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OCCIDENTAL AREA HEALTH CENTER
RUSSIAN RIVER HEALTH CENTER

MERGER STUDY REPORT

Study Period: May – July 1999

Final Report Completed – July 30, 1999

Presented to Joint Meeting of Boards of Directors
August 4, 1999

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TABLE OF CONTENTS

List of Tables

List of Charts

I. INTRODUCTION

The Occidental Area Health Center (OAHC) and the Russian River Health Center (RRHC) are both located in western Sonoma County and have served the small rural communities of the area for a combination of more than 48 years. The organizations share similar missions and similar scopes of services. For the past several years, both organizations have been members of the Redwood Community Health Coalition of Sonoma County. Through the Redwood Health Coalition, the executive directors of both health centers began to talk about the similarities of the organizations as well as the potential benefits of a closer corporate relationship. Both directors had become significant forces within their own organizations in a relatively short period of time; gaining the mutual respect and support of Board members, staff and community members.

The Executive Director of the Russian River Health Center resigned her position for personal reasons and moved to San Jose, California in March, 1999. She recommended to the Russian River Health Center Board that they consider both a potential business alliance with the Occidental Area Health Center and the employment of the current Executive Director of OAHC as their Interim Executive Director. In March, 1999, Mary Szecsey, Executive Director of the Occidental Area Health Center was engaged by the Board of Directors of the Russian River Health Center as the RRHC's Interim Executive Director and was directed by both organizations' Boards of Directors in March 1999 to move forward on a merger study with a consultant.

A merger study report was commissioned and funded in May, 1999. Bobbie Wunsch, MBA, Health Care Consultant, Pacific Health Consulting Group, LLC was chosen to prepare the report. The study report was intended to explore issues related to the potential merger including the possible benefits as well as a process for decision-making. Recommendations were to be developed in the areas of:

- merger benefits
- governance
- corporate entity
- organizational structure
- administration
- financial management systems and staffing
- merger costs and liabilities
- transition plan.

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

- report of the potential merger of Occidental Area Health Center and Russian River Health Center, including issues related to governance and administration, including anticipated cost-savings and additional merger-related expenses.

- process for decision-making.

- 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 regarding the feasibility of the merger of the two clinics. It was anticipated that the study results would be presented in early August, 1999 to a joint meeting of the Boards of Directors.

II. PURPOSE OF THE STUDY

A. Study Process

The merger study began with a request for advance materials from each clinic (see Attachment A - Advance Materials Requested). An initial on-site visit was made in May with follow-up visits throughout June and July. A joint meeting of the Boards of Directors, two joint meetings of the key managers from both organizations, one meeting with the staff of each organization as well as individual meetings with key Board members from both organizations and with any staff member that requested an individual meeting or telephone consultation were held throughout the process. Time was spent before and after the visits studying and critiquing materials, speaking to staff and board members from each clinic involved and in discussions with the Executive Director.

Key to the success of this merger study report was the active involvement of key staff in the merger process. The following staff involvement process allowed staff and key managers a number of opportunities to raise issues of concern and allowed them to preview the recommendations in this report.

Step One: Staff invited to initial joint Boards of Directors meeting in May 1999
Step Two: Separate staff meetings at each organization to hear presentation of merger study purpose and review of advance data
Step Three: Individual meetings with any staff requesting face-to-face or telephone consultation
Step Four: Two joint extended meetings with key managers of both organizations, first to review purpose of study and staff concerns and second to review recommendations of merger study report before they were presented to the Boards of Directors
Step Five: Staff invited to joint Boards of Director meeting in August, 1999.
Step Six: Recommendation R.6. to include staff representatives on Joint Merger Study Committee.

Staff raised a number of key questions throughout the process that may or may not be answered by this report, but will be answered throughout the transition period if the Boards of Directors decide to continue the merger study process as recommended in this report.

At the joint key managers meetings, staff from both health centers expressed concerns about the potential merger:

a. Both agencies' staff wanted to continue to be involved in the process and in the development of the final merger process recommendations.
b. Several staff expressed concern about the role of the Executive Director in the guiding and shaping the merger process; feeling that RRHC was without a "dedicated" advocate since their Executive Director had resigned.
c. Some OAHC staff expressed concern about losing the "strong identity" of their health center and its community-based culture.
d. Both groups of staff wanted to preserve the best of both agencies, including community commitment, HIV focus, compensation and benefits, autonomy of decision-making and separate organizational cultures.
e. Many of the staff from both organizations expressed support for the process as well as the need for the merger. Other staff were concerned about why a merger was necessary.

In addition, important concerns among board members and staff of both organizations were raised relative to how different the communities are and how well they would blend in the merger. While the communities are somewhat different, these differences can be used as a benefit to enhance the process as the two organizations move more closely together.

B. Why Restructure

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

- The resignation in early 1999 of the Russian River Health Center's respected Executive Director and the subsequent decision of the RRHC's Board of Directors to hire the current OAHC Executive Director on an interim basis.

- The two health centers have similar missions, funding sources, complementary services, long-serving staff as well as different communities, different organizational cultures, different services.

- The relatively close geographic proximity of the two health centers, even in rural geography terms, and the overlapping service areas. Almost 50% of patients for both health centers came from the central core of the service areas of the health centers respectively and the other 50% came from overlapping and contiguous towns in Western Sonoma County.

- Mergers were occurring everywhere in the health care community, nationally, regionally, in urban as well as rural communities – in order to achieve economies of scale, administrative and programmatic efficiencies and greater strength in the environment.

- Rural, western Sonoma County is in need of a strong, visible spokesperson and unified voice for health services that is currently fragmented.

- Small organizations find these increasingly difficult to purchase or access alone. New funding sources were becoming available that, in order to access successfully, required more sophisticated management information systems and more technical skills on the staffs of community clinics, both here in Sonoma County as well as everywhere else.

- Cost containment is more and more a driving force in health care organizations.

Recognition that these environmental factors would have tremendous impact, both programmatically and financially on both organizations, led directly to the merger study.

The timing for the two health centers was right for a thorough review of the issues related to merger and for consideration of this new structural option.

C. 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.

Generally these types of alliances, though, 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.

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 populations 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. The successful nonprofit merger that preserves the services of smaller organizations with similar missions, actually does the community a remarkable service.[1]

Even though restructuring rarely yields reductions 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 or to gain economic strength through joining together.

Whatever the reason for considering any collaboration, boards and staff must recognize that the process before and after decision-making or signing the final merger agreement is difficult, 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.[2] The restructuring process can take from 12 to 24 months, a period generally called the transition period.

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

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

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.[3]

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***. Several years of working together in a variety of ways, including sharing after hours call, as well as the most recent efforts in the Redwood Community Health Coalition 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 transition between executive directors. Such is the current situation. Also the current Executive Director is respected by all parties.

- ***Non-overlapping markets***. It is helpful if partners do not routinely compete with each other. With the two clinic configuration, issues of overlapping markets are evident.

- ***Geographic compatibility.*** As was mentioned above, OAHC and RRHC have excellent geographic compatibility given the rural nature of the area. Their geographic proximity is positive.

- ***Complementary culture.*** Mission and values underlie behavior and both partners have complementary missions, values and histories, even through their organization cultures are much different. These ingredients make a merger much easier.

D. Criteria to Evaluate the Merger

A potential merger should be evaluated based on the following achievements[4]:

- Is the new entity more visible in the community or communities it serves?

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

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

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

The following **additional criteria** were developed in discussions with staff and Board members of OAHC and RRHC to evaluate this merger proposal:

1. Ability over time to increasingly achieve the mission of both organizations
2. Ability to maintain awareness and responsiveness to different communities and different health care needs in communities
3. Ability to increase financial stability of services, including access to new funds, economies of scale by consolidation and integration of administrative services
4. Ability to increase skill, sophistication and responsiveness of management systems, necessitated by changing nature of health care system
5. Ability to increase credibility and visibility of West County health needs by joining together with a stronger voice
6. Ability to maintain services that might otherwise disappear due to lack of funding, community support, etc.
7. Ability to serve additional community members with a broader continuum of services at both sites

8. Ability to increase community support within communities and in greater Sonoma county political environment.

These criteria should be adopted by the Boards of Directors in their upcoming deliberations and used to evaluate both the merger proposal as well as the effectiveness of the merger (if it occurs) when the Transition Period is over.

In using these criteria to develop this merger report, it appears that a merger of the two organizations could be extremely effective. Based on assessing both organizations using all of the possible criteria listed previously in this report, a statistical analysis allows a score of 4.23 based on a scale of 1-5, 1 being not potential and 5 being significant opportunity for success. This report rates this merger with a potential for being extremely successful given a process to which both Boards and staff are committed to following.

Chart I
Comparison of Criteria for Success

Criteria	Low Potential →		Potential	→ High Potential	
	1	2	3	4	5
Previous history of successful collaboration			x		
Role of executive director					x
Non-overlapping markets		x			
Geographic compatibility					x
Complementary culture, mission and values				x	
Increased ability to achieve mission				x	
Maintain awareness of different communities					x
Financial stability					x
Increase skill and management systems					x
Credibility and visibility of West County health issues					x
Maintain services that might otherwise disappear			x		
Serve additional community members				x	
Increase community support					x
Total 55		2	6	12	35
Total Score: 4.23					

The Total Score is derived by adding the total number of points assigned (1 criterion with a 2 ranking, 2 with a 3 ranking, 3 with a 4 ranking, and 7 with a 5 ranking). This equals 1 x 2 + 2 x 3 + 3 x 4 + 7 x 5 = 2 + 6 + 12 + 35 = 55. This total is divided by the number of criteria: 55/13 = 4.23

E. What If the Merger Does Not Occur?

What if the merger does not occur? This is probably the most difficult question of all to answer given the fast-paced and constantly changing health care environment. It seems safe to say the following in response to this question:

1. RRHC will need to hire a new Executive Director, spending the appropriate time, energy and resources to recruit, hire, orient and integrate a new director into the health center and its related activities.

2. It appears that there has been approximately a 10% decline in patients at both health centers in each of the last three years and a corresponding reduction in productivity of providers has resulted. Without concentrated efforts and discussions, these trends could continue and jeopardize the stability of both clinics. It appears that minimal strategic attention has been placed on understanding why patients are declining or in designing approaches to retain patients in either health center.

3. After many years of urging and prodding, health care is generally moving to a more preventive focus. Without the plans suggested in this merger, it seems that the health centers individually do not have the resources to activate a highly visible community health outreach and health improvement program.

4. Health care reimbursement and funding systems are requiring more and more sophisticated management, data reporting and outcome measurement systems. These systems currently do not exist at either health center and it does not appear that individually either health center is in the position to implement the necessary systems to measure outcomes of clinical practice or management strategies.

The Study Committee could consider other issues related to the impact of not moving forward with a merger or other close collaboration between the two health centers.

F. Vision and Goals for the Future

Based on this positive assessment of the potential effectiveness of the merger as seen in Chart I, the following vision, guiding principles and benefits of the merger are recommended.

The **vision** of a new corporate entity is proposed as:

The new organization will be a regional primary care community-based health system serving Western Sonoma County. The new organization will position itself to respond quickly and effectively to the changing marketplace in both primary care, dental health, mental health, HIV services and community health improvement. It will advocate on behalf of its community members as health needs change.

The new organization will operate from the following **Guiding Principles**:

1. The merger is a merger of "equals," both organizations having excellent reputations, effective programs, experienced and committed staff, different cultures and serving overlapping communities.

2. For the 24 month transition period after the merger, there should be no program elimination or expansion without a two-thirds endorsement by the new Board of Directors unless market forces demand immediate changes.

3. Individual clinic identities should be maintained in each local community and, in fact, enhanced. The name of each health center will not change.

4. Community support should be increased.

The **objectives** of the merger include:

1. Serve additional community members with a broader continuum of services.

2. Increase technical capabilities, including a more sophisticated outcomes-oriented data management system.

3. Increase fund raising capacity, both in funds raised and in technical skills of those raising both public and private funds.

4. Enhance administrative capability to respond more strategically and efficiently and to target efforts more effectively.

5. Demonstrate economies of scale in managing the organizations.

6. Increase visibility in geographic area and among Sonoma County public and private agencies as well as local, state and federal officials.

7. Seek new health care contracts and new relationships with health care organizations.

8. Increase respect and appreciation from community members in both communities.

The following **short-term benefits** should be apparent from the merger by the end of the Transition Period:

1. reduction in administrative costs, while achieving a higher level of administrative skill, scope and responsibility

2. elimination of duplication of administrative services between the two health centers

3. expanded capacity and expanded continuum of services for residents of West County

4. perception by outside agencies, supporters, funders of a more secure, stronger, more sustainable organization

5. enhancement of financial management capabilities

6. stronger competitor for county-wide, state and federal funds.

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 suggest the feasibility of a merger between the two health centers. The recommendations also suggest other opportunities for systems improvement, where appropriate. *Please note that the findings and recommendations do not include a detailed review of internal staffing or daily operations.*

The findings and recommendations are organized in this order:

- A. Governance and Corporate Management
  - A.1. Culture and Mission
  - A.2. Corporate Structure
  - A.3. Governance
  - A.4. Community Development
  - A.5. Administration
- B. Program Impact and Resource Development
- C. Financial Management and Due Diligence
  - C.1. One Time Only Merger Costs
  - C.2. Costs of Operational Changes
  - C.3. Due Diligence
  - C.4. Financial Projections

A. Governance and Management

A.1. Culture and Mission

Findings:

F.1. The missions of both organizations are extremely compatible, with the distinct geographic emphasis on providing health services in western Sonoma County.

Missions	
Occidental Area Health Center	**Russian River Health Center**
To provide access to high quality and comprehensive primary health care in West Sonoma County to individuals and families of any income.	To provide quality comprehensive health care to meet the needs of Western Sonoma County.

F.2. The histories of the organizations are also extremely similar. OAHC and RRHC incorporated in 1974 and 1975, respectively. The health centers were founded and

continue to be governed by community Boards of Directors who work collaboratively and broadly represent the communities served. The composition of the Boards and organizational structures conform with community health center funding requirements and provide an administrative and financial structure to support quality health care service delivery. Both centers use a management team model and encourage participation and input from staff. The two health centers, 20 minutes apart, are located in a 680 square miles federally designated MUP, and a Medical and Dental HPSA.

F.3. The major difference between the two organizations and an issue of major concern expressed by Board members and staff from both organizations are the differences in the Guerneville and Occidental communities (income, community cohesiveness, behaviors, etc.) and therefore the cultures and patient composition. While there are some differences, the similarities between the two organizations seem overwhelmingly strong. To mention a few:

- Mission, history and organizational structure
- Program services and clinic hours
- Patient demographics and volume of unduplicated patients using the health centers and key diagnosis codes
- Funding sources
- Annual operating cost allocations
- Possibly declining patient numbers
- County, region and state health alliances

These similarities are illustrated in Tables I - VI.

Table I
COMPARISON OF CLIENT AGES

Age	OAHC			RRHC		
	1996	1997	1998	1996	1997	1998
Under 1 year	3%	3%	3%	2%	2%	2%
1-4 years	9%	8%	7%	4%	6%	6%
5-12 years	13%	14%	14%	14%	13%	13%
13-19 years	12%	13%	14%	11%	8%	9%
20-34 years	19%	17%	17%	17%	17%	16%
35-44 years	19%	17%	16%	20%	19%	19%
45-64 years	21%	24%	25%	25%	26%	29%
65 and over	4%	4%	4%	6%	6%	7%
Total Number	2,820	2,688	2,574	3,750	3,089	2,793

Source: 1996, 1997 & 1998 Annual Report of Clinics, p. 10.

Table II

COMPARISON OF PATIENT INCOME

Income Level	OAHC			RRHC		
	1996	1997	1998	1996	1997	1998
# At Poverty Level	43%	44%	44%	59%	46%	42%
200% and Below	21%	7%	11%	4%	3%	4%
Above 200%	36%	49%	45%	37%	50%	55%
Total Number	2,819	2,688	2,574	3,750	3,089	2,793

Source: 1996, 1997 & 1998 Annual Report of Clinics, p. 10.

Table III
COMPARISON OF ANNUAL OPERATING COSTS

Annual Operating Costs	OAHC			RRHC		
	1996	1997	1998	1996	1997	1998
Salaries	83%	74%	76%	77%	75%	76%
Supplies - Office	3%	2%	3%	2%	1%	2%
Supplies - Medical/Dental	5%	3%	4%	4%	4%	4%
Rent/Mortgage	0%	0%	0%	4%	6%	3%
Utilities	2%	2%	1%	1%	1%	2%
Other	7%	19%	15%	11%	15%	14%
Total Operating Costs	$652,605	$811,931	$893,840	$1,364,710	$1,562,098	$1,532,452

Source: 1996, 1997 & 1998 Annual Report of Clinics, p. 8.

Table IV
COMPARISON OF REVENUES

1998	Occidental Area Health Center		Russian River Health Center	
Patient Revenue	$ 701,714	74%	$ 920,469	58%
Federal	$ 23,958	3%	$ 442,572	28%
State	$ 152,361	16%	$ 97,258	6%
County	$ 3,739	0%	$ 102,350	6%
Private/Other	$ 43,204	5%	$ 7,065	0%
Donations	$ 22,957	2%	$ 6,645	0%
Total Operating Revenue	$ 947,933	100%	$ 1,576,354	100%

Source: 1998 Annual Report of Clinics, p. 8.

Table V
COMPARISON OF ENCOUNTERS AND COLLECTIONS BY PAYOR SOURCE

Income Level	1996		1997		1998	
OAHC	Encounters	Collections	Encounters	Collections	Encounters	Collections
Medicare	11%	9%	11%	9%	12%	11%
Medi-Cal	38%	41%	37%	42%	36%	39%
CHDP	5%	6%	8%	4%	6%	3%
CMSP	6%	6%	7%	8%	6%	6%
EAPC	7%	7%	4%	4%	8%	9%
Pvt. Ins. Patients	19%	22%	21%	17%	24%	19%
Patient Pay	14%	12%	11%	14%	6%	12%
Totals	9,644	$525,697	10,613	$630,927	10,854	$714,073
RRHC	Encounters	Collections	Encounters	Collections	Encounters	Collections
Medicare	16%	11%	16%	16%	18%	17%
Medi-Cal	45%	58%	41%	51%	36%	51%
CHDP	2%	2%	2%	2%	2%	2%
CMSP	11%	14%	10%	12%	11%	11%
EAPC	2%	1%	1%	0%	1%	1%
Pvt. Ins. Patients	8%	4%	16%	7%	18%	9%
Patient Pay	16%	18%	13%	11%	14%	9%
Totals	15,145	$730,528	15,542	$918,891	13,735	$887,983

Source: 1996, 1997 & 1998 Annual Report of Clinics, p. 7.

Table VI
TOP 20 DIAGNOSES

Occidental Area Health Center FY 1998	Russian River Health Center 1/1/98 – 5/23/99
Well Child	Immunity Deficiency
Pap	Depression
Depression	Diagnostic Visit
Upper Respiratory Infection	Preventive (Dental)
Otitis Media	Restorative (Dental)
Sinusitis	Anxiety
Allergies	Mood Disorder
Bronchitis	Well Child
Pharyngitis	Stress Disorder
Asthma	Hypertension
Cough	Otitis Media
Hypertension	Back Pain
Diarrhea	Bronchitis
Back Pain	Upper Respiratory Infection
Anxiety	Asthma
Neoplasm	Oral Surgery (Dental)
Urinary Tract Infection	Pap/Pelvic
Viral Syndrome	Cold
Headache	Sinusitis
Well Adult	Hepatitis C

F.4. Both organizations have parallel corporate structures, with somewhat participatory decision-making structures, staff with stability and strong commitments to the organizations, similar funding sources and similar program components. Some program differences do exist, including RRHC's well-known HIV services and dental clinic and OAHC's community health education and outreach efforts.

F.5. The health centers have overlapping service areas with RRHC identifying its service area as Western Sonoma County's Russian River/coastal area and OAHC's service area as Western Sonoma County. Based on a review of the zip codes from which current patients originate it is interesting to note that almost 50% of the patients from both health centers come from the central core of each health center's service area the town or surrounding towns where the clinic is located and the remaining 50% come from throughout the service area. Table VII shows the number and percent of patients from each zip code who use each health center.

Table VII
OCCIDENTAL AREA/RUSSIAN RIVER HEALTH CENTERS
ZIP CODE ANALYSIS, JUNE, 1999

Zip	City	# OAHC	% OAHC	# RRHC	% RRHC
94922	Bodega	39	1.5%	3	0.1%
94923	Bodega Bay	70	2.7%	15	0.5%
94928	Valley Ford	27	1.0%	10	0.4%
94931	Cotati	7	0.3%	0	0.0%
94952	Fallon	14	0.5%	3	0.1%
94972	Bloomfield	15	0.6%	3	0.1%
95401	Santa Rosa	132	5.1%	33	1.2%
95402	Santa Rosa	13	0.5%	5	0.2%
95403	Santa Rosa	46	1.8%	28	1.0%
95404	Santa Rosa	90	3.5%	33	1.2%
95405	Santa Rosa	31	1.2%	9	0.3%
95407	Santa Rosa	70	2.7%	22	0.8%
95409	Oakmont	22	0.8%	0	0.0%
95419	Camp Meeker••	53	2.0%	12	0.4%
65421	Cazadero	109	4.2%	167	5.9%
95430	Duncan's Mills	17	0.7%	45	1.6%
95436	Forestville	139	2.4%	237	8.4%
95444	Graton	78	3.0%	4	0.1%
95446	Guerneville•	213	8.2%	1,347	47.7%
95448	Healdsburg	7	0.3%	12	0.4%
95450	Jenner	15	0.6%	26	0.9%
95462	Monte Rio	102	3.9%	466	9.4%
95465	Occidental••	425	16.4%	57	2.0%
95471	Rio Nido	18	0.7%	92	3.3%
95472	Sebastopol••	572	22.0%	100	3.5%
95473	Sebastopol	33	1.3%	10	0.4%
95486	Villa Grande	24	0.9%	46	1.6%
95492	Windsor	11	0.4%	11	0.4%
	Other Sonoma	84	3.2%	68	2.4%
	Non-Sonoma	121	4.7%	160	5.7%
	Total	2,597	100.0%	2,825	100.0%

• Primary service area for RRHC

•• Primary service area for OAHC

A.2. Corporate Structure

Findings:

F.6. Both organizations are incorporated in the State of California as 50l(c)(3) organizations with community-based boards of directors. RRHC has a non-voting staff representative, chosen by the staff, participating at all Board meetings.

F.7. Both organizations are licensed community clinics.

A. 3. Governance

Findings:

F.8. Both organizations have similar Articles of Incorporation and By-Laws. There are minor differences in these documents which are identified in Table VIII. The lack of differences will make it easier to combine governance structures.

Table VIII
COMPARISON OF BY-LAWS

	Occidental Area Health Center	Russian River Health Center
Number of Board Members	9 -20 (currently 9)	9 – 20 (currently 7)
Terms for Directors	1 year	2 years staggered
Term limits	None listed	None listed
Elections		Elected by majority at Annual meeting, or as needed to fill vacancies
Quorum	Majority	51%
Removal	Resignation	"Unavailable directors" shall automatically cease to be directors; plus 6 other reasons for removal
Board Composition	Need not be California residents according to by laws, however, the Board Roster states that all live in Occidental area and a majority are regular clients, reflecting the diverse social and economic status of overall patient base.	51% must be active health center users All must live within service area.
Number of Regular Meetings	Monthly	Monthly
Annual Meeting	June	February
Officers	President, Vice President, Secretary, Chief Financial Officer	Chair, Vice-Chair, Secretary, Treasurer
Executive Committee	No	Chair, Vice-Chair, Secretary, Treasurer
Committees	Finance Personnel Fundraising	Executive Nominating
Power to hire/fire Executive Director	Yes	Yes
Conflict of Interest Policy	Not more than 49% may be interested persons. A director may not vote on any proposed transaction with another organization or entity of which such director is also an employee, principal or director.	Not more than 49% may be interested persons. Also has formal policy, including disclosure
Equal Opportunity Statement	In personnel policies	In personnel policies
By-Laws Changes	By majority	By majority, after 14 days notice, at a regular meeting of the Board
Members	None	None

Governance Recommendations:

R.1. Create one corporate entity, a 501(c)(3), a new organization called West County Community Health, Inc. which would manage two health centers (RRHC and OAHC) and merge both health center corporations and assets into it. Although this is not the

easiest possible approach it is recommended because of the need to appear that neither health center is being "taken over" by the other. Provisional tax-exempt status will be achievable easily and actual tax-exempt status should be no problem. A pending "tax-exempt" status from the Internal Revenue Service will be relatively easy to obtain given the mission and histories of the two organizations. Legal counsel may advise differently. This should be accomplished and effective by January 1, 2000 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.

R.3. The new organization should maintain service sites at the current locations. In addition, the sites for services should continue to be called their current names for continued name recognition among patients, community organizations and funders. It is extremely important not to lose the identity of the current sites in this process.

R.4. For the 24 month transition period after the merger, there should be no program elimination or expansion without a two-thirds endorsement by the new Board of Directors.

The Board of Directors Recommendations contain the following elements:

A. Board composition and terms of office
B. Staff participation with the Board
C. Board Committees and composition
D. Selection of new President for new entity
E. Selection of new CEO for new entity
F. Board meeting frequency and location
G. New Board member orientation and facilities tours
H. Revised By-Laws
I. Board retreat for strategic planning

R.5. **Board of Directors Composition.** The new entity's 15 – 21 member Board of Directors will be composed of:

- 7 current Directors from OAHC
- 7 current Directors from RRHC
- 3 residents from the Occidental Area
- 3 residents from the Russian River area
- 1 At-Large member with significant ties to West County.

The residents should have never served on the board, and are committed to the concept and bring additional skills. The at-large member could be the District 5 County

Supervisor ***or*** another prominent West County representative, annually chosen by the sitting new Board of Directors.

R.6. **Staff Participation.** The Executive Director, Chief Financial Officer and Medical Directors should attend Board meetings and report to the Board of Directors at each meeting. Staff should not be allowed to sit on the Board of Directors due to federal funding restrictions and FQHC guidelines as well as appearance and difficulty for future decision-making. A staff representative from each clinic site should be chosen annually by the respective clinic staffs and should attend all Board meetings.

R.7. **Terms of Office.** When seated, the new Board will use a combination of self-selection and a lottery system, if necessary, to determine terms of office. Terms of office will be adjusted for two and three year staggered terms for the first term. Term limits will be determined by the committee working on the revision of the By-Laws.

R.8. **Board Committees and Composition**. The new Board is committed to a strong committee structure that will study issues thoroughly and bring proposals to the full Board at its regular Board meetings. The following committees and committee composition are proposed in addition to any other standing committees that might be provided by the By-Laws:

- **The Executive Committee** would be made up of six board members of the new Board with equal representation from both communities; the four officers plus two at-large members. Would act as Budget and Finance Committee.

- **The Membership Committee** would be made up of four board members with equal representation from both communities, responsible for nomination of new board members, officers and Executive Committee at-large members, new Board orientation and on-going Board education and the By-Laws. The Executive Director will be an ex-officio, non-voting member of this committee.

- **Personnel Committee** would be made up of four board members with equal representation from both communities. Responsible for integration of personnel polices and compensation policies.

- **Program Committee** would be made up of four board members with equal representation from both communities plus each center's Medical Directors and other senior program management staff (Dental Director, Mental Health Director, HIV Program Manager, etc.). This committee will be responsible for oversight of strategic planning process, development of collaborative health programs between health centers and with community groups, expansion of services priorities and program integration efforts.

- **Community Relations, Marketing and Outreach Committee** would be a joint committee made up of four board members with equal representation from both communities to oversee promotion of health centers and new organization in the

communities it provides services to, to larger County community, to funders, etc. The Community Development Coordinator and Executive Director will also serve on this committee.

R.9. **Selection of New President for New Entity.** The President of the first Board of Directors of the new organization should come from the organization that the new Executive Director of the organization does not come from; nominated by the originating Board of Directors. This process would occur only once and the new President would serve for a term on two years: a selection process for the new President would be developed in by-laws.

R.10. **Selection of New CEO for New Entity.** The Executive Director would be chosen by the new Board of Directors and evaluated by the Executive Committee.

R.11. **Board Meeting Frequency and Location.** Board meetings will occur monthly and will be rotated every other month between the two health centers.

R.12. **New Board Member Orientation and Facilities Tours.** New Board member orientation will occur early in January 2000 and will include a facilities tour.

R.13. **Revised By-Laws.** The By-Laws will be revised by the Membership Committee and adopted by the Board of Directors, reconciling the difference in the two organization's current By-Laws in advance of the merger, adopted at the first new Board meeting in 2000.

R.14. **Board Retreat for Strategic Planning.** The new organization will begin a strategic planning process including staff, board, consumer and community input by the end of the 6 months of 2000.

R.15. **Merger Study Period.** The Boards of Directors of RRHC and OAHC should spend the period between August, 1999 and November 30, 1999 studying the merger report, its recommendations and timeline. This period of time would be called the Study Period.

R.16. A **Merger Study Committee** made up of 3 board members from each organization and 3 staff members from each organization should be selected to review the merger study report, its recommendations and implications in detail and report monthly to the staff of each health center and to the Boards during the Study Period. The Executive Director should coordinate and facilitate the Study Committee. The Presidents of each Board should appoint the board and staff members of the study committee. The RRHC Medical Director, HIV Director and staff representative to the Board are recommended to serve as staff on the Study Committee from RRHC. It is recommended that the Medical Director, Clinic Manager and another clinician serve as OAHC's staff representatives to the committee.

R.17. **Resolution for Action**. By the Boards meetings in November, 1999 a resolution of action will be presented for a vote to determine what action the Boards want to take before the end of 1999. The Boards of Directors of the two health centers are legally and fiscally responsible for making all decisions that change policies of the health centers. This is one of the most important decisions that the Boards will make. It is their full responsibility.

R.18. **Legal counsel** should be engaged and should develop a resolution of action that would be presented to both boards based on their study of the issues. Legal counsel should also develop new Articles of Incorporation and new By-Laws in coordination with the Board of Directors and the new Membership Committee, utilizing the current documents of both organizations no later than December 1, 1999.

R.19. **A mission statement and core values statement** should be crafted incorporating the best statements of the merging organizations by November 1, 1999 for the new entity.

R.20. **A statement about the histories** of the merging organizations should be written no later than February, 2000, identifying similarities and differences, founding principles, and reasons for the merger. This historical statement should be attached to the mission statement and should be incorporated into the new personnel policies of the new organization.

R.21. New community clinic licenses should not have to be obtained.

A.4. Community Development

Findings:

F.9. An essential component for success of the new organization is an organization-focus on community development, outreach and community relations. OAHC spends more time focusing on developing community support and creating opportunities for community health improvement. All of the staff live in the Occidental Area. RRHC, long a provider and leader in HIV services, has specialized in providing these services, as well as in developing its mental health and dental services, which OAHC does not have in such a well-developed and funded way. RRHC has not been particularly successful with community support or in providing community health improvement activities in its service area. This is clearly an opportunity for joint effort and increased ability.

Community Development Recommendations:

R.22. Create a new management position called Community Development Coordinator responsible for these activities and supervised by the Executive Director.

R.23. It is also recommended that a Community Relations, Marketing and Outreach Committee should be created to work closely with the Community Development Coordinator, the Executive Director and the community at large.

R24. Annually, a general meeting should be hosted in Guerneville and in Occidental to encourage patients and other community members to express their views and concerns about their respective health centers, respectively. These meetings will give the new organization opportunities for more visibility and support in each of the communities.

A.5. Management and Administration

From an 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 collaborative system of care throughout western Sonoma County. This system of care will have the potential of offering a broader range of services, including dental care expanded family planning, mental health, HIV, and community health education services at both sites, with certain economies of scale and the ability to recruit skilled management and clinical 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.

There are many opportunities for economies of scale, increased technical skill and reduction in duplication of effort as the administrative requirements for both organizations are almost identical. With the knowledge gained from the 9 months of sharing an executive director, many other administrative joint efforts will flow more easily.

Findings:

F.10. 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. Changes in the management structure are necessary.

F.11. Personnel policies do exist in both organizations. There are differences between the Personnel Policies, employee compensation and benefits structure between the two health centers. The differences are identified in Attachment B which follows later in this report. The major differences exist in the following Personnel Policies:

- Orientation (formerly probation) period
- Full time and part-time employment hours
- Vacation and sick leave.

There are other minor differences in the following policies:

- At will status is incomplete and incorrect
- Pay periods
- Compensatory time off
- Holidays
- Retirement plan.

F.12. There are many types of staff meetings that currently occur. A new configuration of staff meetings will need to be developed to reflect new priorities and coordinated efforts as well as the new organizational structure.

Table IX
CURRENT MONTHLY MEETINGS

OAHC Monthly Meetings:	RRHC Monthly Meetings:
Supervisors	Providers
All Staff	All Staff
Department	HIV Team
Management	Management Team

F.13. Most of the grants and contracts held by the merging organizations are from similar sources with the major exception of HIV funding. This will make the transition easier, given the staff's familiarity with the different funding sources.

Management Recommendations:

R.25. A new organizational structure needs to be created. See Chart II, Proposed Organization Chart.

R.26. The following positions should be included as part of the management team of the new organization: Executive Director, Chief Financial Officer, Medical Directors, Dental Director, Mental Health Director and Community Development Coordinator.

R.27. The management team will meet weekly during the transition period.

R.28. Communication and coordination of all program areas and services will begin immediately after merger is approved. Integration strategies will be developed by the staff and new Board over time.

R.29. Administrative and management functions for both health centers will be consolidated and integrated as quickly as possible.

R.30. The Executive Director will be the chief executive officer presiding over the new merged entity.

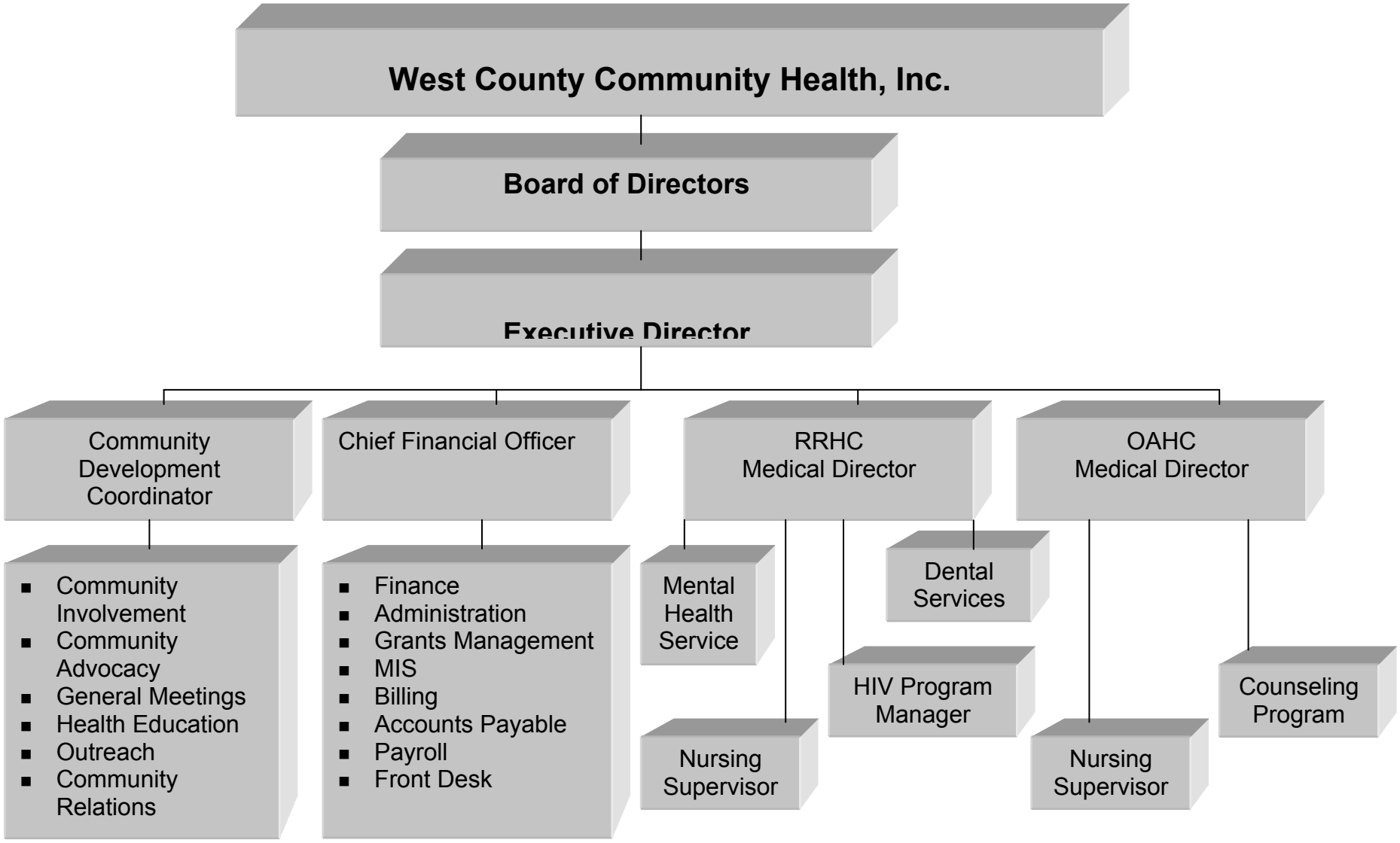
R.31. A new position of Chief Financial Officer will be created to oversee financial operations, grant management, contracting, purchasing, billing, payroll services, accounting systems, facilities management and front desk operations. See Attachment C for a proposed job description.

R.32. A new position of Community Development Coordinator will be created to ensure that community commitments, community involvement, community advocacy, community outreach, health promotion, community health improvement, community relations and marketing efforts directed at both service areas are created and sustained as a priority of the new organization. See Attachment C for a proposed job description.

R.33. The organization will have two Medical Directors, one for RRHC and one for OAHC. In addition to regular responsibilities and during the transition period, the Medical Director for RRHC will coordinate external medical affairs and provide oversight to medical contracting activities for both sites. The Medical Director of OAHC will coordinate the review of medical policies and procedures and the clinical quality improvement program for both sites.

R.34. Each health center site will have an on-site nursing supervisor who will coordinate the daily activities of the health center's clinical services and who will report to the site Medical Director. The site nursing supervisors will meet together at least twice monthly to coordinate activities and share information.

Chart II
PROPOSED ORGANIZATIONAL CHART



R.35. There will be a joint staff meeting of both sites once a month during the transition period.

R.36. There should be joint provider meetings monthly.

R.37. One location for all administrative services may need to be secured in the future, centrally located to both sites in the future.

R.38. New job descriptions should be developed for all management positions no later than January 15, 2000 and adopted by the new Board of Directors.

R.39. Priority should be given to filling staff positions that are created due to this merger with current staff that meet the qualifications and experience needed.

R.40. New personnel policies should be developed no later than February 1, 2000, 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 working in conjunction with the Personnel Committee, so that they are in compliance with current laws and regulations.

R.41. 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 recommendations completed no later than the first quarter of 2000.

R.42. Develop an on-going communication plan to notify the staff 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.43. Create a merger evaluation process, developing benchmarks for measuring the success of the merger incrementally based on the criteria listed previously.

R.44. 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.45. Develop clear performance targets for the Transition Period in terms of patient utilization, financial stability, staff retention, patient satisfaction, community relations, etc.

B. Program Impact and Resource Development

Findings

F.14 Program and service compatibility among the two health centers is extremely high. Services are similar with a few major exceptions:

- RRHC's HIV Program and the Dental Program are not duplicated at OAHC although OAHC does provide HIV testing and refer patients for dental services.
- RRHC's mental health program is more developed than OAHC's mental health services.
- OAHC has a community outreach and health improvement program.
- OAHC has obstetrical services.
- OAHC participates in the Office of Family Planning Family PACT program; RRHC does not.

Otherwise, the services are similar and very compatible.

F.15. Resources and funding sources for the health centers are similar because the funding generally follows program services. The major exception is RRHC's HIV Program which is funded through a large federal grant. This factor should allow for a smooth and relatively easy transition for financial reports, grants management, contract billing, and patient billing.

F.16. Funding for certain services will have the potential for expansion after the merger. In addition to achieving economies of scale in administration, more time and focus can be placed on securing new and expanded funding for a number of services already provided at one or both of the health centers.

Recommendations:

R.46. The programs offered at each health center should remain the same during the transition period unless the Program Committee recommends changes to the Board of Directors.

R.47. For the 24 month transition period after the merger, there should be no program elimination or expansion without a two-thirds endorsement by the new Board of Directors.

R.48. Using the already recommended Program Committee (see page 20, R.8.), a complete assessment of the scope of services for both health centers should be conducted during the Transition Period. The assessment should explore what services at one health center could be offered at the other health center; which services should remain only at one site for economies of scale and efficiencies; how patients can be easily referred and accommodated in services provided only at one of the health centers; what new services should be offered based on patient need and demand; etc.

Recommendations from the Program Committee should be forwarded to the Board of Directors.

R.49. A resource development plan should be created before the end of the Transition Period, identifying additional or expanded funding opportunities. It is anticipated that funds can be secured to support new activities during the Study Period and if approved during the Transition Period. The additional costs incurred by the merger process are a natural opportunity for foundations. Additional service funding should be available through both public and private sources for coordinated and expanded services, depending on recommendations from the Program Committee. The new organization should be able to increase resources for services by at least 15% by the end of the transition period.

R.50. A Community Development Plan should also be developed that incorporates a combination of marketing, public relations, outreach and community health improvement efforts. This plan and the services that will be incorporated into it should be funded through a combination of public and private (foundation) funding over an extended period of time. The Community Relations, Marketing and Outreach Committee will work with staff on the development of this plan.

C. Financial Management and Due Diligence

C.1. Merger Costs

Findings

F. 17. Generally it is expected when starting a merger study that the main benefit of merger is short-term cost savings. It always becomes apparent through the study process, that this should not be a goal of the process. During the Transition Period, cost realignments should be identified and implemented as necessary. The implementation of the merger will include the incorporation of efficiencies and economies of scale in administrative services that will be realized over time. It is not the intention of the merger to take drastic moves to force program integration before the organization is ready. Through the merger it is anticipated that within current costs a more developed staffing design will be achieved.

F.18. In considering the merger of RRHC and OAHC, there are significant advantages beyond the potential of savings over time through elimination of duplication of administrative services. The advantages of this merger involve the strength of the merged organization that comes through the consolidation of administrative functions initially and the effective coordination of programs where necessary.

F.19. The merger creates the ability to enhance and create a new top financial management position called Chief Financial Officer. In addition to managing in-house

financial affairs, the CFO will become the financial management "face" of the organization. The need for this position to interface with the financial management counterparts on the county, state and federal levels is emerging as a critical requirement in order to maximize the multiple funding streams that are rapidly become part of the financial life of the two health centers. This is a very different form of financial responsibility for both health centers and one that is not currently available. It is one that will assist in achieving financial stability and viability.

F.20. Additional one-time only merger costs need to be identified in the Study Period. Funds need to be made available if the merger is to be effectively implemented.

Merger Cost Recommendations:

R.51. The one time only Merger Costs are estimated to be $77,000 - $143,000. Table X shows those costs which 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 $25,000 to $50,000.

- Audit of each of the merging health centers 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 January 1, 2000 as proposed, each health center 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. Total additional non-budgeted costs for securing year end audits for two health centers is estimated at $3,500 to $5,000.

- Purchase of stationery and other printed material with new logo and name for corporate entity only. Estimated cost is $2,500 to $3,000.

- Appraisal of real estate owned by the health centers. Estimated cost is $2,000 to $5,000.

- Computer networking and telephone system networking are optional and estimated on Table X.

- No costs have been included for staff planning time prior to the actual merger and during the Transition Period.

Table X
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	$25,000 - $50,000
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	$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 clinics sites and a central administration office	$20,000 - $50,000*
Total	**$77,000 - $143,000**

** Capital Expenditures*

R.52. The impact of the merger financially given the major staff changes is currently estimated to be a net income of $34,318. This includes the following changes:

- Elimination of one Executive Director position
- Elimination of one position of Director of Operations
- Addition of Community Development Coordinator
- Addition of Chief Financial Officer
- Consolidation of annual audit.

Not included are the costs of bringing parity to the salary differences and personnel policies over the two year transition period.

Table XI
INCOME STATEMENT PROJECTION

	Occidental Area Health Center			Russian River Health Center			Combined Clinics
	1997	1998	1999	1997	1998	1999	2000
	Actual	Actual	Budget	Actual	Actual	Budget	Projection
Patient Services	623,075	701,714	905,626	942,101	920,469	1,245,600	2,151,226
Grant Income	262,282	180,058	184,126	683,952	642,180	574,285	758,411
Other Income	12,318	66,161	36,200	44,100	13,710	51,000	87,200
Total Income	**897,675**	**947,933**	**1,125,952**	**1,670,153**	**1,576,359**	**1,870,885**	**2,996,837**
Salaries & Wages	599,830	683,437	773,890	1,060,279	1,160,751	1,108,406	1,957,588
Fringe Benefits			33,132	82,002		266,017	299,149
Medical, Lab & Program Costs	28,199	34,138	148,764	84,482	58,983	137,500	286,264
Insurance			41,242	36,913		10,000	51,242
Outside Services			35,270	104,178		85,400	120,670
Depreciation			25,200	31,537		30,000	54,000
Rent, Tax & Utilities	14,149	12,952		46,230	73,078	44,500	44,500
Other Expense	168,478	163,313	43,254	85,976	239,640	105,000	148,254
Total Expense	**810,656**	**893,840**	**1,100,752**	**1,531,597**	**1,532,452**	**1,786,823**	**2,961,667**
Net Income	**87,019**	**54,093**	**25,200**	**138,556**	**43,907**	**84,062**	**35,170**

Impact of Merger	
Eliminate one Executive Director	72,540
Add Community Development Coordinator	-49,600
Eliminate Director of Operations	42,408
Add Chief Financial Officer	-68,200
Standardize Benefits	N/A
Consolidate Annual Audit	2,000
Net Income/Merged Entity	34,318

C.3 Due Diligence

Finding

F.21. None of the clinics has any outstanding malpractice claims against it. RRHC currently has one employment-related suit pending.

Due Diligence Recommendation

R.53. Due diligence will be conducted by legal counsel in a complete review of contracts and assets. Due diligence is generally completed as part of the final merger agreements. It was not done as part of this study, although there should be no difficulties based on recent audits of both health centers and a detailed knowledge of current funding sources and the transferability of these contracts to a new corporate entity.

C.4. Financial Projections

R.54. A review of the financial statements and audits for the last three years of both health centers results in a combined net worth estimated at the end of December 31, 2000 of $1,074,140. See Table XII.

Table XII
BALANCE SHEETS 1997 THROUGH 2000

	Occidental Area Health Center			Russian River Health Center			Combined
	December 31, 1997	December 31, 1998	December 31, 1999	December 31, 1997	December 31, 1998	December 31, 1999	December 31, 2000
Cash	88,467	257,588	307,988	120,347	173,254	266,316	551,994
Accounts Receivable	70,557	65,991	71,557	231,410	231,410	231,410	302,967
Prepaid Expenses	6,047	6,953	6,047	15,665	15,665	15,665	21,712
Other Receivables	52,501	26,855	52,501	65,114	65,114	65,114	117,615
Fixed Assets - Net	103,600	490,375	53,200	430,019	400,019	370,019	368,019
Land				121,050	121,050	121,050	121,050
Other Assets	1,323	1,323	1,323	2,500	2,500	2,500	3,823
Total Assets	322,495	874,285	899,485	986,105	1,009,012	1,072,074	1,487,180
Accounts Payable	48,106	48,106	1,233	16,872	16,872	16,872	18,105
Accrued Expenses	13,734	13,734	11,280	59,669	59,669	59,669	70,949
Long Term Debt	294,697	274,697		386,986	365,986	344,986	323,986
Total Liabilities	356,537	336,537	12,513	463,527	442,527	421,527	413,040
Net Worth	309,982	517,748	562,948	522,578	566,485	650,547	1,074,140

IV. MERGER TRANSITION PLAN

The following Merger Transition Plan identifies the next steps based on this report. The transition from two 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.

◆ Occidental Area Health Center ◆ Russian River Health ◆

Merger Transition Plan

January 2000 – December 2001

A. Management Transition Plan

KEY AREAS	ACTIVITIES	BY WHOM	TIMEFRAME
A.1. Develop merger-related processes			
	A.1.1. Each individual Board approves a resolution to move forward in merger process and agrees to create Joint Merger Study Committee	Boards	August 1999
	A.1.2. Engage legal counsel to assist in corporate filings	Boards	September 1999
	A.1.3. Develop Merger Agreement	Legal Counsel	November 1999
A.2. Submit merger recommendations			November 1999 – January 2000
	A.2.1. Each merging entity adopts governance proposal	Boards	November 1999
	A.2.2. Each merging entity adopts Merger Agreement	Boards	December 1999
	A.2.3. Legal counsel revises Articles of Incorporation, By-Laws, dissolution papers, files corporate papers	Legal Counsel/ Boards	December 1999
	A.2.4. Legal counsel assists in transition of assets	Legal Counsel/ Boards	January 2000
A.3. Develop Plan for Establishing New Board of Directors			
	A.3.1. Identify, recruit and seat new Board of Directors	Boards	December 1999
	A.3.2. Plan new Board orientation and facilities tour	Boards/Staff	December 1999
	A.3.3. Establish committees	Boards	January 2000
	A.3.4. Obtain Directors and Officers Liability Insurance	Staff	January 2000
	A.3.5. Set terms of office	Boards	January 2000
	A.3.6. Adopt mission statement and core values for new organization, histories of separate entities and statement about importance of histories to new merged organization	Boards	January 2000
	A.3.7. Conduct new Board orientation and facilities tour	Board	January 2000

KEY AREAS	ACTIVITIES	BY WHOM	TIMEFRAME
A.4. Plan and Implement Integrated Organizational Responsibilities During Transition For Administration and Finance			
	A.4.1. Develop new organizational chart for integrated administration	Staff	December 1999
	A.4.2. Identify outside resources necessary to implement transition	Staff	December 1999
	A.4.3. Develop job descriptions for senior managers	Staff	January 2000
	A.4.4. Develop a consolidated Personnel Policies and Compensation Transition Plan	Staff	January – April 2000
	A.4.5. Identify a senior management team	Staff	January 2000
A.5. Develop a Marketing & Communication Plan			
	A.5.1. Identify spokesperson(s) for the merger effort	Staff	December 1999
	A.5.2. Develop external and internal communications plans	Staff	December 1999
	A.5.3. Develop a system for discussing merger process and progress with funders, grant and contract agencies, community leaders	Staff	December 1999
A.6. Develop a Merger Evaluation Plan			December 1999
	A.7.1. Use Joint Merger Study Committee as evaluation committee and develop benchmarks to measure ongoing impact of merger process	Board	December 1999

B. Financial Management Plan

KEY AREAS	ACTIVITIES	BY WHOM	TIMEFRAME
B.1.	**Develop Staffing Plan for Finance Department, Including Review Of Job Descriptions**	Staff	January 2000
B.2.	**Develop Consolidated Benefit And Personnel Policy Structure**	Staff	January – April 2000
B.3.	**Administrative Offices**		
	B.3.1 Evaluate space for adequacy and appropriateness for administration	Staff	January – April 2000
B.4.	**Integrate Payroll System and Recordkeeping**	Staff	January 2000
B.5.	**Integrate Financial Systems**		
	B.5.1 Coordinate purchasing programs and vendors	Staff	November 1999 - March 2000
	B.5.2 Consolidate billing systems and functions	Staff	November 1999 - March 2000
	B.5.3 Develop integrated MIS system	Staff	November 1999 - March 2000
	B.5.4 Develop integrated accounting system	Staff	November 1999 - March 2000
	B.5.5 Integrate risk management program	Staff	November 1999 - March 2000

C. Strategic Planning and Program Plan

KEY AREAS / ACTIVITIES	BY WHOM	TIMEFRAME
C.1. Create New Program Committee with Board and Staff Representation	Board/Staff	January 2000
C.2. Develop and Implement Strategic Planning Process	Staff/Board	January–December 2000
C.3. Evaluate Areas Where Program Coordination Can Occur More Effectively	Staff	Ongoing
C.4. Coordinate And Integrate Quality Improvement Plan and Program	Staff	January–December 2000
C.5. Organize Activities Throughout New Organization for Staff Education Regarding Merger	Staff	January–June 2000
C.6. Implement joint staff and provider meetings	Staff	January 2000

VI. LIST OF ATTACHMENTS

Attachment A - Advance Materials Requested
Attachment B - Comparison of Personnel Policies and Procedures
Attachment C - Sample Job Descriptions

ATTACHMENT A

ADVANCE MATERIALS REQUESTED

1. Brochures describing health centers that are given to patients or donors
2. List of all services provided at each site, times of day open
3. OSHPD Annual Report of Community Clinics for last 3 years
4. Budget for current year
5. Financial statements for 1987, 1998 and 1999 YTD
6. Audits for both clinics for last 3 years and management letters
7. Personnel Policies
8. By-Laws and Articles of Incorporation
9. Board lists and staff lists
10. Description of property owned, current assessed value, debt
11. Equipment and property leases
12. All malpractice claims, open or resolved for last 5 years
13. Current job descriptions for all staff
14 Minutes of last years Board meetings and staff meetings
15. Staffing for clinics, FTE providers, credentials of providers
16. Utilization and productivity reports for 1997 and 1998 and 1999
17. Outstanding loans and other financial obligations
18. Details of all employee benefits, including employee and agency costs
19. Federal and state tax payments - 199B, 1997, 1998 and 1999 YTD
20. Funding sources and amounts
21. 330 application narrative
22. History of health centers
23. Schedule of upcoming Board meetings

Attachment B
COMPARISON OF PERSONNEL POLICIES AND PROCEDURES

	Occidental Area Health Center	Russian River Health Center
Effective Date	3/97	6/1/97
At Will Employment Status		Yes, but employees are described as permanent employees
Harassment Policy	Yes	Yes
Orientation Period	90 days	90 days probation, 2 weeks orientation
Full time employment	40 hours	32 – 40 hours or more per week
Part time employment	Less than 40 hours	20 – 35 hours per week
Work Day	9 - 5	Midnight to 11:59 – 24 hours
Flexible Work Week		Overtime for non-exempt following 8 hours per day or 40 hours per week
Pay periods	2 times per month, paid on second business day after 15th and end of month.	2 times per month, paid on 15th and last day. Pay period is from 26th to 10th and 11th to 25th
Pay advances	Yes at Executive Director discretion	Yes
Comp time	Not permitted	Bonuses permitted as compensation for some employees
Holidays	9: New Year's Day Martin Luther King Day President's Day Memorial Day Independence Day Labor Day Thanksgiving Christmas New Year's Eve Eligibility upon 3 months employment	10: New Year's Day Martin Luther King Day President's Day Memorial Day Independence Day Labor Day Thanksgiving and Day After Christmas One floating day Eligibility upon 6 months employment
Vacation	First year: 5 days/year 1 – 5 years: 10 days 5 – 7 years: 15 days after 7 years: 20 days	From 5 years: 10 days/year 5 – 10 years: 15 days after 10 year: 20 days Extra days given in contracts to some employees
Medical Insurance	Must work at least 30 hours.	Health Plan of the Redwoods, prorated for part time
Medical Discount	Schedule of discounts for use of clinic as medical home.	
Dental Insurance	Yes	Yes, prorated for part time
Disability Insurance	Yes	Yes
Life Insurance	Yes	No
Dependent Coverage	Paid by employee	Paid by employee
Retirement Plan	No	$25/month
Sick Leave	5 days/year. Eligible after 90	10 days/year. Eligible after 90 days.

	days.	