

Business Plan for Nurse Managed Primary Care Clinic
University of XXXXXXXX School of Nursing, RS-XXXX and XXXX

Introduction

By 2014, more than 32 million uninsured Americans will have access to affordable, quality health care through the 2010 Affordable Health Care Act. In XXXXXXXX alone, 1.2 million individuals who did not have health care coverage will be able to receive health insurance, including children, minority populations, immigrants and the poor, in the XXXX and in Greater XXXXXXXX. The demand will be especially acute due to provider shortages, changing demographics and large rural areas in the Upper Midwest. An adequate supply of highly educated healthcare providers, especially nurses with advanced degrees, is desperately needed on the front lines of health care delivery for our region.

To achieve a significant increase in the nxxxxber of advanced practice nurses prepared to meet the healthcare needs of the state and region, the School of Nursing has made a commitment, supported by the XXXX Foundations \$ 9.9 million gift, to:

One: Expand the capacity for student enrollment to graduate an additional 500 advanced practice nurses in five years.

Two: Establish and lead capacity-building collaborations with nursing programs at the University of XXXXXXXX's coordinate campuses to optimize faculty, administrative and clinical resources, improve efficiencies and increase the nxxxxber of advanced practice nurses to serve the needs of greater XXXXXXXX, and create a national model for healthcare collaborations throughout the country.

This is consistent with the XXXX SON's vision of a world where nurses lead collaborative efforts to attain optimal health for all people. To achieve this vision, the XXXX SON will implement four objectives:

Objective 1: Provide scholarships and stipends to ensure the highest quality and most promising students are recruited and prepared for advanced practice nursing. One of the greatest needs students have to fully engage in graduate study is financial support. Scholarships allow more talented students to pursue advanced practice nursing degrees regardless of their ability to pay, devote more time to their studies, graduate on time and enter the workforce as soon as possible. To achieve this objective, the School of Nursing will increase scholarships and stipends for Doctor of Nursing Practice students, offering \$20,000 for the three-year program which would support approximately one-fourth the total cost of tuition.

Objective 2: Enhance and maximize technology for teaching and learning through the XXXX Healthy Communities Innovation Center. Nursing at XXXXXXXX is once again at the forefront, using this one-of-a-kind learning resource to provide an outstanding educational experience that allows for flexible learning opportunities on site and remotely. These programs allow faculty and students to engage on campus, and in their

home communities, preparing students for practice in urban and rural settings. To achieve this objective, the XXXX SON will expand the use of the Xxxx Healthy Communities Innovation Center, including investments in tele-health equipment, more faculty and classroom computers, technology stations in student lab areas, and enhanced video conferencing and distance learning capabilities.

Objective 3: Develop new clinical education sites, including practice centers in senior housing and other strategic settings, and expand existing clinical sites in the Xxxx and Greater XXXXXXXX. To achieve this objective, the School of nursing will establish new nurse-led clinics and collaborate with other health systems around the state to provide additional learning sites for students, especially in rural areas, where the need is greatest. This will ensure students have quality clinical education experiences that support learning about their advanced practice role and provide new and expanded employment opportunities for graduates throughout the state.

Objective 4: Increase the nxxxxber of faculty to support an expanded student population and evaluate ways to streamline the advanced practice curriculxxxx for efficiency while maintaining the high quality of current programs. To achieve this objective, the School of Nursing will increase its faculty and support professionals and services to meet the needs of a larger student population. This would include student recruitment, student services, advising, and clinical faculty. Partnerships with health systems would include instructional appointments for advanced practice nurses that serve as students' preceptors, and preceptor development support.

An opportunity exists to meet Objective 3 through the development of a nurse managed primary care clinic through a partnership with RS-Xxxx, Xxxx County Medical Center and the XXXX SON. Specifically, \$500,000 has been budgeted for clinical practice expansion and technology investment in Year 1. This business plan describes the development and implementation of The Nurse Center at Xxxx (NCEH), a nurse-led primary care clinic in downtown XXXXXXXXX whose purpose is to provide an interprofessional clinical site for XXXX SON students and faculty and to serve patients in Xxxx and Xxxx County.

Description of the Project

RS-Xxxx

RS-Xxxx, a commercial developer of affordable housing has recently compled an \$18 million building complex at 822 3rd Street South, XXXXXXXXX, MN named Emanuel Housing. The project renovated the existing 44,000-square-foot building on the site with adjacent new construction. The existing building, constructed in 1900, was four stories, and the new building is now five stories. The building will offer 101 apartment units for people who have been homeless, may be struggling with drug or alcohol addictions or have other challenges. RS-Xxxx has become a developer of supportive housing and has been involved in more than 400 units of housing as developer, partner or service provider. Construction on Xxxx was completed in July 2013.

RS-Xxxx integrates treatment programs for substance abuse including counseling,

chemical health, relapse prevention, health care, independent living skills and aftercare, as well as vocational and educational services into its residential facilities. To further extend the range of healthcare services to its residents, RS-Xxxx has contacted the XXXX SON to gauge their interest in developing a nurse-managed primary care clinic in 5,228 square feet (2,614 on the first floor and 2,614 in the basement) of shell space located in Xxxx. The clinic would serve residents in Xxxx as well as RS-Xxxx's residents in its other 400 affordable housing units. In addition, the clinic would be available to serve individuals living in downtown XXXXXXXXX and the greater Xxxx service area.

Xxxx County Medical Center

Xxxx County Medical Center, located three blocks from Xxxx, is a Level 1 Adult Traxxxxa Center and Level 1 Pediatric Traxxxxa Center with a system of primary care clinics and retail clinics located in XXXXXXXXX on East Lake Street, the Whittier Neighborhood and in the suburban communities of Brooklyn Center, Brooklyn Park, Richfield, and St. Anthony, as well as a retail clinic in the Walmart store in Bloomington. HCMC is a safety net hospital providing care for low-income, the uninsured and vulnerable populations. The emergency room and outpatient clinics provide 63,596 and 496,416 visits per year respectively. The HCMC Downtown Medicine Clinic sees more than 25,000 primary care patients each year by providing evaluation, diagnosis, and treatment of adult health problems and primary and preventative health services. These services are provided by an interdisciplinary health care team, which includes physicians, nurse practitioners, nurses, dietitians, psychologists, pharmacists, and social workers. HCMC also has several other outpatient specialist clinics located in the Medical Center location.

HCMC has expressed an interest in expanding its capacity to serve the growing demand for outpatient primary care clinic and emergency room services near its downtown medical center location. Given the location of the proposed nurse managed primary care clinic to HCMC primary care clinics and emergency room, members from the XXXX SON and RS-Xxxx met with representatives of HCMC to explore opportunities to collaborate and mutually benefit from a partnership. HCMC is interested in adding a nurse-managed primary care clinic to its Xxxx Health Accountable Care Organization (ACO) plan and has invited the XXXX SON to consider this.

Xxxx Health (<http://www.xxxx.us/residents/health-medical/xxxx-health>) is a nationally recognized, innovative healthcare delivery program that was approved by the XXXXXXXX State Legislature as a demonstration project in January 2012 (*Statute 256B Xxxx and Xxxx Counties Pilot Program*). The program is a collaboration to share financial risk between a medical center (Xxxx County Medical Center [HCMC] and its primary care and specialty clinics), a Federally Qualified Healthcare Center and healthcare home (NorthPoint Health and Wellness [NHW]), a health plan (Metropolitan Health Plan), and a social services and public health organization (Hxxxxan Services [HS] and Public Health Department [PHD] of Xxxx County). Xxxx Health serves adults in Xxxx County who are earning at or below 75% of the Federal Poverty Guideline (133% as of January 1, 2014) and who do not qualify for other forms of Medical Assistance. Members of HH

fit the following demographics: single adult, ages 21-64, no dependent children in the home; many are jobless, homeless, have chemical addiction or mental health problems, and are socially isolated. The state pays HH a set per-member-per-month (PMPM) fee to cover the cost of care for enrollees. In exchange for payment, HH must provide all Medicaid-Expansion covered services. Currently there are 10,000 lives covered by the ACO and a newly signed State contract will add an additional 10,000 lives to the ACO.

University of XXXXXXXX School of Nursing

The XXXX SON manages several practice agreements with different partners for advanced practice nursing services ranging from psych-mental health, primary care, women's health care to pediatrics. The SoN has practice agreements with University of XXXXXXXX Physicians, the Veterans Administration Medical Center, Children's Hospital and Clinics, HealthPartners, Fairview University of XXXXXXXX Medical Center and the Community University Healthcare Center. Currently, the School has 11 faculty participating in its practice plan or about 15% of total faculty. The XXXX SON is interested in developing a practice at Xxxx for the same reasons it has developed them with other partners. These include:

1. Providing clinical sites where students may train while under supervision of SON faculty.
2. Providing faculty opportunities to maintain their clinical skills while meeting their teaching and research responsibilities.
3. Providing faculty with opportunities to apply for grants and conduct research at clinic sites.
4. Enhancing recruitment of students and faculty.
5. Generating new sources of revenue and maintaining financial sustainability.

The XXXX SON is interested in collaborating with both RS-Xxxx and HCMC to develop a nurse managed primary care clinic to serve both residents of downtown XXXXXXXXX and clients of RS-XXXXX programs.

Primary and Secondary Market

The primary service area for the clinic is residents living in the greater downtown XXXXXXXXX area and the 20,000 lives covered by the Xxxx Health ACO. The estimated population of XXXXXXXXX and its downtown is 387,753 and 36,500 respectively. However, the XXXXXXXXX Downtown Council expects growth in the area to double to 70,000 by 2025. This growth already appears underway as records show that between 2010 and 2012, the nxxxxber of residences in downtown XXXXXXXXX doubled from 15,000 to 30,000 primarily as a result of a condominixxxx boom during the later years of the recent recession. In XXXXXXXXX, for example, new housing project s include a 26-story luxury building at 5th Street and Nicollet Mall, a high-end apartment building on 5th Street and Marquette Avenue and most recently, another new building is slated for 103 N. 2nd St. A Google Maps search returned over 5000 apartment buildings in the Greater XXXXXXXXX area. Large apartment complexes near the Xxxx include:

- Mill City District Apartments

- St. Anthony Mills Apartments
- Stone Arch Apartments
- Park Avenue Lofts
- Grandmarc Seven Apartments
- The Churchill Apartments
- River Gate Apartments
- East Village Apartments
- Seven Corners Apartments

Add to this, new events such as the Riverfest and planned projects such as the new Vikings Stadixxxx and downtown Xxxxxxxx does appear poised for growth. For example a \$400 million mixed-use development near the new Xxxxxxxx Vikings stadixxxx on the east side of downtown Xxxxxxxx has recently been approved. The five-acre project would include 1.16 million square feet of office space in a pair of 20-story towers, a 1,328-stall parking ramp, 40,000 square feet of retail and approximately 300 housing units.

The following demographics are characteristic of residents living within a one mile radius surrounding Xxxx: <http://www.city-data.com/nbmaps/neigh-Xxxxxxxx-Xxxxxxxx.html>

- Income range: \$100,000 - \$120,000
- Age Range: 20 – 40 years
- Unemployment: 5%
- Residence Value: \$300,000 - \$350,000
- Racial Diversity: 50 - 60%

The following population demographics are characteristic of residents living within a two mile radius surrounding Xxxx:

- Income Range: \$20,000 – 40,000
- Age Range: 20 – 40 years
- Unemployment: 5%
- Residence Value: \$100,000-\$150,000
- Racial Diversity: 35 – 50%

The population demographics suggest that residents within a one mile radius of Xxxx are approximately the same age, but have an income twice as high as residents living outside of the one mile radius. The downtown market suggests that residents are a young, racially diverse population with the most affluent within a mile radius of the clinic.

Xxxx County Market

The Xxxx County which includes the city of XXXXXXXXX and its suburban areas. Xxxx County has the highest census in the state of XXXXXXXXX with a population of 1,152,425.¹ The primary service area for the NCEH mirrors HCMC which includes 21 zip codes in XXXXXXXXX, Brooklyn Center, Brooklyn Park, Crystal, Golden Valley, Richfield, and St. Anthony. Its secondary service area includes an additional 13 zip codes and reaches further into Xxxx County.² Xxxx County is home to XXXXXXXXX's largest foreign-born population; 12.5% of Xxxx residents were born in a different country. The city of Brooklyn Park, located within the Centers primary and secondary service areas, had the largest increase in the proportion of its foreign-born population, jumping from 13.3% in 2000 to 25.5% in 2010. Additionally, the largest number of Somali refugees in XXXXXXXXX lives in Xxxx County. With 90 different languages spoken, Xxxx County is the eighteenth most linguistically diverse county in the United States.³

XXXXXXX also has the highest concentration of lesbian, gay, bisexual and transgender population (LGBT) in the state, making up 12.5% of the total city's population with a ranking of 4th nationwide. Between 1998 and 2010, the percentage of Xxxx County adults aged 18-64 identifying as LGBT increased by 130%.⁴ Community survey data shows LGBT respondents were more likely to engage in heavy or binge drinking, particularly those age 50 and older. Additionally, the rate of frequent mental distress, depression, and other psychological distress indicators for Xxxx County LGBT respondents was roughly twice as high as the rate for Xxxx County adults who did not identify as LGBT.⁵

The income level of Xxxx County families and households has decreased significantly over the past decade. From 1999 to 2010 the median *family* income decreased 10% to \$76,7971 while the median *household* income decreased by 11.7% to \$59,2362. In addition, the percentage of Xxxx County families living in poverty increased from 5% in 1999 to 9.4% in 2010.⁶ Within XXXXXXXXX, of the 25 zip codes surrounding the NCEH, 32% of them meet "low-income family" designation for programs included in Titles III, VII and VIII of the Public Health Service Act as having an annual income that does not exceed 200% of the Department's poverty guidelines (<http://www.city-data.com/zipmaps/XXXXXXX-XXXXXXX.html#55401>). All racial/ethnic groups, except for Asians, saw an increase in the proportion of families living in poverty. Income inequality and poverty continue to be highest among Xxxx County's racial and ethnic minority families.

¹ XXXXXXXXX Healthcare System, Inc. Health Services Plan and Community Health Needs Assessment 2013-2014, XXXXXXXXX County Medical Center, XXXXXXXXX, MN.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Survey of the Health of All the Population and the Environment (Shape 2010), Adult Data Book, XXXXXXXXX County Human Services and Public Health Department, XXXXXXXXX.

⁶ XXXXXXXXX Healthcare System, Inc. Health Services Plan and Community Health Needs Assessment 2013-2014, XXXXXXXXX County Medical Center, XXXXXXXXX, MN

In 2012, 9.4% of Xxxx County residents reported their health as fair to poor.⁷ The five leading causes of death include: cancer (23%), heart disease (16%), unintentional injury (6%), chronic lower respiratory disease (5%) and stroke (5%). However, disparities in health are evident when analyzed by income level, educational attainment, race/ethnicity, and geographic area. For example, there is a significant difference in mortality between Caucasians and other races and ethnicities in Xxxx County. Of those reporting fair to poor health, 34.5% had less than a high school education. And within Xxxxxxxx and in the zip codes immediately surrounding the NCEH, residents reported their health as fair to poor at twice the rate of Xxxx County's overall rate of 9.4%.⁸ Data on dental care also shows income- and geographic-related health disparities in Xxxx County. Areas with the lowest levels of dental care access and utilization include Xxxxxxxx neighborhoods in NCEH's primary service area and have been designated by HRSA as a HPSA (Health Professional Shortage Area) for Dental Health Shortage Designation.⁹

The NCEH will be located within the inner city of Xxxxxxxx and two blocks from HCMC. The zip codes surrounding the Center have a "Community Need Index" score in the range of 4-5 or at a rating of the highest disparity/highest community need.¹⁰

http://www.fairview.org/fv/groups/internet/docxxxents/web_content/s_093153.pdf

Community Need Index (CNI) Scores were developed by Catholic Healthcare West and Thompson Reuters. Their underlying data is used to create an objective measure of socio-economic barriers to health care access among populations and their effect on hospital admissions. CNI Scores range from a 5 (highest health disparity/highest community need) to a 1 (lowest health disparity/lowest community need). CNI Scores provide a high-level measure of community need and allow for comprehensive comparative analysis to be made on many levels ranging from individual zip code comparison to regional or multi-state comparisons.

To determine priorities that improve the health of the population and communities they serve, health boards, hospitals, health plans, clinics and other community organizations focus and align their work with the Xxxx County Community Health Improvement Plan (CHIP).¹¹ The CHIP project, convened by Xxxx County Hxxxxan Services and Public Health, engages community stakeholder organizations to identify health needs, opportunities and partners for change, and the top five strategic health issues for Xxxx County. The process involves a survey completed by 239 community organizations doing health-related work and three CHIP forxxxx sessions attended by 110 individuals from multiple sectors serving Xxxx County. This assessment was conducted using comprehensive community surveys and the data gathering was updated in December

⁷ Survey of the Health of All the Population and the Environment (Shape 2010), Adult Data Book, Xxxxxxxx County Human Services and Public Health Department, Xxxxxxxx.

⁸ Community Health Improvement Plan for Xxxxxxxx County Residents, 2012-2015, Community Health Improvement Plan[CHIPS].

⁹ Health Professional Shortage Areas & Medically Underserved Areas/Populations, Health Resources and Service Administration accessed on January 19, 2014 at <http://www.hrsa.gov/shortage>.

¹⁰ Fairview University of Xxxxxxxx Medical Center, Community Needs Assessment Plan, 2013. Accessed on January 19, 2014.

¹¹ Community Health Improvement Plan for Xxxxxxxx County Residents, 2012 – 2015, Community Health Improvement Plan [CHIPS].

2012. From the responses and data five “Community Health Priorities were identified (See Table 1). The creation of the NCEH will address many of the Community Health Priorities identified in the CHIPS plan. Specifically, two priorities, “Health Care Access” and “Social Conditions that Impact Health,” are strongly supported from the following data and responses collected from the survey:

Table 1
Community Health Improvement Plan Survey
Targeted Health Improvement Goals 2013-2015

Community Health Priority	Targeted Health Improvement Goals 2013-2015
Maternal and Child Health	Increase childhood readiness for school
Nutrition, Obesity & Physical Activity	Increase regular physical activity and proper nutrition through improvements to the physical environment
Social & Emotional Wellbeing	Increase community and social connectedness
Health Care Access	Develop health care access strategies that will help achieve the targeted goals above
Social Conditions that Impact Health	Develop strategies to address social conditions that impact the targeted goals above

Community Health Improvement Plan for Xxxx County Residents (CHIPS), 2012 – 2015

- Over one-fifth of county adults (22%) have no usual source of care. This means when they are sick or need medical care, they either have no place to go, or use an emergency room, urgent care or minute clinic. This rate far exceeds Healthy People 2020 aims to reduce persons (all ages) without usual place of care to 5% or lower.
- Adults with low income, low education, being U.S.-born Blacks, Hispanics or Latinos, experiencing recent frequent mental distress, or being lesbians, reported a higher rate of no usual place of care.
- Nearly one out of twenty Xxxx County children (4.5%) are currently uninsured compared to 3.95% in 2006. Hispanic/Latino children were significantly less likely to have access to health insurance coverage than Xxxx County children overall (29.2 % are currently uninsured). The nxxxxber of low income children who used emergency rooms or urgent care centers and had “no usual place of care” has more than doubled (from 2.4% to 6.8%) since 2006.
- In 2010, close to one in ten (9.0%) of Xxxx County adults experienced “Frequent Mental Distress” (FMD). A large geographic variation in FMD rates is observed with the highest rates in adults with low income in North and Central Xxxxxxxx (greater than 10%). Members of the LGBT community reported a rate of FMD twice as high as the rate reported by adults that are not (16.3% vs. 8.4%); the rate is highest for women in the LGBT community (19.3%).

Persons without a usual place of care are less likely to receive preventive care, more likely to have unmet health care needs, more hospitalizations, and higher costs of care.

The NCEH will improve healthcare access to the most vulnerable populations in Xxxx County including low income and education, disadvantaged race and ethnicity, LGBT, and those suffering mental illness. As a participating provider in HH the NCEH will also enhance the existing network of primary care providers and provide better coordination of services across the continuexxx of care for complex, high resource utilization patients.

The Nurse Center at Xxxx will be geographically central to the area it will serve, the surrounding neighborhoods in and adjacent to the cities of Xxxxxxxx, often called the 7-county metropolitan area (2 million population). In addressing underserved areas and racial/ethnic demographics that point to higher health risks, indicators include city, county and state (Xxxxxxxx) data. Depending on data source, slight variations exist in years and/or population descriptions, but there is a consistent pattern of need. The Center will be located in central Xxxxxxxx, an area designated as low income. While racial differences in health behaviors partially explain disparities in outcomes, lack of access to primary care contributes to ongoing disparities. *HP 2020* docxxxents the need for primary care providers in underserved areas of the country. Geographic discrepancies in the availability of primary care providers, along with other factors such as income, elderly and infant mortality rate, led to federal designation of Medically Underserved Areas (MUAs). State designated Healthcare Provider Shortage Areas (HPSAs) are broadly based on at least a 3500:1 population to full time primary care provider and expanded lower threshold for areas with unusually higher needs, e.g., poverty, excessive waiting times, and access barriers. This measure has shown a steady upward trend since 1990. While the criteria differ for these two measures, the intent is to address populations and areas designated as underserved and at-risk/vulnerable. The Xxxx 7-county metro area has MUA/Ps in Xxxx (See Table 2).

Table 2
Xxxx County MUA's

Xxxx County	Type	Score
Phillips Service Area	MUA	55.4
Pilot Service Area	MUA	47.3
Xxxxxxxx Northeast	MUA	59.5
North Xxxxxxxx Service Area	MUA	55.8
Southside Xxxxxxxx Service Area	MUA	47.1
Xxxx Service Area	MUA	48.46
Cedar Riverside Service Area	MUA	49

Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations, Health Resources and Service Administration accessed on January 19, 2014 at <http://www.hrsa.gov/shortage/>.

The HPSAs are also in Xxxx and identify two population groups (low income North and Northeast Xxxxxxxx) that correspond to MUA's, and Comprehensive Health Centers (CHCs) including Community University Health Care Center (CUHCC, a University of Xxxxxxxx owned clinic), Indian Health Board, Southside Community, Cedar Riverside People's Center, Xxxx County Medical Center, and Cedar Riverside People's Center (in Xxxxxxxx).

The NCEH staff will take an individualized, patient and family-focused approach to care; no judgments are made if individuals have never received basic care (common with immigrant families) or if certain medicines are not accepted by the family's culture. Interpreters and multilingual materials will be provided to ensure that the care provided is welcomed and followed. Table 3 provides a summary of the demographics of Xxxx County:

Table 3
Change in Census by Race/Ethnicity in Xxxx County 2000 - 2010

Race/Ethnicity	2000	Percent of Total	2010	Percent of Total	Percent Change 2000-2010
Hispanic/Latino	45,439	4.1%	77,676	6.7%	70.9%
White	881,016	78.9%	826,670	71.7%	-6.2%
Black or African American	98,698	8.8%	134,240	11.6%	36.0%
American Indian	10,212	0.9%	8,848	0.8%	-13.4%
Asian/Pacific Islander	53,702	4.8%	71,966	6.2%	34.0%
Other race	2,115	0.2%	2,321	0.2%	9.7%
Two or more races	25,018	2.2%	30,704	2.7%	22.7%
Total	1,116,200		1,152,425		3.2%

Xxxx Healthcare System, Inc. Health Services Plan and Community Health Needs Assessment 2013-2014, Xxxx Count Medical Center, XXXXXXXX, MN.

As presented in Table 3, minorities, as a percentage of the population in Xxxx County, have increased by as much as 70% between 2000 and 2010.

The secondary market for the clinic will be the 2,235 clients served through RS-Xxxx's corrections, chemical health, affordable housing divisions and Xxxx. These clients come from a diverse base of children and adults. Many clients are from neighborhoods where RS XXXX operates its programs, with the majority coming from low-income families. A substantial number are court referred. Some 70% are of races other than white; most are African American. The majority of adult clients has been abusing drugs for over a decade and/or has been in and out of various correctional institutions. Most have had one or more children by the age of 17 and have had at least one unsuccessful drug treatment experience. RS-Xxxx is interested in having a dedicated clinic that is familiar with its clients and programs where they may refer patients for primary care health problems.

A third potential market is the Somali population in the greater XXXXXXXX Community. Isuroon, an advocacy group (<http://www.isuroon.org/>) for Somali's is seeking a primary health care center that is familiar with Somali culture and healthcare needs. In meetings with the Fartun Weli (Isuroon), the Somali community would like to affiliate with one clinic or health center that would provide primary care. The nurse managed model of care is well liked by those Somalis interviewed. The estimated population of Somalis in XXXXXXXX is 32,000 most of which live in Xxxx County and the greater XXXXXXXX area.

Medical Clinics within the Downtown XXXXXXXX Market

The proposed nurse managed clinic will be located at 822 3rd Street South, XXXXXXXX, MN and one block from the new Vikings stadixxxx. Within the XXXXXXXX downtown area HCMC clinics include:

1. Internal Medicine Clinic at Parkside – 825 South 8th Street
2. Pediatric Clinic – 716 South 7th Street
3. Senior Care Center – 914 South 8th Street
4. Urgent Care Clinic – 730 South 8th Street
5. Parkside Specialty Sevices – 825 South 8th Street

Non-HCMC clinics include

1. Mill City Clinic, University of XXXXXXXX Physicians – 901 South 2nd Street
2. Target Clinic – 900 Nicollet Mall
3. Allina Hospital Clinic- Ollila Eugene W – 825 Nicollet Mall
4. Fairview Clinic Riverside – 606 24th Avenue South
5. North Memorial Clinic – 327 Central Avenue Southeast
6. University Of XXXXXXXX Medical Center Primary Care Center – 516 Delaware Street, SE
7. Community University Health Care Center – 2001 Bloomington Ave.

Description of Clinic

The proposed project will develop a primary care nursing center (NCEH) that mirrors the innovative model of care utilized by HH. The HH care model shifts from a traditional community practice paradigm to a more coordinated approach through a narrowly defined ICS focused on a low income, underserved and culturally diverse population. Traditional community practice models generally provide interventions to address one aspect of an enrollee's health problems, but are challenged by a lack of resources and tools to execute a coordinated approach to managing overall health, either individually or at a population level. This is particularly challenging for Medicaid beneficiaries who disproportionately experience chronic conditions and often face socioeconomic challenges. To address this issue, providers and payers are developing innovative payment and delivery models to help align incentives to improve quality and manage costs. Integrated care systems like accountable care organizations represent one such model and are alliances of health plans and providers that agree to take on responsibility for a defined population of patients, typically under a global budget in which partners share in any deficits or surpluses.

The care model utilized by the HH ICS has significantly improved outcomes for its underserved population of resource intensive clients with complex disease conditions. Partners have aspired to a common belief that by addressing the social, behavioral and hxxxxan service barriers and needs that patients face, and incorporating those remedies into a coordinated, comprehensive, patient-centered care plan, one can end the cycle of costly crisis care. Failing to address those issues produces costly, unsatisfactory medical results, for patients and for the programs that provide and pay for their care.

The NCEH will begin offering primary care services to individuals within its services area by October 30, 2014. By that date, renovation of space in Xxxx will be completed; furniture, equipment, and supplies purchased; and staff hired and oriented to the care model, including specific training and development activities. Currently we are working with RS-Xxxx and CERMAK RHOADES ARCHITECTS

(<http://www.cermakrhoades.com/>) to finalize space design drawings for the Clinic. Construction will begin in April 2014 and be completed by September, 2014. The clinic will begin seeing patients by October 1, 2014. The total construction cost of the project (excluding furniture and equipment) is \$461,953. RS-Xxxx will hold the lease and contribute \$170,000 toward the space build-out for tenant improvements. The clinic will contain a waiting and reception area, a billing office, five treatment rooms, a waived lab testing area, and administrative office space. RS-Xxxx will provide, at no cost, space for educational classes and meetings. Other services such as complex lab, radiology and a pharmacy will be referred to HCMC which is two blocks from the clinic.

The XXXXN SON is currently in the process of applying to the Metropolitan Health Plan to become a participating provider in the HH ICS. As a participating provider, the XXXXN SON will have the option to contract with HCMC to utilize the same electronic health record (Epic) used by HH providers. This is vital for the communication necessary to ensure safe, effective and coordinated care among health care providers, both internal and external to the organization. The electronic health record is one tool to achieve those goals and will allow providers to evaluate individuals and populations across the entire continuum of care. As a contracted provider in the HH network, the clinic will have access to HH staff training and can also share the Interprofessional Curriculum.

The XXXXN SON will recruit and hire family and psychiatric/mental health nurse practitioners and RN care coordinators, who have faculty appointments, to staff the clinic. The XXXXN SON will also collaborate with HH care coordinators that are familiar with community services and affiliate providers within the HH network and share information to assist Center staff efficiently manage patient resources. The College of Pharmacy will provide a pharmacist with a faculty appointment to the Center. Support staff, such as receptionists, a business office coordinator and medical assistants will be recruited and hired by the XXXXN SON.

The NCEH will provide an ideal setting to implement an interprofessional clinical education experiential curriculum for faculty and students. For example, the roles and competencies of nurse practitioners and pharmacists clearly complement each other. The individuals served by NCEH have complicated situations, including both physical and mental health conditions, which have advanced due to lack of primary care services, an inability to afford medications, or challenges regarding medication adherence. A pharmacist teaming with other health care providers and students can provide consultation for identifying potential drug toxicities, and recommending alternative medications when standard therapy is ineffective, contraindicated, difficult for the patient to adhere to, or unaffordable. A collaborative NP and pharmacist practice at an

ambulatory care practice found that the addition of a pharmacist improved medication use, managed treatment guidelines and interpreted computerized drug alerts.¹²

Services provided

The clinic would initially provide the following services:

- Care and treatment of primary care patients within the scope of practice for family nurse practitioners.
- Waived lab testing
- Dental Screening
- Case management/coordination of social services
- Mental health counseling
- RS-Xxxx substance abuse counseling and follow-up

Other future potential services:

- Integrated therapies
- Womens health services
- Health coaching
- Health care home
- Complimentary and alternative therapy
 - Massage
 - Aroma therapy
 - Accupuncture
 - Oriental medicine
 - Other
- Pharmacist consultation

The 2,614 on the first floor of the clinic has the capacity to provide the following functions:

- 12-15 chair waiting room
- Reception area with adjoining file room
- Five exam/treatment rooms
- Nursing station
- Waived lab area
- Two uni-sex bathrooms
- Supply and equipment room
- Clean and dirty utility room

The lower level of the clinic could provide

- One office for the business manager
- One office for the clinic manager

¹²Urbine, T., Link, T., Schneider, P., Schmitz, E., Kistler, K. (2012). *Journal for Nurse Practitioners*. 8(3):231-236

- One break/conference room
- One bathroom
- Remaining shell space

Alternative Business Models

There are two alternative business models that could be accommodated to manage clinic operations.

Alternative 1

The XXXX SON would create an internal business unit for the clinic under its existing partnership with University of XXXXXXXX Physicians (XXXXP). In partnership with the XXXX SON, XXXXP would recruit and hire the clinic manager, XXXX SON faculty and non-faculty staff for the clinic, hold the lease from RS-XXXX and make payments, provide claims processing for client billing, collect reimbursement, distribute payments to contractors for lab, radiology and services, provide general liability insurance, provide access to the Epic electronic health record (EHR), pay faculty and staff salaries and benefits. The XXXX SON would also pay all capital costs for the build-out to XXXXP who in turn would pay RS-XXXX.

Although XXXXP would act as the vehicle to establish and operationalize the clinic, the XXXX SON would be responsible for managing the day-to-operations of it. The XXXX SON would receive net income in excess of net revenue minus all clinic expenses. The XXXX SON would pay XXXXP any clinic losses.

Alternative 2

The XXXX SON would fully operate the clinic. This would include holding the lease from RS-XXXX, paying start-up and buildout costs, managing insurance claims, collecting reimbursement, contracting with payers, providing electronic billing, distributing payments to contractors for lab, radiology and services, providing general liability insurance, purchasing an electronic health record (EHR), and employing all professional and faculty staff through the XXXX SoN at the clinic.

The XXXX SON would contract with an external claims management service to process insurance billing, crxxxxtialing of providers, manage care contracting and other administrative functions.

Budget

Revenue

The payer mix for the State of XXXXXXXX is:

- 14% Medicare
- 10.8 % Medicaid
- 65% Self-insured or fully insured through employers and commercial insurance.

The Payer Mix for XXXX County Medical Center is:

- 27% Medicare

- 43% Medicaid and other public programs
- 24% HMO and other self-insured and commercial insurance
- 6% Bad debt

It is assumed the payer mix will be similar to HCMC with a high percentage of Medicaid, but lower Medicare and higher HMO and commercial insurance. The average revenue per nurse practitioner visit is estimated at \$76 (includes \$5 for CLIA waived lab fees). These fees were calculated from the Medicare and Medicaid fee schedules. No additional revenue has been estimated for other services such as integrated therapies or other services at this time. The Xxxx Health ACO is another source of revenue for the clinic and payment would be negotiated on a “per member per month basis” (PMPM). However, until we negotiate the PMPM with Xxxx Health, we will be unable to determine the impact on clinic revenue.

Expenses

Capital Start-up Costs

The total space build-out furnishings, furniture and equipment costs to accommodate the space requirements are estimated at \$461,953 (see Appendix). RS-Xxxx will contribute \$170,000 to the build out costs if a 5 year lease (\$12/sq foot) is signed. Equipment costs (furniture, medical equipment, and computer hardware) are estimated at \$60,000. Architectural fees are estimated at an estimated \$35,096. Practice management and electronic health record expenses are dependent on whether the XXXX SON contracts with XXXXP to purchase an Epic license or its own practice management and EHR software.

Staffing Plan

The hours of operation, after a one year ramp up period, would be from 8 am till 7 pm, Monday through Friday and Saturday morning 8 am till noon. Radiology and lab services (excluding waived testing) would be contracted to a third party (HCMC or other). One faculty member from the XXXX SoN would be the clinic manager while the remaining providers would be a mix of both faculty and professional staff (but employed by the XXXX SoN).

The staffing plan after a one year ramp-up period would include:

- .5 FTE clinic working manager (XXXX SoN faculty)
- 1.5 FTE of family nurse practitioners (XXXX SoN faculty and professional staff)
- 1.0 FTE of medical assistant
- .5 FTE business manager (claims management and other administrative)
- 1.5 FTE receptionist/file clerk

Coordinating of providers would be provided by XXXXP or by clinic administrative staff. The clinic would also act as a clinical training site for XXXX SoN FNP students during the week.

Recruitment of Family Nurse Practitioners (FNP)

Recruitment of FNP's to the clinic will require a focused plan. There is a shortage of NP's in the Xxxx area and a scan of the major health systems websites (Allina, Fairview, Healtheast, Health Partners and other) shows nxxxxerous openings for NP's. The average annual salary for NP's in the Xxxx Market for base salary is \$95,160 (Bureau of Labor Statistics, 2012. < <http://www.bls.gov/oes/current/oes291171.htm>>) and does not include any bonus payments or benefits. To be competitive, the XXXX SON will need to develop a compensation plan that is market competitive. One alternative is the University of XXXXXXXX's XYZ plan.

The XYX plan consists of drawing on three "buckets" of funds. One is the University base salary, "X," the regular salary, that includes state funds and pays for academic activities such as teaching and research. A second is additional University compensation, "Y," an augmentation or increment that is not guaranteed and arises from additional duties that can be academic or administration. The third element, "Z," is clinical compensation that is productivity-based and comes from patient services. In family practice, the Z portion can range from 50 - 80% of total base pay. For those portions of the salary that are X or Y, the sources of funds include tuition, O&M funds, ICR funds, grants, gifts, clinical income, and other revenues. For the Z portion, the source of funds is clinical income and contains a large productivity component.

Model of Care

The SoN has an opportunity to create a best practices model of care. Initially the clinic will operate under a traditional business model where each provider (nurse practitioner) has their own panel of patients and bills on a fee for service basis. However, with the advent of patient centered medical homes (PCMH) and ACO's, the clinic will need to quickly create a new model of care that accommodates them. For example, Xxxx County Health (ACO) has already inquired whether or not Xxxx will be a PCMH. Fortunately, the National Commission on Quality Assurance (NCQA) started recognizing "nurse-led" primary care PCMH's in October, 2010.

The clinic has also applied for a \$1.5 million HRSA Nurse Education Practice Quality and Retention (NEPQR) grant to implement an interprofessional curriculxxxx at the clinic. The team will consist of faculty and students from nursing, medicine, pharmacy, social work and dentistry.

Quality Metrics

A process for electronically reporting quality measures will need to be in place to complete the crxxxxtialing. Important measures that must be in place include:

- The XXXXXXXX Statewide Quality Reporting and Measurement System
- Meaningful Use Stage 1 and 2
- National Commission on Quality Assurance metrics

Since January 1, 2010, physician and nurse managed clinics and hospitals have been required to submit data through the Department of Health's XXXXXXXX State Quality

Health Measures reporting system < [XXXXXXX Statewide Quality Reporting and Measurement System, adopted rule \(PDF: 37KB/ 1 page\)](#) >. To do so, the clinic will need to integrate various computer applications (EHR, practice management, and quality management software) to enable the collection and reporting of these metrics on a quarterly basis. The clinic will also need to be accredited by a national organization such as the Joint Commission before certain payers will recognize the clinic as a “primary healthcare clinic”.

Financial Performance

The five year financial pro forma (see Appendix) estimates a total annual visit volume of 5,360 in Year 1 with gradual growth to 15,200 by year 5. Financial performance was analyzed by comparing practice management services under XXXXP versus Health Associates, a practice management services specializing in academic center faculty practice clinics. Under the XXXXP scenario a breakeven was achieved at the end of year 2 with total net annual operating revenue of \$664,442 by year 5. This assumes an average net revenue of \$100 per visit (average XXXXP APRN). This could vary considerably if the revenue per visit is below these estimates.