primary care on a regular basis.

F.21. Carrillo provides primary care with full or half- time providers. Patients utilize the clinic for both episodic and health maintenance care. The Medical Director works full time and the other two providers are both half-time. The Internist has indicated to the Medical Director an interest in increasing her hours.

F.22. Westside provides primary care with full or part time providers. They are seeing the largest percentage of elderly patients and the overall number of visits per patient per year is reported as the highest among the three clinics.

F.23. At Isla Vista and Westside, 30% and 40% respectively, of their visits are for HIV testing and counseling, while Carrillo offers fewer hours with about 5% of their visits identified as HIV related. The Medical Director at Westside is very interested in Infectious Disease management, which attracts a patient with HIV to remain in the clinic for on-going care.

F.24. None of the clinics provide pre-natal care to any significant extent. The Westside clinic does offer some patients pre-natal services. They reported 70 pre-natal visits in 1996.

F.25. Carrillo is the fiscal agent for Carrillo Family Dental Clinic, the only subsidized dental service in Santa Barbara County. The Dental Clinic was started as a result of a collaboration among Carrillo, Cornelia Moore Dental Foundation, Cottage Health System, Dental Access Resource Team (DART), Dental Disease Prevention Program/Santa Barbara County Health Care Services, St. Francis Medical Center, Santa Barbara Schools Healthy Start and Santa Barbara/Ventura County Dental Society. The Dental Clinic operates under the Carrillo community clinic license and the staff of the Dental Clinic are employees of Carrillo Medical Clinic. Its policies, though, are established by the Carrillo Family Dental Clinic Steering Committee made up of representatives of the collaborating entities. It is anticipated that the Carrillo Family Dental Clinic Steering Committee will evaluate the benefits of the consolidation effort and will allow the Dental Clinic to continue its relationship with the new entity.

F.26. Isla Vista has an extensive drug and alcohol treatment program that is a

collaboration between several community groups and is funded through various sources.

F.27. Isla Vista is the only clinic that is open on Monday morning before 11 AM, but there is no clinician on Monday, Tuesday or Thursday morning for primary care. Essentially, all clinics are closed on Friday afternoon, with only Westside open until 2 PM. (See Attachment G - Hours of Operation Comparison.)

F.28. In looking at the whole county, Carpinteria and Lompoc appear to be underserved with a low ratio of primary care providers and limited health care access.

Recommendations:

One of the goals in a potential merger is to provide high quality primary care services to populations that do not traditionally have good access to health care; in other words, our goals are more than just about numbers and finances. We are looking at people who are usually dependent on public transportation and who would be unlikely to travel across town for their health care. We are looking at an area that does not have many other options for people who live there. We need to improve the access, not eliminate it. Consequently, our recommendations include the following:

R.35. The need for two downtown sites will have to be studied further, but it is recommended that both Carrillo and Westside be closed at their current locations and the new corporation open, in an appropriate and needed catchment area, a single new, site with exam room and support space for several providers. Planning for this new site should be done in collaboration with the Cottage/Goleta hospital system and with Santa Barbara County Health Services.

R.36. Isla Vista should try to consolidate some of the provider hours into fewer numbers of providers who are in clinic more often. The goal would be to attract more patients on a continuity basis while still providing the urgent care and episodic services. The Internist from Carrillo could increase her hours by providing two or three urgent care or acute care clinics a week at Isla Vista.

R.37. The duplication of services among all three sites could be eliminated by creating a “center of excellence without walls” for both the general population and for special populations. While staffing configurations are totally dependent on who the providers are, and how many sites there are, the new entity can build on its strengths by bringing the providers to the patients rather than expecting patients to get to a single location. Specialty clinics can be created, for example, HIV primary care, family planning, pediatric services, women’s health, etc. that would be offered at different sites at different times using the same providers.

R.38. Monday morning and Friday afternoons are, at most clinics, the busiest times for drop-in appointments and telephone calls for appointments and advice. All three sites should open on Monday morning and Friday afternoon, and market this change to their patients. They could target parents and children for Friday afternoons and focus on urgent and acute care on Monday mornings. Additionally, Friday afternoons could be

scheduled with procedures so that the patients could have the weekend to recover.

R.39. Once the merger is completed, the new organization should advise the community collaborators in the dental and drug/alcohol treatment programs of this new entity and plan, as soon as funding becomes available, to expand these services.

R.40. When the merger is completed, the new organization may want to look to Carpenteria or Lompoc to open a primary care satellite practice after discussions with the County Health Services Agency and community agencies and leaders.

B.2. Capacity And Productivity

In order to measure capacity and productivity, it is necessary to try to capture a snapshot of the practices. It is important to know what services are being used; what the ages are of the patients using the services; what the staffing looks like; and then, where possible, to compare these data with national or regional benchmarks. These findings are based on reports the clinics prepare annually for the state. The benchmarks are simply that--a way to measure the practices against other similar entities. Benchmarks are always subject to challenges around validity, accuracy and applicability.

Comparing the number of support staff FTE (full time equivalent) in various categories to the number of FTE providers is a commonly used measure of productivity in health care. Because the National Association of Community Health Centers (NACHC) has not conducted a survey about staffing ratios, the Medical Group Management Association (MGMA) appears to have the most usable statistics, compiled from surveys of hundreds of members.

These benchmarks are averages and help in the analysis of productivity and efficiency but because there are significant differences between mainstream sophisticated group practices and community health centers, they should be used cautiously when setting targets or goals. Adjustments need to made for practices that serve large numbers of immigrants, non-English speaking clients, high socio-economic and medical risk patients, etc. Adjustments need to be made for services to special populations and for grant funded mandates.

Another measure of productivity is the number of visits per year per provider. The benchmarks against which Isla Vista, Westside and Carrillo are compared are from figures provided by the managed care industry and from the federal government's Bureau of Primary Care that regulates and funds community health centers. These figures are the most subject to challenge and to regional influences and variability.

Industry averages show high utilization in the first two years of life with decreasing averages as the population ages, until 65 and above, when the number of average visits increases. "Members younger than 65 have an average of 3.6 physician encounters per year; Medicare members average 7 encounters per year."[7]

[7] Group Health Association of America. *HMO Industry Profile, Vol. 2: Physician Staffing and Utilization Patterns.*

Findings:

F.29. Based on the reports prepared by the clinics for the state of California, Isla Vista has an unduplicated patient practice of 6,103 patients. 29% are under one year to 19 years old and 64% are between the ages of 20 and 44. 7% are 45 to 65 and over. They reported 11,054 visits in 1996 with 40% of those encounters for HIV testing and counseling. About 5.5% of visits were for Family Planning and 49% or 6,286 of the total visits were for general medical services.

F.30. Carrillo reports an unduplicated patient practice of 5,121 patients. They report 25% of their patients are children and teenagers, with 56% of patients between the ages of 20 and 44. 20% are 45 to 65 and over. There were 8,128 visits reported in 1996. Only 5% of their visit volume is for HIV service. 22% of visits are for Family Planning services and 72% or 7,686 visits were for general medical services.

F.31. Westside has an unduplicated patient practice of 5,899, with 16% children and teens, 60% adults between 20 and 44, and 24% adults between 45 and 65+. There were 15,656 total visits reported with 46% or 9,418 visits listed as general medicine, 30% for HIV services and 5% for Family Planning services.

Washington, DC: Group Health Association of America, 1991.

TABLE IV
Utilization Statistics

	CARRILLO	ISLA VISTA	WESTSIDE
# OF VISITS	8,128	11,054	15,656
# OF GENERAL MEDICAL VISITS	7,686	6,286	9,418
# OF UNDUPLICATED PATIENTS	5,121	6,103	5,899
# & % PTS. 0-19 YEARS	1,303 or 25%	1,766 or 29%	944 or 16%
# & % PTS. 20-44 YEARS	2,766 or 55%	3,903 or 64%	3,539 or 60%
# & % PTS. 45-65+	1,052 or 20%	434 or 7%	1,416 or 24%
# OF PTS. 0-12 YEARS	433	1,205	531
# OF VISITS FOR PTS. 0-12 YEARS	2,253	997	700
# OF PTS. 20-65+	3,818	3,765	4,955
# OF VISITS BY PTS 20-65+ YEARS	3,260	4,692	7,018
# VISITS PER ALL PATIENTS PER YEAR	1.6	1.8	2.6
PEDIATRIC VISITS PER PATIENT PER YEAR	5.2	0.82	1.3
ADULT VISITS PER PATIENT PER YEAR	0.85	1.2	1.4
% GENERAL MEDICINE	72%	49%	46%
% HIV ENCOUNTERS	5%	40%	30%
% FAMILY PLANNING	22%	5.5%	5%

Source: 1996 Annual Report of Clinics

F.32. Carrillo shows 433 pediatric patients between 0 and 12 years with an average of 5.6 visits per patient per year. Isla Vista, on the other hand, has 1,205 patients 1 to 12 years old who average 0.8 visits per patient per year. Westside reports a smaller number of pediatric patients, who are seen on average 1.3 times per year. With the large pediatric population at Isla Vista, one would expect to see more visits per patient per year. The available statistics point to a practice at Isla Vista that has a large number of patients who are seen only once. These numbers support the impression that the population is very transient in this area. Westside's 2.6 visits per patient per year may be related to the larger number of older patients reported in the practice and to the number of HIV patients who receive on-going care and not just testing and pre and post counseling.

F.33. The inverse situation is noted when looking at Carrillo's and Isla Vista's adult population which shows Carrillo's adults averaging only 0.85 visits per year and Isla Vista's up to 1.2 visits per year. Westside's adult visit rate is similar to their pediatric rate. All of this points to the transient and episodic nature of the population served by each of the clinics.

F.34. All three clinics have between 500-600 capitated lives assigned to them by the SBHI. Both Carrillo and Isla Vista are open to new members with Westside open only to new members in their neighborhood. With declining Medi-Cal enrollment, however, increasing capitated lives may not be an option.

TABLE V
Productivity Benchmarks

Other provider productivity goals commonly used as benchmarks are as follows:[8]

VISITS/PROVIDER/YEAR		NATIONAL MEAN
Pediatrics	4,000 - 6,000	5,465 (105.1/wk)
Family Practice	4,000 - 6,000	5,850 (112.5/wk)
Internal Medicine	3,300 - 4,200	3,343 (64.3/wk)

The Federal Government expects its grantees to provide approximately 4,300 visits/year/physician and approximately 70% of that number or 3,010 per mid-level.

F.35. Productivity was calculated based on an aggregate of all providers at each site and compared it to a benchmark of 5,000 visits/provider/year, based on Table IV. Carrillo's 2.0 FTE providers conduct 3,843 visits/provider/year. Isla Vista's 1.18 FTE providers average 5,327 visits/provider/year. Westside has 2.6 FTE providers seeing 3,622 visits/provider/year.

TABLE VI
Support FTE/Provider FTE Comparison With Benchmarks

STAFF CATEGORY	BENCHMARK[9]	CARRILLO	ISLA VISTA	WESTSIDE
TOTAL PROVIDERS		2.00 FTE[10]	1.18 FTE	2.60 FTE
ADMINISTRATION	0.92/FTE	1.25/FTE	2.30/FTE[11]	0.77/FTE
ANCILLARY STAFF	0.95/FTE	0.50/FTE	0.63/FTE[12]	0.52/FTE
MEDICAL SUPPORT	1.88/FTE	2.30/FTE	2.50/FTE	1.30/FTE
TOTAL	**3.75/FTE**	**4.05/FTE**	**5.50/FTE**	**2.60/FTE**

F.36. Carrillo does not used paid employees as Medical Assistants, rather they have one paid supervisor and up to 2.3 FTEs/week of volunteers supporting the providers. Isla Vista has several part-time employees providing support to the practitioners in addition to volunteers working in a one to one ratio with the paid medical support staff.

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8 Kongstvedt, Peter R., *The Managed Health Care Handbook.* Gaithersburg, MD.: Aspen Publishers, Inc.
9 Taken from MGMA surveys, 1993
10 Does not include Dentist
11 Also supports Drug treatment and Detoxification Programs
12 Does not include other professionals serving special populations, i.e., counselors and case managers

F.37. Isla Vista's administrative FTE to provider ratio is impacted by the support provided the non-primary care programs. Similarly, their medical support staff to provider ratio appears to be affected by the other service lines.

F.38. Westside had a separate operational consultation last winter and spring. Following the recommendations of that consultant team, they were able to reduce the FTE/Provider ratio from 3.8 FTE per Provider to the current 2.6 FTE/Provider.

F.39. Exam room constraints do not seem to be a factor in productivity at either Carrillo or Isla Vista. In fact, one would have expected to see more visits at Isla Vista based on the exam room availability. Westside's practice is considerable constrained by not just the lack of space but by the configuration of the space. It is impacted by trying to configure a house into a medical office practice.

Recommendations:

R.41. The providers at these three clinics are reasonably productive. The consolidation of the practices should result in better productivity and more importantly, better access and continuity for the patients. Provider productivity as defined by visits/year should be re-examined after the merger and after some of the other recommendations have been implemented.

R.42. Providers at all three clinics could move between the sites, expanding and contracting clinics as the population and demand change. Attention should be paid to the strengths of each site and provider and to the characteristics of patients at each site. This will become a significant implementation task.

R.43. Isla Vista should try to identify where the area pediatric population is going for continuity care and try to capture some of those patients, if possible. The effort that Carrillo made in attracting pediatric patients should be duplicated and all clinics should attempt to reduce the urgent care nature of these practices and develop strategies to attract and retain patients on a continuity basis.

R.44. Successful primary care practices are using Internists, Pediatricians, Obstetricians and Gynecologists almost as specialists. They see only the sickest and highest risk patients in the appropriate age group. During recruitment of providers, every attempt should be made to attract Family Practice physicians or Family Practice Nurse Practitioners and Physician's Assistants. These practitioners are skilled in caring for a broad range of patients and problems. They are the most versatile and offer the best return on salary investment. Because of this fact, they are in high demand and difficult to recruit. The entire salary structure and benefit package of the organization will have to be reviewed following the merger if the clinics hope to compete.

R.45. Because the configuration the new entity is unknown, it is not possible at this time to predict staffing ratios and costs. Staffing ratios should be re-examined after the merger and after other recommendations are implemented. It's unlikely that any of the clinics would have to hire additional staff after a merger, but rather, would use their staff

differently and more efficiently.

B.3. Role Of Medical Director

A major key to successful clinical practice in today's health care environment is the leadership provided by the Medical Director. Not only should this individual have strong clinical skills, but he or she should participate in the management of the organization as part of the senior leadership team. To evaluate the roles of the Medical Directors in the three clinics, a comparison was made of their current management activities, their interest in administrative responsibilities, their salaries and how those salaries compare to statewide community health center averages. If the new organization has to recruit a Medical Director, a well-defined role with clear responsibilities and competitive compensation will be crucial in that recruitment process. In preparation for a merger, the Medical Director will be key to the development and implementation of the practice model, with a large amount of time devoted to planning and administration. (See Attachment E - Sample Job Descriptions.)

Findings:

F.40. Isla Vista's Medical Director provides about five hours medical administration time a week. Carrillo's Medical Director is full time with 4-8 hours a week identified as administrative time. Westside's Medical Director has about 12-16 hours per week for administrative responsibilities.

F.41. Carrillo's Medical Director has expressed an interest in the role of Medical Director of new entity. Westside's Medical Director has resigned his position, effective December 31, 1997 but will remain as a provider at the clinics for approximately 15 hours per week. Isla Vista's Medical Director has recently taken a position as the Medical Director for the Santa Barbara Health Initiative but does remain providing five hours weekly of administrative time to the clinic.

F.42. The Medical Director at Westside earns the highest hourly salary when compared to the other two directors, but the Medical Director at Carrillo earns more actual dollars because of a $500/month stipend paid for his administrative role. None of the three meets the median range found in community health centers in this region, based on a survey of clinics conducted for the National Association of Community Health Centers. (See Table VII.)

TABLE VII
Medical Director Salary Comparison

BENCHMARK Lo/Med/Hi	CARRILLO	ISLA VISTA	WESTSIDE
$45,000/$120,000/$170,000	$92,000+$6,000	$83,200[13]	$95,000[14]

[13] Annualized from a $40.00/hr. stipend for .13 FTE time

Recommendations:

R.46. The ability to combine the position of Medical Director is one of the more significant cost/benefit positives to come out of a merger. The duplicated functions should be consolidated onto one individual who will require some additional administrative time but not as much as is currently being used by all three. Clerical support for the position will be necessary and two of the sites may need an associate director if the practice grows. For a practice with approximately 35,000 visits/year and approximately 5 FTE providers, a Medical Director should probably have a 50/50 split between administrative and clinical time.

R.47. It seem that the new organization would benefit from a physician who was knowledgeable about managing a primary care/family practice and who was knowledgeable about the community and the health care systems in Santa Barbara. This role in a newly formed corporation will require a close partnership between the new Board of Directors, the Executive Director and the Medical Director. The size will have tripled and the burden of implementation will fall heavily to the Executive Director and Medical Director. Roles and responsibilities should be clearly defined. If current incumbents are hired into these new positions, they need to start with a clean slate and put aside history.

R.48. With the more complex organization, the new Medical Director's salary should be adjusted to the average salary of a Medical Director in a community health center in California.

B.4. Hospital Privileges And After Hours Care System

Access and continuity are increasingly identified by accrediting and funding agencies as indicators of a quality health care organization. The ability of patients to receive appropriate, cost-effective care after hours is a requirement of most managed care organizations. So too is the ability of a practice to provide care for a patient throughout the health care continuum, from health maintenance and illness prevention through hospitalizations, intermediate care and even home care. Since many community-based providers struggle to obtain hospital privileges, i.e., the ability to hospitalize and care for patients in local hospitals, a medical staff with hospital privileges and a strong after hours call system would give the new organization a competitive edge in contracting for new business and in growing their existing business.

Findings:

F.43. The providers at Isla Vista and Carrillo already share call. The providers at Westside do not share call with the other two clinics. There are concerns among the three clinics about how call is shared and about the differing acuity levels of the patients calling in.

[14] Adjusted for .95 FTE

F.44. Isla Vista has a provider who does hospital work for the adult practice; no one does pediatrics. Carrillo uses the admitting team at St. Francis and the residents at Cottage Hospital for in-patient care unless Dr. Sullivan admits the patient. Westside uses the residents at St. Francis and the admitting team at Cottage Hospital, with Dr. Kunz occasionally admitting a patient to St. Francis.

F.45. There is a problem getting hospital coverage for patients admitted to Goleta Valley Hospital. Isla Vista is the only clinic that has a physician on staff at Goleta Valley.

Recommendations:

R.49. The organizations should immediately implement at least a three-way shared call arrangement and consider adding providers from any of the other clinics in the Santa Barbara Clinic Association. A model for a shared call arrangement between geographically distant and separate corporations can be provided from the Alameda Health Consortium. In that arrangement there are providers from five clinic corporations, utilizing eight hospitals spread out from Berkeley in the north to Pleasanton in the east to Hayward in the south. Communication is through a central telephone answering service and fax machines.

R.50. Another goal of the merger is to help expand hospital coverage for all patients from all three clinics. The organizations combined will have more leverage to realize this goal than they currently have as individual clinics.

B.5. Quality Improvement, Medical Records Compatibility, And Use Of Clinical Guidelines

Successful organizations make quality a top priority. They develop ways to measure quality services and care, ways to document quality care and services and ways to assure there is consistent approaches to delivering quality services and care.

Nationwide, indicators of quality are being developed, measured and monitored. Health care organizations are embracing other industry's approaches to systems of assuring quality like Continuous Quality Improvement or Total Quality Management. Quality Management programs help an organization manage risks and employee relations as well as helping to assuring quality clinical care is provided. Quality management programs offer staff the opportunity to participate in the decisions that affect their work lives. They give people responsibility and authority. They reinforce the principles, long held by community-based organizations, that the staff are the most important asset.

The documentation of care and services has become a major focus of the health care industry. Not only are Medical Records and the systems that support the documentation of services important from a clinical perspective, they are important from a risk management perspective, from a contracting and payment perspective and from an oversight perspective. Every payor demands a certain standard of documentation. More and more entities from the Federal, State and local government, to the HMOs and insurers are demanding and gaining the right to review and audit medical records.

Individual provider productivity is impacted by the ability to gather, store, document and retrieve information about the patient in a safe and timely manner.

If there is one area that community health centers and private providers lag behind other providers, it is in their Medical Records systems. Many are very primitive. They are manual and letter based, rather than computerized and number based. The use of a computerized Medical Record for a primary practice is not common. The technology is not well developed and is very expensive. However, computerized registration systems and numerical filing systems are well developed and in common use throughout the health care industry.

Developing and using clinical guidelines, that describe an accepted approach to both health maintenance and disease management are expected by purchasers and insurers of health care. These standards of practice can help an organization define its own quality benchmark, can be used to determine costs of services, can support challenges to authorization and payment denials and can afford the providers a structure on which to base peer review and credentialing and privileging activities.

Findings:

F.46. Isla Vista has a written Quality Improvement plan and does four clinical audits per year. In addition, they have an ongoing Peer Review process. Carrillo has a one page written statement about quality but there is no system in place to define problems, collect data and change processes or performance based on this information. Dr. Sullivan reviews the Nurse Practitioner's records at Carrillo. No other Peer Review type activity takes place. Westside does not have a written Quality Improvement plan; the Nurse Practitioners' charts are reviewed and signed by the Medical Director. No clinic has a comprehensive Quality Improvement process that includes support, business, management, fiscal as well as clinical staff and looks at the structure, process and outcomes of not only the clinical practice but the systems that support that practice. Risk management, health and safety, patient access, legal requirements, business processed as well as clinical indicators all should come under the purview of a quality management program. Problem solution should be pushed to the level of the user of the solution. Isla Vista, by incorporating support staff and addressing process issues, comes closest to an integrated quality management program.

F.47. All clinics file their records alphabetically. There is no other common forms or features to the record.

F.48. No clinic has an automated appointment system. They currently all make appointments manually, using different types of appointment books.

F.49. There is no formal use of clinical guidelines in any of the clinics, with the exception of some standardized protocols that are used by the Nurse Practitioners at all three sites.

Recommendations:

Putting these operating systems into place for a new organization will be the major focus of the Medical Director and the clinical staff following the merger. The process of clarifying operating procedures and defining performance goals and objectives will be one of the keys to a successful merger. These clinical systems are areas where the consultant team can play a major role in helping the clinics implement the merger.

R.51. The organization needs to have a formal system for managing quality improvements and peer review. None of the clinics are in compliance with the usual expectations of Managed Care Organizations (MCOs) and other funding sources regarding quality management.

R.52. The clinics need to enter into the computer age. While an automated Medical Record is not realistic, the clinics should automate their registration and appointment processes. They should convert their Medical Records from the inefficient alphabet system to a standard record filing system that is number based. The merger provides an excellent opportunity to do this as the practices are combined.

R.53. The use of practice guidelines and standards can help an organization identify its costs and clarify its practices. They are not only for mid-level providers. The development of guidelines and standards is an on-going process that can be streamlined by the adoption of already written standards that have been modified for the actual practice.

B.6. Patient Satisfaction

The measurement of patient satisfaction has become an expectation of funders and purchasers of health care. While it is difficult for a lay person to determine clinical quality from a technical perspective, it is increasingly evident from experience that the relationship of quality to certain aspects of the delivery system is related. Patient wait times, access to health maintenance and prevention visits, staff courtesy and responsiveness, and financial accuracy all impact the patients' experience and their receptiveness to care and treatment. Patient feedback can help pinpoint problem areas and help focus limited resources.

Finding:

F.50. Isla Vista conducted a patient satisfaction survey in May 1997. Neither Carrillo or Westside has conducted a patient satisfaction survey recently. It does not appear that the Santa Barbara Health Initiative requires its contractors to conduct annual surveys as is common among most managed care organizations.

Recommendation:

R.54. Prior to or soon after the merger, the clinics may want to conduct extensive surveys both anonymously and through focus groups; questioning satisfaction with current services and operations and soliciting feedback on desirable services. Patient surveys can be an excellent source of information during the planning process for the merger.

B.7. Malpractice Claims History

None of the clinics has any outstanding claims or suits against it. The last was in 1993 at Isla Vista.

B.8. License Status

Unlike a private physician's practice, clinics in California must be licensed by the state prior to providing patient services. As part of this licensing process, an on-site inspection is conducted. The focus of this inspection is to assure that the services are provided in a sage environment and that the practice complies with all related laws and regulations. Fire safety, handicapped access, security of medical records and pharmaceuticals, exam room size, air circulation, storage of cleaning supplies, the number of bathrooms, licenses of medical and nursing staff, documentation practices, condition of the laboratory and other equipment all fall under the purview of the state's licensing board.

Furthermore, it is a requirement that when a new health care corporation is formed, it

must be inspected and licensed, even though the component clinics, in the case of a merger, are already licensed. Any changes to the requirements since a previous review will apply to the new organization.

Findings:

F.51. All clinics are licensed in California. It has been many years since Carrillo or Westside were surveyed by the state. Isla Vista underwent a survey when they moved to their new building.

F.52. Westside is a wood-frame building that is a very high fire risk. Hallways are narrow, stairs are shallow and deep and are the only exit from the second floor. It appears that construction is being done in the clinic without a permit, increasing the liability should there be a fire or other disaster. Air circulation is poor and patient and staff movement through the clinic is tortuous. Bathrooms, storage space and medical record security all appear to be out of compliance with state expectations.

F.53. Carrillo is also in a high fire risk wood-frame building, although it has only a single level. Rooms are small and cramped and patient and staff movement is uncomfortable. It appears dark and somewhat dingy, while storage and sufficient space to support the practice are lacking.

Recommendations:

R.55. It is unlikely that either Westside or Carrillo could pass a licensing inspection in their current condition if the new corporation decided to maintain the three existing practice sites rather than close Carrillo and Westside and open a new site in the appropriate area, as recommended in R.35. Should Westside not join the merger, the condition of Carrillo is still a problem regarding its ability to pass a licensing inspection. In fact, once the inspection team is in an area, they have been known to do “spot” checks of other nearby licensed organizations. A decision by Westside not to merger will not automatically protect them from a state inspection.

Clinical Systems Conclusions

From a clinical practice perspective, a merger between the three clinics, Carrillo, Isla Vista and Westside is not only feasible, it is reasonable, practical, and achievable. The commitment of the providers at each of the clinics to the people served is true and strong.

While there are specialty interests among the providers, the practices are all primary care based serving similar socio-economically disadvantaged populations. The quality of care and range of services will improve for all clients as the combined strengths, skills and talents of each organization are applied to the practices. Access to care and specialty services will increase. Availability of more choice for patients than currently exits will result from a merger. The practice styles and patterns are more similar than

dissimilar. From a scope of services viewpoint, these practices are very compatible.

Practical issues like a common medical record, automated appointments, clinical tracking, quality management and protocol development are more readily addressed because these practices are on a level playing field. In other words, no one clinic is that much farther ahead in the development of these systems that it poses either an unfair advantage to keep it or an unfair burden to give it up.

The ability to identify and recruit a Medical Director will be one of the greatest challenges for the new organization. The importance of finding a strong clinical leader who can gain the respect of the clinicians, the board, the management, the staff and the community cannot be emphasized too much.

Today in Santa Barbara and everywhere else, the economics of providing health care have made “strange bedfellows.” These clinics are not strangers; they are friends, neighbors, and colleagues who can and should work together to overcome their differences, build on their strengths, and produce a service delivery model that exemplifies service excellence.

C. Financial Management

Introduction

The three clinics have many financial processes in common: claims billing and collections, payroll and accounts payable processing, cash management, requiring similar financial reporting systems, requiring similar risk assessments. In addition, they face similar financial challenges: declining reimbursement rates from insurers, increased need for sophisticated medical and financial data tracking systems, fluctuating cash receipts. All three clinics function on a day to day basis, paying the most urgent bills as cash becomes available, securing short term financing to weather cash shortages, attempting to attract and retain staff without offering financial incentives. This daily scrambling leaves little time or energy for strategic thinking regarding development of new or expanded sources of revenue, evaluating efficiencies of current operations, or the use of technology as a tool to improve service and performance.

Responses to these challenges have differed slightly among the three clinics. Isla Vista attempts to take a business-like approach, using competitive salaries and benefits to attract full and part time staff and evaluating vendor contracts on a periodic basis to secure the most favorable pricing. In addition, staff review carefully the SBHI contract and trust account statements to insure all revenue due under this contract are received.

Westside has been successful in securing financial assistance from a variety of sources either in the form of cash grants or heavily discounted rates for services provided and

has recently successfully appealed to the larger community for large cash contributions. Staff focus is concentrated on fund raising and grant writing with less emphasis on practice development or cost accounting.

Carrillo's approach is somewhere between Isla Vista and Westside with some grant assistance for certain capital purchases and reliance on volunteer staff combined with a business-like approach to vendor contracting. Carrillo counts heavily on annual trust account payments from SBHI. Staffing levels and other expenditures had been established in reliance on these payments. With the reduced payment in 1996, Carrillo has eliminated a receptionist and janitor (see Section C.2.b.ii).

As was pointed out earlier in this report, the merging of two or three clinics will likely not result in cost savings during the merger process or the initial several years of merged operations. Rather the anticipated benefit is the replacement of weak financial management systems with an effective financial system directed by experienced and trained financial management staff who manage assets, produce current and relevant management reports and are responsive to identified financial problems and opportunities.

This report addresses three financial areas:

1. costs that can be expected to be incurred during the merger process;

2. costs and savings resulting from the merger; and

3. operational changes which can result in greater efficiencies of the combined entity. Some of these operational changes could be implemented by individual clinics in the absence of a merger but would be more effective for a larger entity, e.g., the purchase of a medical management system.

C.1. Merger Costs

Several one time costs can be expected to be incurred during the merger process. Some of these costs are referenced in other parts of this report. These costs include:

- Consulting services including legal review of merger documents, personnel consultant review of personnel policies, salaries and benefits, financial and MIS consultant review of financial and computer systems and organizational consultant and process facilitator. Estimated cost is $110,000 to $125,000.

- Audit of each of the merging clinics as of the date of the merger to fully disclose the financial obligations or other matters which might impact the newly created entity. If the clinic merger is effective July 1, 1998 as proposed, each clinic could engage an auditor to perform the usual year end audit. Timeliness would be critical - the audit should be completed 45 to 60 days after the end of the fiscal year. This could

conceivably require a higher audit fee than the annual fees currently charged. Carrillo is not required to conduct annual audits and none is included in the current budget. Isla Vista and Westside have included the cost of an annual audit in fiscal year 1997-98 budgets. Total additional non-budgeted costs for securing year end audits for two or three clinics is estimated at $3,500 to $5,000.

- Purchase of stationary and other printed material with new logo and name. Estimated cost is $2,500 to $3,000.

- Appraisals of real estate owned by the individual clinics. This may be postponed until it is decided to transfer this real estate to the new entity or sell it. Estimated cost = $2,000 to $5,000 per property.

- No costs have been estimated for Executive and Medical Director planning time prior to the actual merger.

One time expenditures are listed in Table VIII, One Time Merger Costs.

Items financially affecting the new entity are:

- Savings from eliminating the billing services at Isla Vista and Westside and moving all billing in-house to Carrillo's computerized billing system.
- Savings from a single payroll service rather than three.
- Savings from elimination of multiple Medical and Executive Directors.
- Increased cost to hire experienced financial management team.
- Loss of rental income from space where management team will be officed.
- Additional cost of having a quarterly review of financial statements by an outside accountant.
- Cost savings from having a single audit rather than three.
- Elimination of cost of property insurance on Westside building if building is sold. Offset by additional cost of employee dishonesty coverage.
- Additional rental cost for larger clinic site to combine Westside and Carrillo medical practices. This change is not anticipated prior to the year 2000.

C.1.a. Costs and Savings Resulting from the Merger

Merging the operations of two or three clinics allows for certain economies of scale. These savings can and should be returned to clinic operations in the form of staff and system upgrades which will allow the newly created entity to operate in a more effective and efficient manner to fulfill the mission of the community clinics.

The effects of the merger are not easily separated from other opportunities for operational efficiencies. Therefore the following sections will have much overlap.

Costs and savings of the merger include the following:

- Savings from consolidation of billing services.
- Savings from consolidation of payroll services.
- Savings from consolidation of staffing.
- Cost of creating management team including salaries and administrative offices.
- Cost of annual audit and quarterly accounting reviews.
- Savings from audit of single entity rather than two or three.
- Cost savings from single insurance policies rather than two or three.
- Cost of software and hardware to link clinic site computer systems.
- Cost of telephone system to link clinic sites.
- Cost of medical management software.
- Cost of upgrading the medical records.

Section C.3. Financial Projections summarizes the ongoing financial impact of the merger of Isla Vista and Carrillo clinics and the financial impact of a merger which also includes Westside (Combined 3 clinics). This section includes profit and loss as well as balance sheet projections for 1997-98 and 1998-99.

TABLE VIII
One Time Merger Costs

Consulting Fees Legal review of merger documents; personnel consultant review of staffing, benefits and salaries; financial consultant review of financial management systems; MIS consultant review of computer system; organizational consultant review of organizational structure	$110,000 - $125,000
Pre-Merger Audit In excess of funds currently budgeted for annual audit	$3,500 - $5,000
Stationery and Printed Material New corporate name and logo would require reprinting of clinic materials	$2,500 - $3,000
Real Estate Appraisals For Isla Vista and Westside buildings. Could be delayed until buildings are sold or transferred to new corporate entity	$6,000 - $10,000
Network Hardware and Software Computers, modems, printers and wiring to allow central billing, financial reporting and patient scheduling to multiple clinic sites	$20,000 - $25,000*
Telephone System Telephone hardware and software to connect multiple clinics sites and a central administration office	$20,000 - $50,000*
Medical Management Software Software to allow patient scheduling, centralized billing, productivity reporting, utilization reporting, provider profiling, periodic screening reminders, etc.	$50,000 - $100,000*
Medical Records System System to allow computerized registration and numerical filing of medical records.	$10,000 - $25,000
Clinic Relocation Costs If Westside and Carrillo relocate to a single site. Anticipated no earlier than year 2000.	Not applicable at this time
Total	**$222,000 - $343,000**

** Capital Expenditures*

Please note: No costs have been estimated for Executive and Medical Director planning time prior to the

actual merger.

C.1.b. Billing Service Consolidation

Elimination of the billing service at Isla Vista would save $32,400 per year. Elimination of the service at Westside would save $15,000 per year. Consolidation of administrative services for two or three clinics would permit in-house claims processing with only minor equipment purchases. Additionally, it is not anticipated that additional staff would be required to process claims in-house. However, some shift in job duties and additional training might be required. Staffing recommendations and related costs are described in greater detail later in this report.

C.1.c. Payroll Service Consolidation

Combining Isla Vista and Carrillo using the current payroll processor would result in $30 to $50 savings per pay period. Adding Westside would probably result in no further cost savings due to Westside's current very low processing cost.

Payroll services generally charge a fixed rate based on the types of services and reports requested, e.g., sick time accrual tracking, plus a variable fee based on number of employees. Thus, it is likely that the combined larger entity could secure a lower cost service or expanded services at the current rate.

C.1.d. Staffing Consolidation

Due to the limited administrative time of the Medical Directors at Isla Vista and Carrillo, combining these two would result in no cost savings.

Combining all three clinics would save between $2,700 and $22,000 through Medical Director consolidation. Additional savings of approximately $30,000 would be generated by the elimination of one Executive Director.

C.1.e. Creation of Management Team

For the most part, the management team could be created from current clinic staff at current salaries. The one new position is that of the Financial Manager. No one currently employed by the clinics has the experience or expertise to perform the job functions described. The annual salary range for this position would be $35,000 to $40,000, an annual increase of $11,000 to $16,000.

Location of the management team in a central administrative office will result in the loss of rental revenue generated by the building owned by Isla Vista. The annual impact is a loss of $25,000 in rental income.

C.1.f. Quarterly Accounting Reviews

Annual cost is estimated at $2,500. This would be the case whether two or three clinics merge.

C.1.g. Audit Consolidation

Single financial statements prepared by a single accounting staff require less audit time than audits of three statements for three individual organizations. A conservative estimate of audit fees for a combined entity would be 150% to 200% of the cost of a single clinic audit or a savings of $3,000 to $5,000 per year.

C.1.h. Insurance Consolidation

Since the combined entity will be serving approximately the same number of patients with roughly the same number of staff and generating an equivalent amount of revenue as the sum of the merging clinics, little savings can be expected from consolidating insurance policies. However, the variations in the premiums paid by individual clinics (See Attachment I - Insurance Coverage Comparison) would indicate that there is some opportunity to re-bid this business.

C.1.i. Inter-Clinic Communication Links

Each clinic site should be able to provide backup telephone coverage for the other sites as well as scheduling appointments for other sites. Further, the centralized finance and billing office should have access to billing information entered at individual clinic sites. This will require telephone and computer networks among clinic sites. This network would also be necessary to support remote access to the medical management software. Installation costs including additional telephone lines, computer upgrades and network software is estimated at $40,000 to $75,000. (In Table VIII, One Time Merger Costs, this item is reflected in telephone system and network hardware costs.

C.1.j. Medical Management Software

This is not strictly a cost of the merger since the clinics could merge and continue operations without this system. However, such a system would greatly improve operations and the high cost of this item would suggest that only a consolidated entity could justify such a purchase. Software cost is estimated at $50,000 - $100,000. Hardware consisting of a network server ($3,000 - $6,000), a minimum of two additional PCs at each clinic site ($2,500 per PC) plus miscellaneous wiring and software would total approximately $20,000 to $25,000.

C.1.k. Medical Records Upgrade

Again, this is not strictly a cost of the merger but the cost of the upgrade would be more easily borne by a larger entity. Estimated cost of material and staff time is $10,000. If an outside firm is engaged to complete the conversion, the estimated cost is $25,000.

C.2. Cost Impact of Operational Changes

As mentioned above, certain operational changes could be realized separate from any clinic merger. However, the impetus for change generated by an organizational restructuring can also afford a fresh look at ongoing operations and effect changes which might be overcome by inertia when attempted by an individual clinic. The following are findings and recommendations regarding ongoing operations of a combined entity. The recommendations apply to a two or three clinic merger. The goal of these recommendations is the creation of an effective, efficient Financial System.

Such a Financial System should incorporate the following elements:

- Cash Management including Accounts Receivable and Accounts Payable
- Billing and Collections
- Payroll including Staffing and Benefit Costs
- Building and Occupancy Costs Evaluation
- Debt Management
- Budgeting and Financial Planning
- Fiscal Reporting
- Annual Audit
- Risk Management

C.2.a. Cash Management

C.2.a.i. Cash Reserves

Findings:

F.54. All three clinics suffer from periodic cash shortages. Vendor payment backlogs vary from current to three months. Prior to the recent donations, staff at Westside were regularly asked to delay cashing payroll checks.

Carrillo has become heavily dependent on the SBHI trust account payments. The dramatic reduction in this revenue from an annual average of $90,000 to $11,000 in 1995-96 is a primary cause of Carrillo's current financial fragility. Carrillo has a $25,000 line of credit which was fully drawn on in August and September. In November, $16,000 of this loan was repaid.

Isla Vista is seeking a line of credit to be available in early 1998 when funds from rent prepayment are depleted. If SBHI trust account payments are comparable to prior years, this line of credit financing may not be necessary.

Westside recently received donations and loans in the amount of $152,000. These funds were used to pay outstanding immediate debts. No principle payments were made on the bank loan. As of November 11, $57,000 of this cash infusion remains unspent. The focus at Westside is on obtaining operating and capital cost assistance through donations and grants. SBHI trust account funds have been earmarked for principal payments on the bank loan, not for operating expenses or cash reserves.

Recommendations:

R.56. The new board should develop a cash reserve target. While there are no standards for an adequate cash reserve and this would be a management decision for the new board, realistically clinic operations could support no more than two or three months operating costs. A process should be developed to “pay yourself first” by funding this reserve on a monthly basis to achieve full funding within a certain time period, possibly two years. This cash reserve funding should be included in budget projections.

For example: If the average monthly operating costs is $120,000, the reserve target would be $240,000. A separate savings account could be established and $10,000 would be paid into this account each month for 24 months.

C.2.a.ii. Accounts Receivable

Findings:

See section on Billings and Collections.

Recommendations:

See section on Billings and Collections.

R.57. Monthly aging reports, showing how long it takes to collect from various payors and what percentage of billings are collected, should be prepared and shared with senior management staff as well as the Board of Directors, to fully inform responsible parties of the financial status of the newly combined entity.

C.2.a.iii. Accounts Payable

Findings:

F.55. All clinics experience periodic cash shortages. Vendor payments are delayed up to three months depending on cash availability.

F.56. Isla Vista accrues outstanding payables through a journal entry at the end of each month rather than entering invoices as they are received as is more customary.

Recommendations:

R.58. Enter all payables as invoices are received or a liability is incurred (for example, monthly rent payments which are generally not invoiced).

R.59. Prepare monthly aging reports which highlight which payables have been outstanding for the longest period of time. These reports should be shared with senior management staff as well as the Board of Directors to fully inform responsible parties of the financial status of the newly combined entity.

Financial Impact:

Effective cash management will allow the clinics to meet current obligations without resorting to short term financing thereby eliminating related interest charges. Isla Vista incurred short term interest expenses of less than $500 in 1996-97. Annual interest charges for Carrillo's current line of credit are estimated at $800 to $1,800 depending on continued repayment or draw levels. Westside interest expense for financing operations (distinct from financing the Westside building) is approximately $2,500 per year.

More importantly, timely and comprehensive reporting of cash management activities will allow management staff to take timely steps to meet cash management goals. Reporting should include Accounts Receivable and Accounts Payable agings, three to six month cash flow projections, and current profit and loss statements.

C.2.b. Billing And Collections

C.2.b.i. Billing Procedures

Findings:

F.57. Isla Vista uses an outside billing service for a fee of $32,400 per year. Clinic staff prepare superbills and summary sheets which are forwarded to the service. The service reviews pended and denied claims and reports back to the clinic. The clinic receives summary reports of number of claims processed, total charges billed and outstanding

receivables by payor type.

F.58. Westside also uses a billing service at a projected annual cost of $18,000. The service processes all billing except CHDP and special contract programs. Under the contract, the billing service is responsible for reviewing and reprocessing pended and denied claims. Clinic staff also review claims and make corrections where possible. According to clinic staff, the billing process is fragmented among several clinic staff and could use an overall supervisor.

F.59. Carrillo's bookkeeper does all billing using TLG Medical Office System, an automated billing system. In addition to creating billing documents, the system allows Medicare to be billed electronically. Research is underway to upgrade the system to increase the amount of electronic billing. The target is to have all billing processed electronically. Electronic billing generates quicker payment. In some instances electronic billing can result in payment seven days after billing. Bills are currently prepared weekly. Denied and pended claims are reviewed and corrected and re-billed whenever possible.

F.60. None of the clinics were readily able to determine what percentage of billings are actually collected.

Recommendations:

R.60. Eliminate billing service at Isla Vista (and Westside if Westside becomes part of the merged entity) and process all previously outsourced billing through Carrillo's billing system.

R.61. All billing should be prepared at a central location in the new organization.

R.62. Hire billing staff experienced in Medicare, Medi-Cal, CHDP, Workers' Compensation, Family PACT and private insurance billing. Current staff may be able to do all required billing with some limited additional training and support.

R.63. Prepare monthly aging reports to track how long it takes to collect from various payors and what percentage of billings are collected from each payor. This will allow billing staff to concentrate efforts on designated focus areas e.g., oldest claims, highest dollar claims, payors with lowest percentage of collections to billings.

R.64. Develop percentage collection standards for each payor type from published industry standards modified if necessary for differences unique to community clinics. Overall collection rates should be 90 to 95% of billings if billings are priced at expected reimbursement and not at the clinic fee schedule. Reporting of actual collections vs. established standard should be included in monthly management review meetings. A sample of such a report is included as Attachment J - Financial Indicators Worksheet.

R.65. A merged entity with $1.2 million annual revenue (Isla Vista and Carrillo merged)

or $1.9 million (all three clinics merged) would justify the purchase of a Medical Management system to allow on site entry of billing information. A comprehensive Medical Management system would include the following functions:

Patient Scheduling
On-Site Entry of Billing Information
Aging Reports of Outstanding Receivables
Productivity Reporting
Utilization Reporting
Provider Profiling
Periodic Screening Reminders
Mailing Labels

Estimated cost of such a software package is $50,000 to $100,000. Additional hardware costs should be limited to $20,000 to $25,000. Implementation would take place over three to six months depending on time availability of staff.

R.66. Follow-up of denied and pended claims is essential. Billing limits (time from date of service to date claim may be filed) should be determined for each payor. This information should be used in conjunction with the Accounts Receivable aging to determine which accounts should be prioritized for collection.

C.2.b.ii. Capitation Revenue and Trust Payments from SBHI

Analysis of the trust account activity can be divided into three parts. The first is the budget or trust account allocation. Allocation rates are developed for each capitated member. These rates vary by aid code (eligibility designation), age and sex. The monthly capitation rate to providers for AFDC welfare recipients tend to be lower than the rate paid for the disabled. The rate paid for the Medically Needy (those beneficiaries who are on Medi-Cal because of their medical condition) are considerably higher than those on Public Assistance who receive Medi-Cal benefits as a by-product of cash assistance. Further, premiums paid for children tend to be lower than adults. These rates are totaled for all members assigned to a PCP to create the total budget allocation. Table IX displays the budget allocations for each clinic for the last two years.

TABLE IX
SBHI Budget Allocations

	Carrillo		Isla Vista		Westside	
		pmpm		pmpm		pmpm
1994-95	$715,687	$92.75	$480,778	$69.32	$600,721	$101.75
1995-96	$604,823	$78.88	$561,272	$70.76	$533,554	$85.51
% Change	-15.5%	-14.9%	+16.7%	+2.1%	-11.2%	-16.0%

As can be seen in Table IX, the allocation for Westside and Carrillo changed significantly from 1994-95 to 1995-96. Unless there was a corresponding reduction in benefit responsibility, it would be difficult to justify this change.

The second part of the Trust Account equation is the cost of actual services provided. The costs are determined by the number of covered services, the level of services rendered, and the cost of the service. For most services, SBHI payments are based on the Medi-Cal fee schedule regardless of who provided the service. So total costs differences are the result of differences in the number and level of services provided. One exception to this schedule is payment for inpatient hospital stays. The hospitals contracting with SBHI are paid different per diem rates for the same services. More utilization of the high cost hospitals will obviously adversely effect costs. The cost trends for the clinics can be seen in Table X.

TABLE X
Trust Account Cost Trends

	Carrillo		Isla Vista		Westside	
		pmpm		pmpm		pmpm
1994-95	$519,937	$67.38	$328,495	$47.36	$475,088	$80.47
1995-96	$604,300	$78.80	$408,692	$51.52	$486,788	$78.01
% Change	+16.2%	+16.9%	+24.4%	+8.8%	+1.8%	-3.1%

This table shows that costs per member per month at Westside actually decreased from 1995 to 1996. And yet Westside's annual trust account payment decreased from $70,548 to $27,796, a 61% reduction. If the budget allocation for Carrillo and Westside had remained at the same level in 1995-96 as in the prior year, the trust account payments for 1995-96 would have been approximately $63,000 for Westside and $61,600 for Carrillo.

The medical loss ratio (MLR) analysis is one method to make this comparison. MLR is the actual cost of services divided by the budget allocation. As can be seen in Table XI, Carrillo and Westside went from a favorable ratio (in the 70% range) to a virtual break-even status (nearly 100%).

TABLE XI
Clinic Medical Loss Ratios

	Carrillo	Isla Vista	Westside
1994-95	72.6%	68.3%	79.1%
1995-96	99.9%	72.9%	91.2%
% Change	+37.6%	+6.7%	+15.3%

Findings:

F.61. Capitation payments and trust payments have historically been a material source of revenue for all three clinics. From 1991 to 1995 these funds have represented 10-15% of annual revenues for each of the clinics. The most recent distribution declined to less than 5% of total revenue for Westside and Carrillo. See Table XII for a five year comparison.

F.62. The number of individuals served by the Santa Barbara Health Initiative has been declining over the last year. The decrease of 10% has been primarily in the Share of Cost membership which is not assigned to a primary care provider and therefore this decline in membership has not affected the clinic capitation and trust account payments. Member count is included in Table XII.

F.63. Trust account payments fluctuate from year to year, dependent on the make up of the SBHI membership, the overall financial success of SBHI and the utilization patterns of the population served by each clinic.

Carrillo received a preliminary trust account payment in November, 1997 and was told that the total annual payment will be approximately $60,000. The other two clinics were provided no information regarding the status of their accounts.

F. 64. SBHI is moving to a system whereby more surplus dollars are paid out on the basis of “quality indicators” rather than low claim costs. The impact of this change on future clinic trust account payments cannot be predicted. SBHI staff have indicated that the goal is not to radically change pay-out patterns.

TABLE XII
Revenue From SBHI Contract

	Isla Vista		Westside		Carrillo	
	Total	PMPM	Total	PMPM	Total	PMPM
1991-92						
Capitation	49,385	7.55	45,270	8.25	54,464	7.89
Trust Account	90,333	13.81	100,334	18.29	95,056	13.77
Average number of lives	545		457		575	
1992-93						
Capitation	53,066	7.68	41,862	8.23	49,795	7.81
Trust Account	49,648	7.19	80,113	15.75	91,646	14.37
Average number of lives	576		424		532	
1993-94						
Capitation	56,591	7.69	44,903	8.42	58,141	8.12
Trust Account	75,807	10.30	68,545	12.85	82,829	11.57
Average number of lives	614		445		597	
1994-95						
Capitation	52,116	7.51	49,770	8.44	62,420	8.10
Trust Account	80,024	11.54	70,548	11.96	108,376	14.06
Average number of lives	578		492		643	
1995-96						
Capitation	59,523	7.51	51,527	8.26	60,364	7.88
Trust Account	87,533	11.04	27,796	4.46	11,883	1.55
Average number of lives	661		520		639	

Recommendations:

R.67. Clinic staff (probably the Financial Manager, Medical Director and Executive Director) should meet with SBHI staff in order to thoroughly understand the capitation rate structure and how trust accounts are defined and calculated. A critical part of the discussion should an explanation of the dramatic reduction in Carrillo and Westside's budget with the resulting virtual elimination of a year end trust account payment. One of the goals of the Santa Barbara Health Initiative is to maintain an adequate network of primary care providers to serve the Medi-Cal population in Santa Barbara County. The community clinics have formed a critical component of this provider network serving 5% of the members enrolled in SBHI. Further, as safety net providers, the community clinics should be and appear to have been afforded special protection by the Health Initiative over the past fourteen years. Changes in SBHI operations which will dramatically reduce revenue to providers need to be justified to those affected by the changes. This does not appear to have been done.

R.68. Ideally, trust account payments should not be included in budgeted revenue. Clinic staff should consult with SBHI finance staff to obtain the most realistic yet

conservative estimate for each year's trust account payment. Budgeting should not merely duplicate the prior year's receipt. As demonstrated in Table XIII, the change in trust account allocations has affected Carrillo and Westside much more dramatically than Isla Vista.

R.69. The Financial Manager and Medical Director should also work with SBHI staff to develop and interpret utilization reports which will allow the clinic to more effectively forecast and manage utilization patterns and the resulting trust account payment.

Financial Impact:

The declining SBHI enrollment does not allow the clinics to significantly increase capitation revenue in the short term. However increased collaboration with SBHI may avoid the unexplained reduction in trust account payments experienced by Westside and Carrillo. The clinics may also inquire of SBHI staff if there are any specific provider needs the clinics could meet. An example of this type of selective contracting is a proposal by Planned Parenthood in Solano County to provide primary and reproductive health services to members with disabilities for an increased capitation rate.

C.2.c. Payroll, Staffing And Benefits

C.2.c.i. Payroll Processing

Findings:

F.65. All three clinics use a payroll service to calculate and process payroll checks. Isla Vista and Carrillo use PayChex. Westside uses an accounting firm.

F.66. Isla Vista and Westside make payroll tax deposits directly. PayChex makes deposits for Carrillo.

F.67. Quarterly and annual information returns are prepared by the payroll service for Westside and Carrillo. Isla Vista staff prepare information returns.

F.68. Costs of the payroll service are: Isla Vista - $137 per pay period plus a year end reporting fee; Westside - $45 per pay period; Carrillo - $110 to $190 per pay period depending on number of employees on payroll plus a year end reporting fee. Westside fee appears to be heavily discounted probably because the accounting firm regards this as a community service.

F.69. Westside had an outstanding payroll tax liability of $7,200. A payment schedule of $500 per month was proposed by EDD in June 1997. In October, 1997, Westside received donations and loans in the amount of $152,000. The outstanding tax liability was paid off from these funds. Westside requested that interest and penalties (currently approximately $1,800) be waived. As of November 10, 1997, EDD had not responded to this request.

F.70. Among the employee benefits offered by Westside is a cafeteria plan where employees may have pre tax dollars deducted from payroll which are then available to pay medical, childcare and retirement costs. Westside clinic stopped making deposits into employees' accounts and as of early October owed employee accounts approximately $6,700. This liability was also funded from the donations received in mid October. All accounts are current and employees have requested that payroll deductions be resumed including extra deductions to make up for months when no deductions were taken.

Recommendations:

R.70. All clinics should continue to have payroll processed by a payroll service.

R.71. In view of the deeply discounted fees charged by Westside's accounting firm, a better price may be secured by soliciting small accounting firms rather than a commercial payroll service. Further, if all three clinics merge, the cost of payroll processing may decrease overall as services generally charge less for one company with 30 employees than 3 companies with 10 employees.

R.72. The payroll service should make tax deposits and issue quarterly and annual IRS reports as well as issuing payroll checks and reports. Payroll services can also make non-tax deposits such as retirement plan deductions or cafeteria plan deductions. This would avoid future problems with outstanding payroll related liabilities.

Financial Impact:

Cost savings may be realized by the consolidation of payroll as well as researching lower bids for this service.

Since neither Isla Vista nor Carrillo have outstanding tax or other payroll related liabilities, they will realize no interest and penalty reductions from having payroll service make deposits. However, all staff and employees will be sheltered from future potential tax deposit and reporting irregularities.

C.2.c.ii. Finance Department Staffing

Findings:

F.71. Isla Vista employs a part-time controller whose job duties include financial statement preparation, budget preparation, and processing daily activity including bank deposits, time sheet preparation, and vendor payments.

F.72. Westside and Carrillo employ full to nearly full time bookkeepers who process daily activity but have limited understanding of financial reporting. Year end financial

statements are prepared by an outside accounting firm.

F.73. Carrillo's bookkeeper also processes all clinic billing.

Recommendations:

R.73. The new entity should hire a financial manager to oversee the financial management, computer systems and reporting systems for the combined entity. The ideal financial manager should be experienced in community clinic financial reporting as well as cash flow projections, budgeting and general financial operations including cash receipts, disbursements, inventory, accounts receivable and accounts payable. The primary responsibilities of the financial manager include timely preparation of monthly financial, utilization and management reports and reviewing reports with senior management. The financial manager would also negotiate all contracts. Administration of grants and contracts would be a major function of the position. This is particularly important as it relates to the SBHI trust account reports. Annual salary is estimated at $35,000 to $40,000. If Westside is included in the merger, the financial manager would need a half time assistant to process daily activity. The estimated hourly salary for this position is $10.

R.74. In addition to the financial manager, a full service biller should be hired to process all clinic billing and collections as well as produce utilization reports. The biller should be experienced in billing Medicare, Medi-Cal, CHDP, Worker's Compensation, Family Planning, private insurance as well as collecting from private pay clients. Current staff could possibly move into this position. Annual salary is estimated at $25,000 to $28,000. If Westside is included in the merger, a half time billing clerk would be needed. A single individual could perform both the daily financial and billing functions, creating one full time position.

R.75. Engage services of an accounting firm to perform quarterly reviews of financial statements and compliance with internal control policies. Annual cost is estimated at $2,500 for Isla Vista and Carrillo, $3,000 if Westside is included.

Financial Impact:

Reconfiguration of Finance and Billing staff would result in annual cost increase of $11,000 to $16,000 per year.

C.2.c.iii. Salaries and Benefits

Findings:

F.74. The three clinics have varying benefit levels. See Table II and Table III.

F.75. Hourly salaries at the clinics are generally comparable - Physicians:

$38.41(Carrillo), $35-$40 (Isla Vista), $45 (Westside); Nurse Practitioners: $25 (Carrillo), $20 (Isla Vista), $24-$26 (Westside). Variations result primarily from higher paid part time employees who are not eligible for benefits. Exceptions are Clinic Manager: $8 (Carrillo), $16 (Isla Vista), $15.88 (Westside); and Medical Assistants: Volunteers (Carrillo), $8-$12 (Isla Vista), $11.03 (Westside). (See Attachment H.)

Recommendations:

R.76. All clinics should have the same benefit program and wage scale.

R.77. As outlined in R.25, a personnel expert should be engaged to determine an appropriate benefit package. It is recommended that the overall cost of the new benefit package be equal to the combined current costs of the individual clinics.

Financial Impact:

Isla Vista offers the highest level of benefits with four more holidays than the other two clinics, partial benefits for part time employees and more vacation days earned after a shorter period of employment. The cost of offering this higher level of benefits to all staff of the new merged entity is an estimated annual increase of $23,000 for two clinics, $37,000 for three clinics.

Carrillo offers the lowest level of benefits overall with 20 vacation days only after 10 years of employment, 0.5 days sick leave accrual per month, no benefits for employees who work less than 32 hours per week. The savings realized if this level of benefits is selected for all employees of the new organization is an estimated annual reduction of $21,000 for two clinics, $34,000 for three clinics.

A restructuring of Isla Vista medical staff from largely part time to full time with benefits could increase annual salary and benefit costs $12,000 to $17,000.

Bringing the Medical Director salary up to the medium benchmark salary would increase annual salary cost by $22,000.

C.2.d. Building And Occupancy

Findings:

F.76. Isla Vista owns its building and additional space from which the clinic collects monthly rental income of $6,015. One tenant currently paying $2,124 will be vacating effective June, 1998. Another tenant whose monthly rent is $190 is currently six months in arrears. The Isla Vista clinic occupies 4,992 square feet of the 9,908 square foot building. The clinic building was appraised in November 1994 and valued at $475,000. No appraisal has been conducted on the remainder of the building.

F.77. Westside owns its building valued at $375,000 at an appraisal 2 to 3 years ago.

F.78. Carrillo rents space under a ten year lease which expires August 9, 2003. The annual rent for the medical clinic is currently $45,900; rent for the dental clinic is $9,000. Square footage occupied by the Medical clinic is 3,500; the Dental clinic occupies 800 square feet.

Recommendations:

R.78. Since Westside and Carrillo serve the same geographic area, it is recommended that the two clinic sites be combined if Westside is part of the merger. Since neither clinic has adequate space to serve the combined population, it is recommended that a new site be secured in downtown Santa Barbara. The current Westside building and its related debt should be retained by the current Westside entity pending sale of the building. Any proceeds from the sale in excess of the Westside debt should be donated to the new entity. In the interim, the new organization will have to pay rent to the building holders to support the loan and insurance payments the current Westside entity must make.

R.79. The current Isla Vista corporate entity should retain the building and related debt. The newly created entity would be allowed to operate the clinic rent free. Net income from the building leases would be provided for clinic operations.

R.80. Since Isla Vista will be losing a tenant effective June, 1998, it is recommended that this space be considered for the administrative offices of the merged clinics. Space would be provided for the Executive Director, Medical Director, Community Services Director, Financial Manager, Claims Biller and Administrative Assistant. This space would be made available rent free.

Financial Impact:

Combining Carrillo's current clinic space (4,300 sq.ft.) and Westside's space (1,500 sq.ft.) while reflecting the move of the management staff to the Isla Vista building, would indicate that the new clinic site should be between 5,000 and 6,000 square feet including space for the dental clinic. At Carrillo's current rent per square foot, annual rental cost of the new clinic would be $66,000 to $79,200. The net increase or decrease in operating costs would be dependent on the sale price of the Westside clinic building. However, since Westside's mortgage is in the form of a balloon note, it is estimated that monthly cash payments will increase by approximately $1,000. This would be somewhat offset by annual savings of $3,310 for property insurance for the Westside building.

Allowing the Isla Vista clinic to operate rent free and use rental income for clinic operations would in effect continue the current financial arrangement. If the administrative staff were to take over the soon to be vacated space rent free, the annual reduction in rental income would be $25,000.

C.2.e. Debt Management

Findings:

F.79. Isla Vista is liable for $405,000 under Series 1988 D Bonds which are limited obligations of the California Health Facilities Financing Authority. First Trust of California would have to agree to any merger. Discussions with Edward Gibson of First Trust revealed that such an agreement could be readily obtained.

F.80. The bonds mature June 1, 2018. Monthly payments vary slightly from year to year. Currently monthly payments equal $3,648 including interest at 7.83%. In addition, an annual trustee fee of one half of one percent of the outstanding principle balance is assessed.

F.81. Westside recently refinanced two loans - a mortgage and a line of credit for $24,000. The new loan for $155,330 is payable in monthly installments of $963 including interest at 6%. Remaining principle and interest is due in a lump sum July 1, 2002. The estimated amount of the lump sum payment is $143,000. However, the lender, the Hutton Foundation, has requested annual principal reductions which are not mandated by the loan documentation. Additionally, Westside received $25,000 in short term loan. These funds are currently on deposit on a Money Market account. The principal plus $1,750 in interest is due September 30, 1998. Currently, Westside plans to use the new $25,000 loan to make the first principal reduction payment to the Hutton Foundation. There are not plans yet for subsequent year principal payments or the repayment of the $25,000 loan.

F.82. Carrillo has a line of credit in the amount of $25,000. During August and September of 1997, the clinic drew on the credit line to fund operations. As of September 22, 1997, the full amount of the credit had been drawn. Interest at an initial rate of 9.5% is due monthly beginning December 13,1997. Estimated monthly interest payments equal $200. The principle balance and any unpaid interest is due November 13, 1998. In November, Carrillo received approximately $14,000 in trust account payments from SBHI. These funds and other cost cutting measures allowed Carrillo to pay off current liabilities and to reduce the outstanding line of credit to $9,000.

Recommendations:

R.81. Isla Vista should request a legal review of the effect a merger might have on the Bond liability.

R.82. A merger including Westside would include the transfer of short term debt. The balloon mortgage would remain along with the building under the current Westside entity. If a decision is later made not to sell the building, a plan would have to be developed to pay off the balloon payment.

Financial Impact:

An estimated total of $2,500 in interest payments could be avoided if Carrillo had not needed short term financing. An estimated $4,250 could be saved on Westside's interest expense.

C.2.f. Budgeting And Financial Planning

Findings:

F.83. All clinics prepare annual income and expense budgets which reflect expenses equal to or slightly higher than income.

F.84. Budgets appear to be based on prior year experience.

Recommendations:

R.83. An annual budget should be prepared for each clinic location and for the new entity's administrative office.

R.84. The budget should include monthly cash reserve funding.

R.85. Santa Barbara Health Initiative trust account payments should not be included in budgeted revenue. If these payments are included estimated amounts should be booked conservatively after discussion with SBHI regarding projected levels of payments.

R.86. The budget should be reviewed quarterly and revised if contract or other business changes make parts of the budget inappropriate.

R.87. Actual performance should be reported against budgeted expectations each month. These reports should be shared with senior management staff as well as the Board of Directors to fully inform responsible parties of the financial status of the newly combined entity.

Financial Impact:

No cost savings will result from updating budgets and reporting activity against budget. However, problem areas can be more readily identified and action can be taken quickly to address them.

C.2.g. Fiscal Reporting

Findings:

F.85. Monthly financial reports are prepared by clinic staff on an irregular schedule at all clinics.

F.86. Statements received from Carrillo Clinic showed a balance sheet that did not balance and unusual balances in some of the accounts. Further, liabilities like accrued vacation were not reflected.

F.87. Isla Vista statements listed the same balance for accrued vacation at 6/30/96 and 6/30/97. It appears that this account is not updated. Funds on deposit with trustee appear also not to be updated.

F.88. Westside does not record clinic revenue until cash is received. Receivables are only adjusted at year end.

Recommendations:

R.88. Financial statements with all necessary accruals should be prepared on a monthly basis and reviewed with senior management staff as well as the Board of Directors. Financial statements should include a comparison of actual performance to budget.

R.89. Monthly financial reports reviewed should include a cash flow projection, an aging of receivables and payables, clinic productivity reports, actual collections compared to established standards, utilization reports including type of patients seen, types of services provided, capitated encounters, etc.

Financial Impact:

No cost savings will result from preparing and reviewing financial reports on a regular monthly basis. However, problem areas can be more readily identified and action can be taken quickly to address them.

C.2.h. Annual Financial Audit

Findings:

F.89. Isla Vista has an annual audit at a cost of $4,000.

F.90. Westside's annual audit fee is $3,500.

F.91. Carrillo's last audit was for the year ended June 30, 1995. Quote received for an annual audit is $3,500.

Recommendations:

R.90. An audit of each of the merging clinics should be performed as of the date of the merger to fully disclose any financial obligations or other matters which might impact the newly created entity.

R.91. An annual audit should be required whether grant funding calls for this or not.

Financial Impact:

Since Carrillo has not budgeted the cost of an annual audit, $3,500 in additional costs would be incurred.

In future years, once clinics have formed a single entity, audit fees will be reduced since only one audit will be required not three.

C.2.i. Risk Management

Findings:

F.92. All three clinics carry basic insurance coverage including general liability, professional liability and directors and officers coverage.

F.93. Coverage limits vary slightly.

F.94. Coverage appears to be adequate for each clinic.

F.95. See Attachment I - Insurance Coverage Comparison.

Recommendations:

R.92. Current coverage should be maintained.

R.93. As part of the consolidation employee dishonesty coverage should be extended to cover all employees.

R.94. Errors and omissions coverage (an employees medical premium is inadvertently not paid, the employee becomes ill and insurance will not cover) should be investigated.

R.95. Obtain Directors and Officers Liability Insurance for new Board of Directors.

Financial Impact:

Since clinic operations and number of patients served are not anticipated to decrease, merging the entities will probably not realize savings from Professional Liability

insurance and Directors and Officers insurance premium reductions. Savings may be generated through a competitive bid process.

If the Westside building is sold and the clinic services of Westside and Carrillo are combined at a single new location, $3,310 in property insurance would be saved.

Extending employee dishonesty coverage to two clinics would cost an additional $365 per year. Including Westside in the merger but consolidating clinic operations in two sites would probably not result in a higher premium for this coverage.

C.3. Financial Projections

Predicting the future is always a risky business. However, if certain assumptions are agreed to, trends may be developed which will give some indication of where the clinics might be as a result of this merger. These projections consist of three tables: income statements for the year ended June 30, 1997 and projected for the next two years as well as balance sheets for the same periods for the clinics individually and for the merged entity.

Table XIII, Income Statement Projection begins with the income statements for each clinic as of June 30, 1997. These are unaudited statements and have been reviewed for reasonableness. Where items were clearly missing (no depreciation expense for Westside on the clinic building), the statements have been adjusted. These June 30, 1997 income statements appear under each clinic name in the column headed “1996-97 Actual.”

Income and expenses for the year ending June 30, 1998 were projected using budget projections prepared by each clinic’s staff and were not developed by consultants or auditors. Again, obviously missing items were adjusted. These projections appear under each clinic name in the column headed “1997-98 Budget.”

The final two columns project what income and expenses would be for the year ending June 30, 1999 after the new entity has operated for a year. The column “Combined 3 clinics” assumes all three clinics merge. The column “Combined 2 clinics” assumes that Carrillo and Isla Vista alone merge. In either case, revenue and expenses are estimated to remain the same for all clinics.

The bottom portion of Table XIII quantifies the financial impact of the merger. Detailed descriptions of each item are contained earlier in this report.

Table XIV shows balance sheets for each clinic as of June 30, 1997 and projected balance sheets as of June 30, 1998 and 1999. Again, the balance sheets have not been audited but were adjusted for obvious discrepancies. Balance sheets for 1998 and 1999 were projected from 1997 adjusted by the net income projected in Table XIII and any debt payments required during the fiscal year. These are balance sheets as they might

be expected to appear if no merger were to take place.

Table XV shows the projected June 30, 1999 balance sheets for the proposed merged entity. Again, the column “Combined 3 clinics” represents a merger of all three clinics and the column “Combined 2 clinics” represents a merger of Isla Vista and Carrillo. The net impact of the merger is included in these projections.

The income projections underscore the similarities of the three clinics. Revenue levels are similar with Westside earning the highest patient services receipts while Isla Vista supplements patients service revenue with rental income. While the projected margins of both profit and loss are not significant, Westside is projecting a profit, while the other two clinics are projecting losses, in great part due to the influx of recent contributions to Westside.

Isla Vista has fared better than the other two clinics in revenue from SBHI, primarily because their trust account payments have remained strong. It should be noted that projections for 1998 and 1999 are at the 1995-96 level of trust account payments. If Carrillo and Westside payments return to historical levels, both clinics should enjoy a more comfortable year. Conversely, if Isla Vista were to see a loss of SBHI trust account payments similar to the other clinics, it would project a significant loss.

The financial impact of the merger would appear to favor a three clinic merger with a $65,000 increase in net income while the two clinic merger virtually maintains the same bottom line.

The balance sheet comparison shows a different story for the individual clinics’ net worth. Isla Vista’s ownership of a building, part of which is available to rent out, combined with little debt, make it the “strongest” of the three clinics. Westside’s sizable debt in 1997 has been offset to some degree by recent donations. Finally, the balance sheets representing the merged entities carry forward the merger savings detailed in Table XV. Again, a three clinic merger creates a stronger balance sheet than a merger of two clinics.

TABLE XIII
Income Statement Projection

	Isla Vista		Carrillo		Westside		Combined 3 clinics	Combined 2 clinics
	1996-97 Actual	1997-98 Budget	1996-97 Actual	1997-98 Budget	1996-97 Actual	1997-98 Budget	1998-99 Budget	1998-99 Budget
Patient Services	300,957	228,650	388,251	376,096	547,760	559,876	1,164,622	604,746
SBHI cap & claims	149,259	155,100	74,798	58,800	80,800	60,000	273,900	213,900
Grant Income	148,873	212,170	137,625	146,120	111,500	88,280	446,570	358,290
Rental Income	72,176	72,176					72,176	72,176
Other Income	13,730	12,000	8,075	15,516	2,850	1,500	29,016	27,516
Total Income	**684,995**	**680,096**	**608,749**	**596,532**	**742,910**	**709,656**	**1,986,284**	**1,276,628**
Salaries & Wages	302,656	297,455	369,273	408,736	438,600	430,237	1,136,428	706,191
Fringe Benefits	54,266	53,542	45,052	19,200	59,040	64,800	137,542	72,742
Medical, Lab & Program Costs	87,217	56,750	60,934	48,200	75,800	71,800	176,750	104,950
Insurance	22,190	23,641	28,155	19,530	20,400	13,310	50,850	43,171
Rent, Tax & Utilities	9,011	9,280	66,038	60,792	19,800	9,600	79,672	70,072
Depreciation	30,000	30,000				17,000	47,000	30,000
Interest Expense	30,187	31,806			14,000	9,000	40,806	31,806
Other Expense	195,952	186,313	56,228	56,520	103,632	66,975	309,808	242,833
Total Expense	**731,479**	**688,787**	**625,680**	**612,978**	**731,272**	**682,722**	**1,984,487**	**1,301,765**
Net Income	(46,484)	(8,691)	(16,931)	(16,446)	11,638	26,934	1,797	(25,137)
Impact of Merger								
Consolidate Billing Service							47,400	32,400
Consolidate Payroll Service							1,040	1,040
Consolidate Staff							42,500	0
Management Team Salaries							(14,000)	(14,000)
Administrative Offices							(25,000)	(25,000)
Quarterly Financial Review							(2,500)	(2,500)
Consolidate Annual Audit							4,000	2,000
Consolidate Insurance Policies							(385)	(365)
Net Income/Merged Entity		(8,691)		(16,446)		26,934	54,872	(31,562)

Notes:

- The columns headed “Combined” compute the sum of the respective clinics’ 1997-98 budget amounts. “3 clinics” sum all three clinics, “2 clinics” sum only Isla Vista and Carrillo. These budget projections assume the same revenue and expenses for 1998-99 as are budgeted for 1997-98.
- The bottom section of the table list the items which will financially impact the combined entity on a ongoing basis.
- Negative numbers represent additional costs, positive numbers represent cost savings.

These calculations are based on information provided by the individual clinics and are not based on audits conducted. These tables are intended to demonstrate a theoretical model based on the recommendations included in this report.

TABLE XIV
Balance Sheets 1997 - 99

	Isla Vista			Carrillo			Westside		
	June 30, 1997	June 30, 1998	June 30, 1999	June 30, 1997	June 30, 1998	June 30, 1999	June 30, 1997	June 30, 1998	June 30, 1999
Cash	19,018	18,327	17,636	29,546	15,100	654	3,458	37,392	46,326
Accounts Receivable	33,611	33,611	33,611	38,436	38,436	38,436	40,000	40,000	40,000
Prepaid Expenses	2,248	2,248	2,248	3,646	3,646	3,646	307	307	307
Supplies Inventory	9,212	9,212	9,212	4,500	4,500	4,500	3,500	3,500	3,500
Fixed Assets	882,475	882,475	882,475	197,090	197,090	197,090	249,872	249,872	249,872
Accumulated Depreciation	(354,581)	(372,581)	(390,581)	(176,586)	(178,586)	(180,586)	(202,000)	(219,000)	(237,000)
Land	22,500	22,500	22,500				59,543	59,543	59,543
Other Assets	51,375	51,375	51,375	2,000	2,000	2,000	8,097	8,097	8,097
Total Assets	665,858	647,167	628,476	98,632	82,186	65,740	162,777	179,711	170,645
Accounts Payable	3,244	3,244	3,244	6,061	6,061	6,061	79,976	10,000	10,000
Accrued Wages and Taxes	22,259	22,259	22,259	20,000	20,000	20,000	48,000	23,000	23,000
Other Current Liabilities				26,915	26,915	26,915			
Current Portion of Long Term Liabilities	10,000	10,000	10,000				24,900	27,500	2,500
Long Term Debt	386,979	376,979	366,979				102,483	152,830	142,830
Other Long Term Liabilities	20,350	20,350	20,350						
Total Liabilities	442,832	432,832	422,832	52,976	52,976	52,976	255,359	213,330	178,330
Net Worth	223,026	214,335	205,644	45,656	29,210	12,764	(92,582)	(33,619)	(7,685)

Please note: These calculations are based on information provided by the individual clinics and are not based on audits conducted. These tables are intended to demonstrate a theoretical model based on the recommendations included in this report.

TABLE XV
Projected Balance Sheets for Merger
As of June 30, 1999

	3 Clinics Sum	3 Clinics Merged	2 Clinics Sum	2 Clinics Merged
Cash	64,616	117,691	18,290	11,865
Accounts Receivable	112,047	112,047	72,047	72,047
Prepaid Expenses	6,201	6,201	5,894	5,894
Supplies Inventory	17,212	17,212	13,712	13,712
Fixed Assets	1,329,437	1,329,437	1,079,565	1,079,565
Accumulated Depreciation	(808,167)	(808,167)	(571,167)	(571,167)
Land	82,043	82,043	22,500	22,500
Other Assets	61,472	61,472	53,375	53,375
Total Assets	864,861	917,936	694,216	687,791
Accounts Payable	19,305	19,305	9,305	9,305
Accrued Wages and Taxes	65,259	65,259	42,259	42,259
Other Current Liabilities	26,915	26,915	26,915	26,915
Current Portion of Long Term Liabilities	12,500	12,500	10,000	10,000
Long Term Debt	509,809	509,809	366,979	366,979
Other Long Term Liabilities	20,350	20,350	20,350	20,350
Total Liabilities	654,138	654,138	475,808	475,808
Net Worth	210,723	263,798	218,408	211,983

Financial Management Conclusions

The community clinics participating in this merger study face similar financial difficulties. Cash flow is a recurring problem. All three clinics have historically relied on SBHI trust account payments. In 1996, these payments declined dramatically for two of the clinics with no clear explanation. In addition, financial resources to attract experienced financial management staff have not been available.

An operational audit of Westside recommended several operational changes to address the financial crunch at Westside nearly a year ago. Some of these recommendations have been implemented. However, Westside still struggles financially from day to day. Clinic liabilities include two balloon payment loans, payroll checks for two pay periods which staff were asked not to cash, an outstanding payroll tax liability, an employee benefits liability, as well as holding vendor payments up to 90 days. Without the recent financial gifts which allowed the clinic to pay off these outstanding debts, Westside's financial viability would be in serious question. The gifts have allowed Westside clinic staff and board to continue to operate with an emphasis on fund raising and grant writing to meet operating costs rather than examining the root causes of the financial crisis and seeking operational solutions.

Carrillo Clinic has relied heavily on the annual SBHI trust account payments as have all the community clinics. Carrillo's trust account payment in 1996 declined substantially and clinic staff were faced with a need to reduce costs. Two positions were eliminated and short terms loans were accessed. A projected increase in trust account payments along with an interim payment has allowed the clinic to repay much of the short term loan. The staff reductions are projected to be permanent. Carrillo Clinic stands ready and poised to begin the process of consolidation, recognizing the benefits to be gained from merging administrative functions.

Isla Vista appears to be in the strongest financial position. SBHI trust account payments continue to be a substantial revenue source. In addition, rental income from the space not occupied by the clinic is used to support clinic operations. These cash flow infusions have avoided the need for short term borrowing. However, like the other two clinics, operations are at best at break-even level with no funds available to fund contingency reserves or any expanded activities.

Given the status of the three clinics, it would appear that a strong alliance could be created between Carrillo and Isla Vista. While both clinics are struggling, each provides resources which would strengthen the combined entity while also realizing cost savings. Adding Westside to the combination would strengthen the potential viability of the merger project, if recommendations contained in this report regarding staffing and other cost consolidations are implemented quickly.

Regardless of which clinics are finally included in the merger, the new entity will require a new approach to financial management. Merging operations can permit a concentration of resources which will provide effective, efficient financial oversight and maintain the financial viability of these facilities. Critical factors are the use of experienced trained staff, regular financial reporting and review and timely responses to issues revealed by financial data. The rewards of the merger will be realized in operational and management efficiencies resulting in greater stability for both clinic staff and patients.

While one of these efficiencies might be expected to include an increase in the negotiating power of the clinics with SBHI, this is unlikely since SBHI sets reimbursement rates rather than negotiating them. However, a closer relationship with the SBHI might allow the clinics to develop strategies to address unmet needs in the community. Further, since the trust account payments are such a large part of the life blood of the traditional safety net providers including the community clinics, rate reductions whether in capitation payments or allocations affecting the annual trust account payments need to be fully explained and justified to the affected providers.

While benefits of merging operations will be realized once the merger becomes effective, the actual merging process will be a costly one. Staff will have to be hired, offices relocated, possibly some clinic sites relocated, additional hardware and software purchased. These merger costs cannot be funded by the individual clinics struggling to meet daily expenses. Grant or other assistance will be required to assist in funding the

merger process.

In summarizing the merger costs and operational cost savings, a comprehensive financial impact analysis should be prepared. Such an analysis would include monthly projections for a two year period of revenue and expenses, cash flow and balance sheets of the combined entity. However, this proposed merger is currently subject to too many variables including the number of clinics that will be merging, the number and location of clinics sites, salary and benefit levels to make more comprehensive financial projections at this time. Therefore, the projections included in Tables XIII, XIV, and XV evaluate the financial impact of a merger assuming that the operations at each clinic will continue as currently budgeted with the exception of the merger savings described once the next round of decisions regarding the parameters of the merger are made, additional projections can be created.

Tables XIII, XIV, and XV quantify certain economies of scale, e.g., the elimination of certain administrative functions and positions. The greatest savings are generated from combining certain administrative operations. However, the additional costs of hiring and locating an experienced financial management team virtually cancel out these savings. Benefits to be realized over time focus on greater financial management expertise, the impact of which cannot be readily quantified at this time.

IV. IMPLEMENTATION PLANS

The following Implementation Plans re-organize the recommendations found earlier in this report in a proposed sequence of events. The Summary of Key Areas reflects the key items listed in the following detailed Management, Clinical and Financial Implementation Plans (pages 72 - 81) in order to provide an overview of what will be happening in each of the three areas at approximately the same time. The transition from two or three organizations to one new organization will be time-consuming and will require an intricate orchestration of events and decision-making while day-to-day services continue.

Summary Of Key Areas of Implementation Plans

MANAGEMENT		CLINICAL		FINANCIAL	
KEY AREAS	**TIME FRAME**	**KEY AREAS**	**TIME FRAME**	**KEY AREAS**	**TIME FRAME**
1. Develop new organization structure	January - July 1998	1. Inventory All Clinical Resources	January - March 1998	1. Personnel Consultant Review Of Job Descriptions And Benefit And Personnel Policy Structure	March - June 1998
2. Develop new governance structure, seat new Board of Directors and new Executive Director	March- July 1998	2. Recruit And Hire A Medical Director	January - April 1998	2. Management Team Recruitment	March - June 1998
3. Develop administrative and financial implementation plan	March- October 1998	3. Develop Models Of Clinic And Staff Schedules	March - April 1998	3. Management Team Relocation	June - July 1998
4. Develop Marketing and Communication Plan	March- December 1998	4. Identify And/Or Recruit And Hire Key Clinical Support Positions	April - July 1998	4. Payroll Service RFP	May - June 1998
5. Develop a Merger Evaluation Plan	October 1998	5. Develop A Common Medical Record Format	October 1998 - March 1999	5. Secure New Insurance Coverage	April - June 1998
6. Develop a Strategic Planning Process	July 1999			6. Consolidate Billing System	May - June 1998
				7. Telephone And Computer Support To Allow Inter-Clinic Telephone, Scheduling And Billing Consolidation	July - August 1998
				8. Purchase And Installation Of Medical Management System	August - November 1998

A. Management Implementation Plan

The implementation of most of the governance and administrative recommendations must occur in an aggressive fashion to take advantage of each of the clinics' interest in moving forward. While the timeline is rapid and challenging, prolonging the process out for another year beyond the proposed timeline would be problematic given the overall financial instability of the clinics and the support that the merger has among key funders and stakeholders in the community.

A. Management Implementation Plan

KEY AREAS	ACTIVITIES	BY WHOM	TIMEFRAME
A.1. Develop new organization structure			January - July 1998
	A.1.1. Create Ad-Hoc Transition Committee to oversee merger activities until the new Board is seated		January 1998
	A.1.2. Engage legal counsel and consultants to assist in merger planning		February 1998
	A.1.3. Develop Letter of Intent to Merge		February 1998
	A.1.4. Create Merger Agreement		April 1998
	A.1.5. Develop hiring process for Executive Director, Medical Director and Financial Manager and recruit for positions.		April 1998
A.2. Develop new governance structure and seat new Board of Directors			January - July 1998
	A.2.1. Each individual Board approves a resolution to move forward in merger process and appoints members of Ad-Hoc Transition Committee		January 1998
	A.2.2. Each merging entity adopts Letter of Intent to Merge.		February 1998
	A.2.3. Each merging entity adopts concept for new Board of Directors		March 1998
	A.2.4. Develop mission statement and core values for new organization, histories of separate entities and statement about importance of histories to new merged organization.		March 1998
	A.2.5. Legal counsel assists in developing new Articles of Incorporation, By-Laws, new corporate name		April 1998
	A.2.6. Boards of Directors adopt Merger Agreement		April 1998
	A.2.7. New members of new Board of Directors are identified and chosen		May 1998
	A.2.8. Legal counsel assists in creating vehicles related to buildings		June 1998
	A.2.9. Obtain Directors and Officers Liability Insurance		July 1998
	A.2.10 Seat new Board of Directors		July 1998

KEY AREAS	ACTIVITIES	BY WHOM	TIMEFRAME
A.3. Develop Administrative and Financial Implementation Plan			February- October 1998
	A.3.1. Identify all administrative areas and persons/committees responsible for decision-making, communication and problem-solving in each area.		February 1998
	A.3.2. Identify all financial areas and persons/committees responsible for decision-making, communication and problem-solving in each area.		March 1998
	A.3.3. Identify outside resources, both financial and human (staff and consultants) necessary to supplement staff work.		March 1998
	A.3.4. Develop job descriptions and salary ranges for Executive Director, Medical Directors and Financial Manager, have adopted by Ad-Hoc Transition Committee and individual Boards of merging organizations.		March 1998
	A.3.5. Working with Personnel Consultant, develop a consolidated Personnel Policies and Compensation Transition Plan.		March-June 1998
	A.3.6. Develop merger Agreement for individual Boards, working with legal counsel and Ad-Hoc Transition Committee.		April 1998
A.4. Develop a Marketing & Communication Plan			March-December 1998
	A.4.1. Identify a spokesperson for the merger effort.		January 1998
	A.4.2. Develop a communications plan for staff involvement.		March 1998
	A.4.3. Develop a notifications system for all funders, grant and contract agencies, community leaders.		April-May 1998
	A.4.4. Develop patient information letters to allay fears related to change.		June 1998
A.5. Develop a Merger Evaluation Plan			October 1998
	A.5.1. Use Ad-Hoc Transition Committee as evaluation committee and develop benchmarks to measure ongoing impact of merger process.		October 1998
A.6. Develop a Strategic Planning Process			July 1998

B. Clinical Systems Implementation Plan

The implementation of many of the clinical recommendations is dependent upon several key decisions after the merger and merger partners have been decided. A decision needs to be made regarding the Westside and Carrillo clinic sites. Staffing and clinic configuration will depend upon how many sites are involved and where they are located.

The time frames are listed in weeks with the assumption that where meetings or group efforts occur, it will be done for 1-3 hours each week. It is not my intention to imply that each item will take full-time weeks. Other clinic activities have to occur during this time. The majority of expense for these projects will come in the form of hours lost to other productivity.

The implementation activities listed to this point should all occur prior to the official merger of the clinics. These tasks should be accomplished before the new organization begins to function. Following that date, there will be an on-going and probably endless effort to implement systems that currently are not in place or to align different systems under one standard. This list of activities includes in priority order:

- Implementation of a shared on-call system that includes all providers.
- Adoption of Standards of Practice that are universally (within the organization) agreed upon.
- Development of a Quality Improvement Program that includes a Peer Review process based on the above standards.
- Development of a Utilization Management program that is based on mutually acceptable clinical protocols, guidelines and benchmarks.

B. Clinical Systems Implementation Plan

KEY AREAS	ACTIVITIES	BY WHOM	TIMEFRAME
B.1. Inventory All Clinical Resources			January - March 1998
	B.1.1 Credential and privilege all providers (physicians and mid-levels		January - February 1998
	B.1.1.a Develop a credentialing tool that catalogues the traditional elements of provider credentialing, e.g., school, degrees, residency, licenses, DEA, health status vis-à-vis hepatitis and TB but in addition includes a list of procedures and clinical activities that the provider is capable of performing, e.g., colposcopy, suturing, other minor surgical procedures, sonography, labor and delivery, etc. If the providers are currently on staff at local hospitals, those institutions privilege the providers for membership. This tool would include those privileges and any others that are now more primary care based, e.g., sigmoidoscopy.		
	B.1.1.b. The hospitals where the provider has privileges should be listed as well as the on-call responsibilities.		January 1998
	B.1.1.c. List each provider's current hours of practice and desired hours of practice.		January 1998
	B.1.1.d. Identify each providers stated areas of special interest, e.g., adolescents, HIV, etc.		January 1998
	B.1.2. Determine all paid and volunteer clinical staff competencies		February 1998
	B.1.2.a. Develop a tool to catalogue and credential clinical support staff		February 1998
	B.1.2.b. List education, training and special skills, e.g., HIV counselor, Family Planning counselor, etc.		February 1998
	B.1.2.c. Identify current hours of work and desired hours of work.		February 1998
	B.1.3 Determine other clinical resources		March 1998
	B.1.3.a. List all equipment at each site, e.g., EKG machines, autoclave, centrifuges, pediatric and adult scales, etc.		March 1998
	B.1.3.b. Identify in-house maintenance capabilities and outsourced activities related to equipment.		March 1998

KEY AREAS	ACTIVITIES	BY WHOM	TIMEFRAME
B.2. Recruit And Hire A Medical Director			January - April 1998
	B.2.1. Identify a personnel committee comprised of board members, providers, senior management, etc., to develop job description and interview candidates		January 1998
	B.2.2. Determine source of Medical Director candidates, e.g., internal, external, either or exclusively one or the other.		January 1998
	B.2.3. Develop a salary structure that is competitive and compensates fairly for the work and responsibility required.		February 1998
	B.2.4. Develop a job description for a Medical Director		February 1998
	B.2.5. Develop a contract that includes all benefits, salary and requirements of the position.		February 1998
	B.2.6 Interview and negotiate with candidates.		March - April 1998
B.3. Develop Models Of Clinic And Staff Schedules			March - April 1998
	B.3.1. Using the information compiled above and considering the ultimate number of sites, model various schedules and staff configurations		March 1998
	B.3.2. Identify gaps in services and develop strategies to meet them.		March 1998
	B.3.3 Conduct patient-centered focus groups to help determine needs and gaps.		April 1998
	B.3.4. Identify the phasing or timing of implementing new schedules		April 1998
B.4. Identify And/Or Recruit And Hire Key Clinical Support Positions			April - July 1998
	B.4.1. Identify a committee of administrators and providers to develop a plan for staffing each site with key clinical support staff, e.g., clinic manager, laboratory technician, medical record manager, etc.		April 1998
	B.4.2 Review existing job descriptions for the key positions.		April 1998
	B.4..3. Edit or develop, as necessary, new job descriptions for these positions.		May 1998
	B.4.4. Conduct a salary survey and develop a salary scale that is in line with competition and market rates.		May 1998
	B.4.5. Interview all applicants for these positions. It should not be a “given” that existing staff will be hired into these positions.		June 1998
	B.4.6 Hire as needed for the number and location of sites.		On-Going

KEY AREAS	ACTIVITIES	BY WHOM	TIMEFRAME
B.5. Develop A Common Medical Record Format.			October 1998 - March 1999
	B.5.1. Identify a group of providers and support staff to act as a Forms Committee.		October 1998
	B.5.2. Compile a catalogue of all forms and formats currently in use.		October 1998 - January 1999
	B.5.3. Identify similarities and differences among the three clinics.		January 1999
	B.5.4. Reconcile differences and reach consensus on forms to be used and the format and order in which they will be filed.		February - March 1999

C. Financial Management Implementation Plan

As with the Clinical Systems implementation, several key decisions will impact the scope of the implementation steps.

Clearly, the personnel recruitment and development has the highest priority and must take place prior to the actual merger. Consolidation of payroll and billing services and securing insurance coverage should be targeted to coincide with the merger date. Telephone and MIS upgrades will require participation of clinic site staff in the design and implementation. Therefore, these activities should be scheduled after the merger has had time to “jell.”

C. Financial Management Implementation Plan

KEY AREAS	ACTIVITIES	BY WHOM	TIMEFRAME
C.1. Personnel Consultant Review Of Job Descriptions And Benefit And Personnel Policy Structure			March - June 1998
	C.1.1 Design scope of services to be provided		March 1998
	C.1.2 Solicit bids from consultants		March 1998
	C.1.3 Select consultant		April 1998
	C.1.4 Gather material for consultant review		April 1998
	C.1.5 Consultant review of material and development of findings		April 1998
	C.1.6 Review consultant report and suggest modifications		May 1998
	C.1.7 Consultant revisions of report		May 1998
	C.1.8 Implementation of report recommendations		June 1998
C.2. Management Team Recruitment			March - June 1998
	C.2.1. Identify a personnel committee comprised of board members, providers, senior management, etc., to develop job description and interview candidates		March 1998
	C.2.2. Determine source of Management Team candidates, e.g., internal, external, either or exclusively one or the other.		March 1998
	C.2.3. Develop a salary structure that is competitive and compensates fairly for the work and responsibility required.		April 1998
	C.2.4. Develop job descriptions for Management Team		April 1998
	C.2.5. Develop contracts that include all benefits, salary and requirements of the positions.		May 1998
	C.2.6 Interview and negotiate with candidates.		June 1998
C.3. Management Team Relocation			June - July 1998
	C.3.1 Evaluate Isla Vista vacant space for adequacy and appropriateness for relocation including telephone and wiring needs		June 1998
	C.3.2 Coordinate outside vendors regarding timing of move, e.g., cleaning service, telephone, moving company		July 1998
	C.3.3 Move		July 1998

KEY AREAS	ACTIVITIES	BY WHOM	TIMEFRAME
C.4. Payroll Service RFP			May - June 1998
	C.4.1 Design scope of services including, reporting, to be provided		May 1998
	C.4.2 Solicit bids from vendors		May 1998
	C.4.3 Select vendor		May 1998
	C.4.4 Gather material for service switch-over		June 1998
	C.4.5 Implement change to new vendor		June 1998
C.5. Secure New Insurance Coverage			April - June 1998
	C.5.1 Gather three year loss history from current carriers		April 1998
	C.5.2 Select broker to secure bids		April 1998
	C.5.3 Design scope of coverage desired with assistance of broker		May 1998
	C.5.4 Solicit bids		May 1998
	C.5.5 Review bids		June 1998
	C.5.6 Select vendor		June 1998
	C.5.7 Cancel current policies and secure new coverage		June 1998
C.6. Consolidate Billing System			May - June 1998
	C.6.1 Hire billing staff		TBD
	C.6.2 Investigate upgrades to current billing software		May 1998
	C.6.3 Purchase and install upgrades as deemed appropriate		June 1998
	C.6.4 Design paper flow systems to ensure all necessary billing documentation gets from clinic site to administrative office		June 1998
	C.6.5 Notify billing services of cancellation of agreement		See Contract Requirements
C.7. Telephone And Computer Support To Allow Inter-Clinic Telephone, Scheduling And Billing Consolidation			July - August 1998
	C.7.1 Design scope of services needed		July 1998
	C.7.2 Solicit bids from vendors		July 1998
	C.7.3 Select vendors		August 1998
	C.7.4 Schedule installation of new lines, etc.		August 1998
	C.7.5 Installation		August 1998

KEY AREAS	ACTIVITIES	BY WHOM	TIMEFRAME
C.8. Purchase And Installation Of Medical Management System			August - November 1998
	C.8.1 Design scope of services desired		August 1998
	C.8.2 Solicit bids from vendors including on site demonstrations		September 1998
	C.8.3 Review bids		October 1998
	C.8.4 Select vendor		October 1998
	C.8.5 Negotiate contract		October 1998
	C.8.6 Installation and training		November 1998
	C.8.7 Modification and expansion of functionalities of system		ongoing

V. CONCLUSIONS

At the beginning of this study report, ten merger questions were asked. Each of those questions has been answered in a way that promotes the positive potential of a merger of either two or three of the clinics.

While there is no doubt that this will be an intensive, stressful and demanding process, it is one that can benefit the health care delivery system in southern Santa Barbara County. The advantages of both combinations of clinic options are clear with more financial gains from a three clinic merger than a two clinic merger. There is considerable support for the merger, particularly a three-way merger, from many of the key stakeholders in the health care and funding community.

Perhaps the most difficult part of the process initially will be the first decision of each Board of Directors to "commit" to move forward. It is recommended that each Board meet and make a decision to move forward no later than January 1998 with a Letter of Intent to Merge approved by each board no later than February 1998. Based on those two actions, the Ad-Hoc Transition Committee can be appointed and begin to seek additional funds to assist with the many tasks of the merger implementation plan from outside funding sources.

Mergers are no panacea that will solve all of an organization's problems; nor are they as easy to implement as the above report recommendations and implementation may tend to suggest. However, this merger is a strategic option the participating Board of Directors and organizations should pursue as they strive to delivery quality services effectively and efficiently while remaining viable and relevant to the communities they serve.[15]

[15] *Nonprofit Mergers and Alliances*, Thomas McLaughlin, NCNB, 1996.

VI. LIST OF ATTACHMENTS

Attachment A	-	Merger Feasibility Proposal
Attachment B	-	Consultant Resumes
Attachment C	-	Advance Materials Requested
Attachment D	-	Westside Merger Study Participation Letter
Attachment E	-	Sample Job Descriptions
Attachment F	-	Clinical Elements Comparison
Attachment G	-	Hours of Operation Comparison
Attachment H	-	FTE and Salary Comparison
Attachment I	-	Insurance Coverage Comparison
Attachment J	-	Sample Financial Indicators Worksheet

ATTACHMENT A

MERGER FEASIBILITY PROPOSAL

ATTACHMENT B

CONSULTANT RESUMES

ATTACHMENT C

ADVANCE MATERIALS REQUESTED

ATTACHMENT D

WESTSIDE MERGER STUDY PARTICIPATION LETTER

ATTACHMENT E

SAMPLE JOB DESCRIPTIONS

Executive Director

Sample
Job Description

JOB TITLE: Executive Director

GENERAL SUMMARY OF DUTIES: The Executive Director, appointed by the Board of Directors, is the General Manager or Chief Executive Officer of the corporation. Subject to the direction of the Board, the Executive Director is responsible for program planning, implementation of board policy, staff development, fiscal viability of clinic operations, and agency-wide evaluation.

The Executive Director has the authority to supervise the direction and day-to-day operations of the center and its staff. In performing supervisory responsibilities, the Executive Director works closely with the management team including the Medical Director, Financial Manager and program directors.

REPORTING RELATIONSHIPS: Board of Directors
Medical Director
Financial Manager
Department Supervisors
Management Team

SPECIFIC RESPONSIBILITIES:

A. Strategic Planning

1. Ensure that the beliefs and principles as stated in the program's mission are embodied in the way in which services are organized and delivered to the community.
2. Develop, with assistance of staff and board, annual and long range strategic plans.
3. Develop, with assistance of staff and board, annual goals and objectives to meet strategic planning targets.
4. Develop, with the assistance of the financial manager, the financial plan to obtain funding as necessary to achieve agency goals and objectives.
5. Ensure that the annual goals and objectives, as developed through the strategic planning process, are achieved.

B. Program Development.

1. Research the feasibility of developing new programs or offering expanded services through the clinic.
2. Receive and review all requests for proposals for new program funding.
3. Write grants to secure funding or delegate this responsibility to other members of the management teams.
4. Develop fee schedules for all new services and programs with the assistance of the financial manager.
5. Supervise implementation of all new programs and monitor for cost effectiveness and operational efficiency.

C. Administration

1. Implement board policies and decisions.
2. Act as liaison between board and staff.
3. Negotiate and sign all contracts as the Chief Executive Officer of the corporation.
4. Work with the medical director and the nursing coordinator to ensure that all contract requirements are met for the provision of services.
5. Report to funding agencies as required to meet funding criteria and to governmental agencies as required by law to meet licensure and other legal requirements.
6. Ensure that administrative records, including bylaws, board minutes, contracts, and personnel records are up-to-date and maintained in accessible administrative files.
7. Ensure that all policy and procedure manuals are kept up-to-date.
8. Develop an annual line item budget with the assistance of the financial manager and monitor for data accuracy and compliance with set standards.
9. Prepare and present monthly reports to the board of directors.
10. Prepare the annual report of the corporation to be presented at the annual membership meeting of the board of directors.
11. Preside at the annual membership meeting of the board of directors.

D. Personnel Management

1. Working with the management team, maintain up-to-date job descriptions for all employees including board members.
2. Working with the management team, recruit new employees when there are openings. Supervise the preparation of notices for vacant positions, review resumes, interview prospective employees, determine the salary level, and approve the hiring of all new

employees.

3. Working with the management team, conduct or review the results of all annual employee assessments.
4. Review staff schedules and payroll records, including time sheets and vacation schedules.
5. Periodically review salary levels for all clinic positions. Make recommendations to the personnel committee of the board for salary level increases.
6. Develop and oversee a program of staff development that includes inservice training, educational conferences or workshops, personal development, and annual evaluation for every staff member.
7. Participate in revision and evaluation of personnel policies and in hiring, firing, and grievance procedures as a member of the personnel committee of the board of directors.

E. Fundraising

1. Work with the board of directors to set fundraising goals to meet the objectives of the financial plan.
2. Assist the board of directors to develop skills and implement an annual fundraising drive or other fundraising events.
3. Develop relationships with other voluntary organizations in the community who can assist in fundraising efforts.

F. Community Relations

1. Establish ongoing communications with the service area community through contact with community organizations and the media.
2. Represent the agency by speaking to community groups.
3. Participate in community health planning and maintain relationships with other health care providers through membership on task forces or other provider organizations
4. Maintain membership in organizations that further the mission and goals of the agency in improving access to health care for all community residents.

G. Agency-wide Evaluation

1. Evaluate the cost and effective of clinic programs and services.
2. Conduct frequent assessments of client satisfaction with the provision of health services.
3. Monitor changing health care needs and evaluate the ability of health center programs to meet those needs.
4. Develop and oversee risk reduction and quality assurance programs, with the assistance of the medical director.

Medical Director

Sample
Job Description

JOB TITLE: Medical Director

GENERAL SUMMARY OF DUTIES: Primary responsibilities include the quality and content of medical services, implementation of medical policy and maintenance of clinical standards and procedures.

SPECIFIC RESPONSIBILITIES:

1. Propose new medical policies and protocols. Work with Director of Client Services to implement and monitor programs.
2. Revise existing medical programs and protocols.
3. Consult in development of new programs and services with other members of the management team.
4. Assist in development of medical forms, consent forms and other medically-related written information.
5. Periodically review and keep current written guidelines and standing orders for clinician practice.
6. Consult with clinicians in conjunction with the Director of Client Services regarding management of individual clients and interpretation of policy and protocol.
7. Evaluate applications and credentials for physicians and clinicians. Supervise mid-level providers as required by law.
8. Evaluate new providers during the orientation period.
9. Conduct peer reviews on a regular basis; contribute to and review clinician performance evaluations as necessary.
10. Prepare Medical Director Reports as needed.
11. Review contracts for physicians who provide medical services for the health center.
12. Participate as a member of the management team. Advise Executive Director, Client Services Director, and board of directors as requested.
13. As requested, represent the organization to the media in regard to medical issues.
14. Implement and manage the quality improvement program.

15. Prepare clinical services budgets in conjunction with the other members of the management team.

Financial Manager

Sample
Job Description

JOB TITLE: Financial Manager

GENERAL SUMMARY OF DUTIES: Plans, organizes and directs all aspects of the financial department including development and administration of policies on finance, accounting, internal controls, budget, auditing, payroll, benefits, billing and collections.

SUPERVISES: Billing staff and finance clerk.

SPECIFIC RESPONSIBILITIES:

1. Oversee all accounting functions to ensure accurate representation of financial status of the organization.

2. Establish and maintain accounting procedures including procedures to maintain adequate internal controls.

3. Ensure compliance with all reporting and regulatory requirements as determined by law, GAAP or contractual obligations.

4. Interview and select qualified candidates for finance and billing department; provide daily supervision, train staff, monitor and evaluate performance of staff.

5. Prepare annual budget, monitor and report variances to senior management staff and Board of Directors.

6. Maintain bank accounts and relationships; oversee daily cash management.

7. Develop and prepare management reports to assist in tracking trends and financial health of the organization.

8. Monitor accuracy of payroll processing system and related IRS and management reports.

9. Provide documentation and other assistance to auditors to ensure accurate and appropriate audit findings.

Insurance Biller

Sample
Job Description

JOB TITLE: Insurance Biller

GENERAL SUMMARY OF DUTIES: Plans, organizes and directs all aspects of the financial billing including scheduling of billing to meet billing time limits and cash requirements, and follow-up of denied and pended claims.

SPECIFIC RESPONSIBILITIES:

1. Ensure collection of all necessary documentation from clinic sites to support accurate and timely billing for services provided.

2. Ensure that billing documentation meets requirements of reimbursement agencies and companies.

3. Evaluate adequacy of billing software and hardware and make recommendations for modifications and upgrades.

4. Review all remittance reports for accuracy of reimbursement and reconcile discrepancies with remitter.

5. Prepare aging reports and evaluate which claims require re-billing, modification or write off.

Finance and Billing Assistant

Sample
Job Description

JOB TITLE: Finance and Billing Assistant

GENERAL SUMMARY OF DUTIES: Perform daily clerical functions to support Financial Manager and Insurance Biller.

SPECIFIC RESPONSIBILITIES:

1. Process invoices received through accounts payable system.
2. Prepare vendor payments for Financial Manager review from invoices received.
3. Balance daily cash receipts and make bank deposits.
4. Prepare billing documentation under direction of Insurance Biller.
5. Prepare monthly management reports under direction of Financial Manager.

Community Services Coordinator

Sample
Job Description

JOB TITLE: Community Services Coordinator

GENERAL SUMMARY OF DUTIES: Provides supervision of dental, drug and alcohol, outreach and other community-based programs, including handling special projects and trouble shooting systems as assigned.

SUPERVISION RECEIVED: Reports directly to Executive Director.

SUPERVISION EXERCISED: Supervises staff as assigned.

TYPICAL PHYSICAL DEMANDS: Requires prolonged sitting, some bending, stooping and stretching. Requires eye-hand coordination and manual dexterity sufficient to operate a keyboard, photocopier, telephone, calculator, and other office equipment. Requires normal range of hearing and eyesight to record, prepare and communicate appropriate reports.

TYPICAL WORKING CONDITIONS: Normal office environment.

SPECIFIC RESPONSIBILITIES:

1. Supervises individual (non-medical) programs and related staff as assigned.

2. Analyzes and updates policies and procedures as requested to ensure interdepartmental effectiveness.

3. Troubleshoots systems and interdepartmental problems on a daily basis.

4. Attends meetings of various departments, third party reimbursers and other external agencies as liaison of the clinic.

5. Participates actively in safety and quality assurance efforts.

6. Completes special projects assigned by Executive Director and assists other staff with completion of their projects as requested.

7. Monitors changes in related legislation, regulations and funding.

8. Participates in professional development activities to keep current with health care trends and practices.

9. Maintains strictest confidentiality.

10. Performs related work as assigned.

PERFORMANCE REQUIREMENTS:

Knowledge, Skills and Abilities:

Knowledge of organization policies and procedures. Knowledge of medical practices and systems. Knowledge of computer systems and applications. Knowledge of health care administration principles. Skill in examining and evaluating data with reference to standards and requirements. Skill in written and verbal communication. Skills in adult education and development. Ability to serve as a resource of technical information. Ability to work effectively with all departments, staff, patients and external agencies. Ability to exercise initiative, problem-solving, decision-making. Ability to identify problems and recommend solutions.

Education:

1. Bachelor degree in health care administration.

Experience:

Three years of health care experience including one year of community services coordination.

Certificate/License: None

Alternative to Minimum Qualifications:

Additional appropriate education may be substituted for two years of health care experience.

Site Manager

Sample
Job Description

JOB TITLE: Site Manager

GENERAL SUMMARY OF DUTIES: Coordinates operations and activities of the clinic sites as assigned and performs other day-to-day duties as necessary.

SUPERVISION RECEIVED: Reports directly to Executive Director.

SUPERVISION EXERCISED: Supervises clinic staff as assigned.

TYPICAL PHYSICAL DEMANDS: Requires prolonged sitting, some bending, stooping and stretching. Requires eye-hand coordination and manual dexterity sufficient to operate a keyboard, photocopier, telephone, calculator, and other office equipment. Requires normal range of hearing and eyesight to record, prepare and communicate appropriate reports.

TYPICAL WORKING CONDITIONS: Normal office environment. Occasional evening or weekend work.

SPECIFIC RESPONSIBILITIES:

1. Participates in recruitment, siring and supervision of staff as assigned and helps staff develop performance goals and objectives.

2. Evaluates performance and recommends merit increases, promotions, and disciplinary actions.

3. Maintains clinic site, offices and equipment.

4. Provides data for financial and statistical purposes including reviewing invoices and statements.

5. Assists in the creation and implementation of medical support systems and procedures.

6. Monitors appointment, patient flow, medical record, medical transcription systems and staff.

7. Supervises fee, credit and collection procedures.

8. Working with the Medical Director, ensures compliance with regulations and clinic standards of quality patient care.

9. Identifies and resolves operational problems.

10. Attends required meetings and participates in committees as requested.

11. Participates in professional development activities to keep current with health care trends and practices.

12. Maintains strictest confidentiality.

13. Performs related work as assigned.

PERFORMANCE REQUIREMENTS:

Knowledge, Skills and Abilities:

Knowledge of organization policies and procedures. Knowledge of fiscal management and human resources management practices. Knowledge of computer systems and applications. Knowledge of health care administration principles. Skill in gathering, analyzing and interpreting information. Skill in written and verbal communication. Ability to exercise initiative, problem-solving, decision-making. Ability to apply policies and principles to solve everyday problems and deal with a variety of situations. Ability to work effectively with patients, staff and the public. Ability to identify problems and recommend solutions. Ability to establish and coordinate work activities.

Education:

1. Associate degree in health or business administration.
2. Bachelor degree preferred.

Experience:

Three years of office management experience including one year in a health organization.

Certificate/License: None

Alternative to Minimum Qualifications:

Additional appropriate education may be substituted for two years of office management experience.

ATTACHMENT F

CLINICAL ELEMENTS COMPARISON

CLINICAL ELEMENTS COMPARISON

SBCCA MERGER FEASIBILITY STUDY CLINICAL ELEMENTS COMPARISON			
SYSTEM	**CARRILLO**	**ISLA VISTA**	**WESTSIDE**
Scope of Services	• Family Practice Clinic • Less geriatrics & more Peds • CHDP provider • No OB because of Malpractice costs, community doesn't want it and providers don't want it. • Do colposcopy, lesions • HIV testing & counseling done by Peter on Friday 9-12:30 • Dental Services	• Primary Medical Care • HIV testing, counseling, education, outreach • Drug Treatment Medical outpatient detox. program First Steps-Case Management for substance abusing pregnant women & mothers Drug Diversion Program • Community Service Center • No OB or Peri-Natal Services except as above	• Primary Medical Care • 4 hours/week devoted to Indian Health Services • HIV testing and counseling on Tues., Thurs., & Fri. AM • Doing a little pre-natal practice • Some Mental Health Services • CHDP provider • Colposcopy
Productivity[1]	• 7,686 medical visits/year = 3,843/provider (based on 2 FTE providers) • 2-3 pts./hour • Providers do own immunizations	• 6,286 medical visits/year = 5,327/provider (based on 1.18 FTE providers) • Immunizations done by Lab Tech • Support staff crossed trained to perform MA, Front Desk and Lab Tech duties	• 9,418 medical visits/year = 3,588/provider (based on 2.625 FTE providers) • Immunizations done by Lab Tech • 2.2-2.5 pts./hr. since July

[1] Based on Santa Barbara Community Clinics Association Member Clinic Data, p. 5, 1996 figures only.

SYSTEM	CARRILLO	ISLA VISTA	WESTSIDE
Exam Room Usage	• 7 exam rooms: usually 2 providers each session 4 for Dr. Sullivan 3 for Dr. Holmes 2 for Nurse Practitioner	• 2 exam rooms/provider	• 1-2 exam rooms/provider depending on number of providers/session
Medical Director Role	• Medical Director for 10+ years • 4-8 hrs./wk. Administrative time • Sees patients Mon.-Fri. and every other Sat. • Gets stipend every paycheck = $500/mo.	• Medical Director for 3-4 years • 5 hrs./wk on paper; stays 2-3 nights/wk. • No clinical practice now; wants to start 2 hrs./wk. • Just appointed permanent, full-time Medical Director of SBHI--will continue to provide ~5 hours/week to IV	• Medical Director for years • Does 5-1/2 shifts per week • Does ID clinic at UCSB • No differential for Medical Director role
Medical Records Filing, retrieval, storage	• File by 1st three letters of last name • Use volunteers, lab tech, front desk & MA to retrieve & file • Keep charts for 3 years • Providers would like to be able to dictate & have typed notes	• File by 1st three letters of last name • No one especially trained in Medical Record Management • All records are hand written	• File by 1st three letters of last name • No one especially trained in Medical Record Management • All records are hand written

SYSTEM	CARRILLO	ISLA VISTA	WESTSIDE
Appointment Scheduling	• Appoints are made manually • 20 minute slots with 2 walk-ins per shift • SBHI assigns patients to clinic-capped for 600 pts. Practice open, can accept up to 1000 pts.	• Appointments are made manually but the clinic is implementing a new IS system that includes the appointment making function • Annual exams are scheduled for one hour • 1st and last patient limited to acute or follow-up patient • Scheduling guidelines average 20 minutes/visit	• Appointments are made manually • No internal process for assigning PCP but try to keep with same provider • Appointments are made in 20 min. Increments
Quality Improvement & Peer Review	• No written QI Plan • No QI Meeting • Dr. Sullivan reviews NP records	• No written QI Plan • Medical QI/Peer Review regularly • Complete CASA immunization audits	• No QI Plan or process • No Peer review process except for Medical Director review of NP charts
Hospital Privileges & After Hours System	• Shares call with Isla Vista • Every 4th week for each provider • Mid-levels do not take call • St. Francis has an admitting team • Cottage Hospital--use residents to admit	• Shares call with Carrillo • Dr. Chirman does hospital work for the practice • Dr. Susan McClair had privileges on her own • No one doing kids-use Pedi on-call at Cottage Hospital • Uses in-patient hospital group at St. Francis	• Shares call only within practice--Medical Director would like to propose joint call coverage with other clinics • Uses in-patient hospital group at St. Francis • Patients admitted to Cottage are turned over to attending on call and covered by residents (Dr. Kunz cannot admit to Cottage because he is not an Internist.)

SYSTEM	CARRILLO	ISLA VISTA	WESTSIDE
Clinical Guidelines	• Not used	• Used mostly by mid-level providers • Guidelines resisted by medical community in Santa Barbara	• Have clinical guidelines for special populations
Utilization Review & Managed Care	• Just started Patient Satisfaction Surveys--No results yet. • Referrals tracked by Executive Director • SBHI sends letter every 6 months on ER use. Dr. Sullivan reviews and Peter sends follow-up letter.	• SBHI reports are not timely • Do not track referrals--look only at outliers • Did a Patient Satisfaction Survey this year	• No Utilization management of referrals and ER use • No managed care impact on staffing and functions noted • Old patient satisfaction surveys
Malpractice Claims & Oversight History	• NP ten years ago • MD no longer on staff	• None since 1993 • 2 suits, 1 claim, and 1 event between 1991 and 1993	• None • Last survey from the state in 1987

ATTACHMENT G

HOURS OF OPERATION COMPARISON

HOURS OF OPERATION COMPARISON

SBCCA MERGER FEASIBILITY STUDY HOURS OF OPERATION COMPARISON						
DAY OF THE WEEK	**CARRILLO**		**ISLA VISTA**		**WESTSIDE**	
	AM	**PM**	**AM**	**PM**	**AM**	**PM**
MONDAY	11-2	3-6	9-12	2-6	Closed	12-5
			No clinician			5-6 AIH
TUESDAY	10-1	2-6	9-12	1-6	8-11	12-1 AIH
			No clinician			
WEDNESDAY	10-1	3-6	9-12	2-6	Closed	12-5
		Staff Meeting				
THURSDAY	10-1	3-6	9-12	1-6	9-12	4-5 AIH
			No clinician			5-8
FRIDAY	9-1	Closed	9-12	Closed	9-2	2-3 AIH
SATURDAY	9-1	Closed	9-12	Closed	9-12	Closed

ATTACHMENT H

FTE AND SALARY COMPARISON

FTE AND SALARY COMPARISON

SANTA BARBARA COMMUNITY CLINICS ASSOCIATION						
	CARRILLO		ISLA VISTA		WESTSIDE	
POSITION	FTE	SALARY	FTE	SALARY	FTE	SALARY
EXECUTIVE DIRECTOR	1.0	$20.00/Hr.	1.0	$16.44/Hr.	0.75	$18.50/Hr.
ADMIN. ASSISTANT	NONE		1.0	$10.00/Hr.	NONE	
MEDICAL DIRECTOR	1.0	$44.21/Hr.	0.13	$40.00/Hr.	0.95	$48.33/Hr.
OTHER PHYSICIANS	0.5	$38.41/Hr.	0.82	$35-$40/Hr.	0.65	$45.00/Hr.
NURSE PRACTITIONERS	0.5	$25.00/Hr.	0.10	$20.00/Hr.	1.00	$22-$26/Hr.
PHYSICIAN'S ASSIST.	NONE		0.13	$23.00/Hr.	NONE	
CLINIC MGR./COORDIN.	1.0	$8.00/Hr.	0.75	$16.00/Hr.	0.875	$15.88/Hr.
MEDICAL ASSISTANTS	2.6	Volunteers	1.50	$8.00-$12/Hr.	1.75	$11.03/Hr.
COUNSELING DIRECTOR	NONE		1.0	$17.44/Hr.	NONE	
COUNSELORS	NONE		1.5	$16.00/Hr.	0.55	$13.50/Hr.
OTHER PROFESSIONALS	NONE		1.75	$16.50-$11.50/Hr.	0.025	$24.00/Hr.
LAB TECHNICIAN	1.0	$8.00/Hr.	0.25	$15.00/Hr.	0.875	$14.00/Hr.
LAB ASSISTANT			0.5	$8.00-$12/Hr.	0.475	$10.00/Hr.
RECEPTIONISTS	1.0	$10.00/Hr.	0.75	$8.50/Hr.	0.875	$8.00/Hr.
BILLER/BOOKKEEPER	1.0	$13.00/Hr.	0.75	$15.39/Hr.	0.5/0.75	$11.03/Hr.-$14.50/Hr
DENTIST	0.5	$32.50/Hr.	NONE		NONE	
DENTAL ASSISTANT	0.5	$12.00/Hr.	NONE		NONE	
JANITOR		Contract		Contract		Contract

ATTACHMENT I

INSURANCE COVERAGE COMPARISON

TABLE XVI - Insurance Coverage Comparison

	Professional Liability	General Liability	Property	Directors & Officers	Employee Dishonesty
Isla Vista					
Carrier	Norcal Mutual	Norcal Mutual	Aetna	Reliance	Travelers
Limit	$1 million per loss	$100,000 Fire Damage	$826,450 building	$1 million per loss per period	$50,000
	$3 million aggregate	$5,000 Medical Exp	$100,352 contents	$2,500 deductible per loss	$1,000
			$19,060 computers		
			$500 ded; 10% co-in		
Premium	15,462	Included w/ Prof. Liab.	2,321	2,250	365
Westside					
Carrier	Fremont	Fremont	American State		
Limit	$1 million per claim	$1 million per claim	$347,800 building		
	$3 million aggregate	$50,000 Fire Damage	$65,000 contents		
		$5,000 Medical Exp	$210,000 loss of earn	Claims made	
			$10,000 computers		
			$250 ded; 10% co-in		
			3,310	Paid by Board members $1,255	
Premium	11,420				
Carrillo					
Carrier	Fremont	St. Paul			
Limit	$1 million per claim	$300,000 premises		$1 million per loss per period	
	$3 million aggregate	$5,000 Medical		$2,500 deductible per loss	
	Claims made basis	$300,000 injury		Claims made basis	
		$600,000 general		Tail available @ 25% of premium	
		$500,000 loss of earn			
		$300,000 unowned auto			
Premium	12,400	1,000		3,500	
Recommended					
Limit	$1 million per claim	$100,000 Fire Damage		$1 million per loss per period	$50,000
	$3 million aggregate	$5,000 Medical Exp		$2,500 deductible per loss	$1,000
Premium (2 clinics)	27,862	1,000	2,321	5,750	730
Premium (3 clinics)	39,282	1,000	2,321	7,005	730

ATTACHMENT J

Sample Financial Indicators Worksheet

TABLE XVII
Sample Financial Indicators Worksheet

Indicator	Standard	Clinic Actual	% Variance
Average amount collected per encounter	Should be close to 100%		
Collection ratio	Between 90% and 95% after contractual adjustments		
Average Collection Period	30 to 45 days for self pay or private insurance, 60 to 75 days for Medi-Cal and Medicare (unless electronic - then 7 - 10 days)		
Billings: Cost Ratio	Billings collected should cover as close to 100% of the cost of services provided		
Number of users per provider	1,500 - 2,000 per 1.0 FTE provider per year		
Number of encounters per provider	4,200 to 6,000 per 1.0 FTE provider per year		
Number of support staff per FTE provider	2 support staff per 1.0 FTE provider		
Percent of total costs that are for administrative services	No more than 20%		